Care Before Crisis

Research on the involvement of BME communities in Early Intervention and Prevention Services in Cheshire East

April 2015

Contents

1. Executive Summary

This report outlines the findings and recommendations from a piece of research carried out by Cheshire, Halton and Warrington Race and Equality Centre (CHAWREC) for Cheshire East Council. The Council commissions services from third sector providers under the banner 'Early Intervention and Prevention' and had become aware that there was a low take up of these services among people from BME communities. CHAWREC was asked to research the reasons for this low take up.

The main findings from this research can broadly be summarised as follows:

1. The majority of Early Intervention and Prevention service providers are not aware of all the barriers faced by people from BME backgrounds when accessing services.
2. The majority of service providers are not taking steps to overcome all of these barriers. In addition, some do not see the need to do this, citing the relatively small population of people from BME backgrounds in Cheshire East to legitimise this.
3. The people from BME backgrounds spoken to were aware of the barriers faced by people from their communities. Some had experienced these barriers themselves when attempting to access services.
4. Cheshire East Council is not taking adequate steps to ensure that the services delivered under the Early Intervention and Prevention umbrella are accessible to people from BME communities.

2. Research Background

As a result of government initiatives related to adult social care, Cheshire East Council commissioned a range of services from local third sector service providers. Under the banner 'Early Intervention and Prevention', these services are aimed at those adults who are assessed as having low to moderate needs, since they no longer fall under the remit of the Council's Social Services Department. The aim of these commissioned services is to support these people in the community and prevent them from reaching crisis point, which results in distress for the individual and the need for more costly and intensive support. Each third sector provider was awarded an initial three year contract, which began in April 2014.

Early Intervention and Prevention service providers send monitoring information to the Council on a quarterly basis. After the first six months, the Council was beginning to have

concerns about the numbers of people from Black and Minority Ethnic (BME) communities accessing the services. Although ethnic monitoring information received from the service providers was patchy and incomplete, the information indicated that there was a low-take up of services among local BME populations, but the Council could not be sure what the reasons for this were.

As a result, Cheshire, Halton and Warrington Race and Equality Centre (CHAWREC) was engaged to carry out a piece of research looking at the reasons for low-take up of Early Intervention and Prevention Services among BME communities in Cheshire East and to produce recommendations on how this might be improved.

3.   Barriers to Access for BME Communities

In recent decades, the population of Cheshire East has become more ethnically diverse, rising from a BME population of 13,488 (3.8% of the total population) at the time of the 2001 Census to 23,863 (6.5% of the total population) by the 2011 Census (see Appendix for a breakdown of the population in 2011). However, people from BME groups remain very much in the minority within Cheshire East and, consequently, can be overlooked when it comes to ensuring services are adequately meeting their needs and take-up of services by people from BME groups has historically been low.

National evidence suggests that people from BME groups are more likely to suffer with poor physical and mental health when compared with the general population, and that their health problems are often more severe. These inequalities result from many interlinking factors, including social ones. However, when suffering ill-health, BME groups are over-represented among those consulting their GP but under-represented among those using social care or early intervention services.

The reasons for this under-representation are mainly due to the barriers facing BME groups when it comes to accessing services. These include language barriers, lack of awareness or information, social isolation, a lack of culturally sensitive services and stereotypical attitudes about communities. These barriers may affect the perception, availability, use and potentially the outcome or effectiveness of a service.

The low-take up of services cannot be taken as evidence that people from BME groups do not want assistance, nor can it be viewed as evidence that BME communities are simply 'looking after their own'. It is the responsibility of service providers to be aware of the barriers and ensure that they are doing all they can to overcome them.

The methodology for this research was informed by these barriers, identified in many previous studies across the UK. The research sought to understand how many of these were recognised by Early Intervention and Prevention providers and what steps, if any they were taking to overcome them. It also sought information from the perspective of BME communities, by speaking to both service users and non-service users about what might prevent or facilitate their engagement with these services.

4. Research Methods

4.1 Service provider focus groups

Two focus groups with service providers were held. Each service provider was approached and asked to nominate someone to attend. 15 of the 22 service providers were represented at these focus groups. Telephone interviews were held with representatives of three of the organisations who could not attend the focus groups, meaning that in total 18 of the 22 providers were spoken to.

The aim of the focus groups was to understand whether service providers had considered the potential barriers faced by BME communities in accessing services, any steps they had taken to overcome these barriers and where improvements were needed in both awareness of barriers and overcoming them.

4.2 Service user interviews

Each service provider was asked to approach one White British service user and one service user from a BME background to take part in an interview regarding their experiences. The aim was to compare the ways in which they each heard about the service, engaged with the service provider and their experiences of the service they received.

Unfortunately, not many of the service providers were able to provide details of service users who were willing to be contacted and only five interviews took place. Three out of

these five were from White British backgrounds, making any meaningful comparisons difficult. Therefore, the views of the BME service users have been incorporated into Section 6 of this report.

4.3 BME focus groups

Three focus groups were held with people from a range of ages and BME backgrounds, including Eastern European, African Caribbean and Indian.

The aim of these groups was to understand whether the individuals were aware of the Early Intervention and Prevention Services; how they had heard about them and whether they had used any of the services; what had prevented them accessing the services if they knew about them but had not used them; and to understand about their experiences of accessing services in general, how they become aware of them and what facilitates or prevents them from accessing them.

5. Findings and Recommendations from Service Provider Focus Groups

Since previous research has identified the potential barriers people from BME groups encounter when accessing services, we were interested in understanding whether service providers had considered these and, if so, what steps they had taken to overcome them. The focus groups were therefore structured around good practice in service provision with regards to BME groups. A list of good practice indicators was compiled and these were used to stimulate discussion. Service providers exhibiting good practice in engaging with BME communities should:

- Have a good understanding of local demographics
- Ensure information about services reaches a broad range of communities and is available in the main languages spoken locally
- Undertake effective ethnic identity and satisfaction monitoring
- Engage with partners from the BME sector to reach diverse communities
- Be able to deliver culturally appropriate services and avoid stereotypical assumptions
- Have policy and practice guidelines relating to working with BME service users
- Consult with BME communities when developing services

The findings from the service provider focus groups have been analysed in line with these good practice indicators and the findings and recommendations follow.

5.1 Understanding local demographics

In order for service providers to adequately respond to the diversity of their users, they should have a good knowledge of the community they serve in terms of its ethnic make-up.

5.1.1 Findings

- The majority of service providers did not demonstrate a good understanding of local demographics in terms of ethnicity or religion. Most relied on the limited diversity of people they saw coming through the door as an indicator of diversity in the local population. Few indicated that they had sought information on demographics in order to understand the community they served

- Some service providers were aware that they could get information on demographics from the Census, although none said they had done this. None indicated that they were aware of other sources of information about the local population, such as ethnic monitoring data from GPs or data on National Insurance Registrations made by people coming from outside of the UK.

- Most of the service providers spoken to felt that it was the responsibility of the local authority to provide them with demographic information, although some were unsure whether the local authority themselves would have this information. Some felt that if the local authority wanted them to engage with BME communities, they needed to demonstrate the 'need' via quantitative information. These providers said that they needed this in order to justify the allocation of the extra time and resources that they felt it would take to engage with these communities.

5.1.2 Recommendations

- Service providers need to understand the communities they are serving. Without this knowledge, they are not able to design and deliver appropriate services or provide information in the relevant formats and at relevant locations.

- Service providers should take responsibility for finding out about the communities they serve and ensure their information remains up to date. Improved information sharing between providers would aid this.

- Service providers must be aware that demographics are ever changing and, as a consequence, the needs of local BME communities will change too.

- Staff should receive training on how to access and interpret demographic information.

5.2 Ethnic identity and satisfaction monitoring

Effective monitoring enables service providers to assess whether their client group is representative of the wider population. Satisfaction monitoring allows providers to identify successful engagement methods and forms of service delivery, as well as highlighting areas for improvement.

5.2.1 Findings

- All providers spoke about the ethnic identity monitoring information that they are required to provide to the local authority as part of their contract to deliver services. None said they monitor satisfaction by ethnicity.

- Whilst some providers felt the information they provided was as accurate as it could be, the majority felt that it was still rather patchy. They felt this was due to some staff being reluctant to ask clients about their ethnic identity for fear of offending or because they were not sure when to bring this up. One provider described how they ask for clients' ethnic identity at the end of their relationship with them, when they send out satisfaction questionnaires, but that this was on a separate sheet from the main questionnaire and often was not returned.

- Some felt that the local authority was using the ethnic monitoring information produced by service providers to build up a picture of the local BME population. They felt that this type of information sharing was a good thing and that it should be encouraged between the service providers themselves as well as with the local authority.

- Very few of the service providers were able to describe how they use ethnic identity monitoring information within their own organisations. Those that did tended to be from larger, national organisations where the data is collated and analysed centrally.

- Those who receive referrals from public sector agencies such as hospitals, GPs and the local authority, reported that the ethnic identity and religion of the client is rarely passed on as part of the referral. This means that they are not able to think about how best to meet a client's potential needs regarding ethnicity or religion ahead of their first contact with them. It also means that clients are being asked for this information again following the referral.

- None indicated that they had worked with referral agencies to understand how these organisations' client diversity compared with their own and whether they were seeing more or less clients from BME backgrounds than the referral agencies. However, some did suggest that this could be a route for them to explore in order to understand whether there was a difference and, if so, what the causes were.

- All said that the number of service users they saw from BME communities was very low. Some used these numbers as a basis for decision making about whether they should put resources into attempting to engage further with BME communities. The rationale being that if numbers were low, then there probably weren't sufficient numbers to justify resource allocation.

- There was little evidence that any of the service providers recognised that the relatively low numbers of BME people present in Cheshire East increases the risk of social isolation and increases the likelihood that there will be a lack of appropriate services

5.2.2 Recommendations

- Effective monitoring of ethnic identity must be viewed by service providers as crucial to understanding who they are serving and whether they need to increase engagement efforts with particular groups.

- Front line staff should be trained on the importance of effective ethnic identity monitoring and when and how to collect this information.

- Service providers should re-evaluate when and how they request information on ethnic identity. For example, consider whether it is necessary for this to be on a separate sheet when sending out questionnaires.

- Service providers should monitor satisfaction by ethnic group. This will enable them to identify how well they are serving the needs of diverse groups and whether improvements need to be made.

- Referral agencies must provide accurate information on clients' ethnicity and religion to service providers. Service providers must then use this information to ensure they are prepared when dealing with BME people on pre-arranged appointments.

- Ethnic identity monitoring information should be shared between providers to help build up a picture of who is accessing services and where they are.

5.3 Diversity in staff and volunteers

A diverse workforce enables service providers to be more reflective of the communities they serve and thus increases their cultural relevance, meaning people from BME backgrounds are more likely to find the service inclusive. Furthermore, the level of engagement between a staff member or volunteer and the service user may be enhanced if there is a shared ethnic or cultural background, or individuals may feel more comfortable talking to 'strangers' in their first language. A diverse workforce also helps foster cultural competence among the organisations' staff and volunteers.

5.3.1 Findings

- There was evidence that some providers recognised the benefits of a diverse workforce and had recruited both employees and volunteers from BME backgrounds. These providers were able to articulate the benefits of this, which included an increased awareness of diversity and cultural difference among staff in general.

- However, the majority did not indicate that they had taken positive steps to attract employees or volunteers from BME communities. It was unclear whether this was because they hadn't considered it or whether they had considered it but did not feel there would be sufficient benefit.

- Some providers did describe how they were aware that their organisation might appear to be wholly 'white middle class' and that this might be perceived as a barrier to people from BME backgrounds.

5.3.2 Recommendations

- Service providers should make themselves aware of the benefits of recruiting staff and volunteers from BME backgrounds.

- Service providers should take positive steps to engage with BME communities when recruiting staff and volunteers.

- Service providers should consider advertising vacancies via media that is targeted towards people from BME groups, or in venues that BME people might be more likely to frequent.

5.4 Cultural awareness and stereotyping

In order to provide culturally appropriate services, providers must be aware of the differences and similarities between and within cultures, including their own, in order to design responsive services. They should be aware of the potential stereotypes associated with different cultures and avoid applying these in service design and delivery. They should also be able to provide appropriate translation and interpreting services.

5.4.1 Findings

- Most providers said they did not actively seek information on how to provide culturally appropriate services to clients from diverse backgrounds and did not feel culturally competent with regards to dealing with many groups of people.

- Since most service providers did not have a good understanding of the demographics in their local communities, they were not able to identify which cultures it would be most beneficial for their staff to understand.

- Some of the larger service providers had given some consideration to training their staff in dealing with members of the most populous BME community, those from Eastern Europe, but felt there was probably more that could be done.

- Although some had provided culturally appropriate services to some of their clients, this had been done on an ad hoc basis. Therefore, they had responded to a specific individual's needs as they were presented with them. In terms of providing culturally appropriate services, one provider described it as: 'It's suck it and see, see how you get on with them', before considering how the service might be made more appropriate.

- There was no indication that providers understood the importance of being culturally competent before a client approached them, rather than retrospectively.

- Most providers said they felt that they would be able to respond positively in order to provide culturally appropriate services, although again this would be in a reactive rather than proactive manner. One or two were able to give examples, for instance one had been able to respond to a client request to see only female staff. In general, though, understanding of the types of cultural differences providers might come across appeared to be limited.

- There did appear to be a tendency for providers to believe that because BME groups are a minority, their needs are either marginal or will be covered by more general approaches.

- Some of the larger providers knew who they would contact for translation services, if required. However, most providers said they would identify a translator as and when the need arose. None indicated that they were aware of the most frequently spoken languages in their local area.

- There was little evidence that providers had sought information about the types of illnesses most likely to be experienced by members of particular BME communities (e.g. the high incidence of schizophrenia among African Caribbean people), nor any of the cultural attitudes or lack of awareness regarding some illnesses and how to access help within particular communities. One provider did mention that there are different cultural attitudes towards health provision, but admitted they hadn't looked into that, despite being a provider of help in this area.

- If providers felt the need to learn more about a particular community, there were a limited number of ways they said they might go about this. The larger providers said they would be able to speak to colleagues in areas with large numbers of people from particular communities and get advice on how to work effectively with them. One or two smaller providers said they could work with similar organisations in other areas of the country to achieve the same ends and some said they would seek advice from CHAWREC. However, the majority of providers did not appear to have considered how they could get information and advice on working with particular groups.

- There was some evidence of cultural stereotyping, particularly in relation to people from Eastern Europe. Some described these communities as 'closed', 'difficult to access' or not interested in accessing services. However, in discussion these same providers described very limited attempts to engage with people from these communities.

- There was no evidence that any of the providers were aware of the public sector duties set out in the Equality Act 2010 and their responsibilities with regards to these.

5.4.2 Recommendations

- Service providers must be aware of their legal obligations to provide culturally appropriate services that can be accessed by everyone in the community they serve.

- Services must be organised so that cultural preferences, such as the gender of a worker, can be accommodated as far as is practicable. It is important to set out what is appropriate for each community, but service providers should:

  - be aware of cultural differences
  - avoid making culturally specific assumptions

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- ask people how their needs can be met in an appropriate way

- It should be recognised that we do not all have the same needs, therefore treating everyone identically will not further equality. Each individual's circumstances are constrained by barriers, structures, processes and experience.

- BME people will come with different life experiences, values and cultures, which often need recognition and empathy.

- Service providers should plan how to make their services culturally appropriate, not respond to need as it arises.

- All staff should be trained on cultural diversity and cultural competence to increase confidence and avoid racial stereotyping.

- Language difficulties may make it harder to access help practically and emotionally. Service providers should ensure they have access to reliable translation and interpreting services. This might be a service that can be shared by all providers and a reduction in cost negotiated.

- Front line staff should attend training on working with and without interpreters.

- Management staff should attend training on the Equality Act 2010 and their duties with regard to this. They should also be trained in understanding institutional racism and how it operates to disadvantage some groups.

5.5 Information and engagement

One of the main barriers to services for BME people is a lack of awareness about what is available. Information about services must therefore be available in the places that BME people are likely to frequent (e.g. faith centres, community centres, BME specific shops) and available in the languages spoken locally. Service providers also need to engage with BME communities through events, information sessions and more informal methods. This can be achieved by building effective networks with third sector and community groups who serve BME communities and by building links and trust within the communities themselves.

5.5.1 Findings

- There was an awareness among the majority of providers that they could do more to reach out to BME communities. Despite this, many cited a lack of time and resources as being limiting factors to achieving this.

- The majority of providers described a lack of awareness about where and how to make contact with people from BME communities. Only a few had contacted local BME community groups such as OCEAN. None described having worked with CHAWREC to engage.

- In the main, providers described very limited attempts at engagement with some sections of the BME communities. For example, one provider described how they had spoken to a group of Polish people about their services, but since no-one had come forward to receive the service as a result, the provider assumed they were not interested.

- Some providers did not feel there was a need for them to reach out specifically to BME communities, as if members of these communities needed their services then they would come forward. They required 'evidence' that there was a large enough requirement for their services among the BME population for them to seek to engage.

- There was limited evidence that providers had sought to ensure that information about their services was available in places that BME communities were likely to frequent.

- Most providers had given some thought to providing their literature in a variety of languages, although few had done this. Most were not aware of the languages spoken locally and were therefore unsure which languages it would be most useful to have their literature translated into. Others were under the impression that they would have to have it translated into an almost never ending number of languages.

- None of the providers spoke about a need to ensure that the images used on their literature and advertising was representative of diverse communities.

- Many providers described how they felt they were 'open to everyone' and 'did not discriminate', feeling that anyone would feel comfortable using their services. There was little evidence that providers had considered how the impact of being in a minority or previous experience of racism or discrimination might lead to mistrust and a reluctance to engage on the part of people from BME communities.

- Wishing Well stood out as an exception to many of these findings, as evidenced in the case study on page 18.

5.5.2 Recommendations

- Raising awareness of Early Intervention & Prevention Services within BME communities is a critical part of improving the uptake of these services. Service providers are urged to ensure that information about services is available in places frequented by BME groups and in the languages spoken locally. They should also utilise social media, especially

groups set up specifically for BME communities and other forms of BME targeted media such as newsletters and cultural radio shows and have a presence at cultural events such as Diwali, Eid and Chinese New Year.

- Service providers must recognise that they have a legal duty to ensure information about their services is available to people from BME groups in accessible formats. An institutionally racist approach to service delivery would locate the responsibility for finding out about and accessing services with BME people themselves.

- Providers should develop an awareness of the different ways in which people from different groups access information. In some BME communities, this is often done in informal ways, by word of mouth or from trusted sources.

- Providers need to seek the advice and guidance of third sector and community organisations on how to effectively engage with different groups of people.

- Service providers should consider delivering services or holding engagement events in locations that are familiar to BME communities.

- Providers must recognise that it will take time to build trust with some communities and that holding one-off events will not be sufficient. A variety of repeated interventions will help build success.

- All staff should be aware of the potential barriers to engagement faced by people from BME backgrounds and work consistently to overcome these in their own service delivery.

- Monitoring of take-up of services by ethnicity and how users heard about the service are crucial to establishing a picture of how and when information is accessed and utilised.

Engagement Case Study – The Wishing Well Project

The Wishing Well Project, based in Crewe, stood out as an example of successful engagement with people from a range of BME backgrounds. Although members of the staff team acknowledge that this is something that has developed organically, rather than as a result of a specific strategy to engage BME communities, it has nonetheless enabled the project to engage with a diverse range of groups.

Partnership Working

The project works in partnership with OCEAN, a multi-ethnic community group, who run activities at Wishing Well, including a very successful Caribbean cookery class. One of the results of this partnership has been increased contact between members of OCEAN and those in the wider community who use Wishing Well's services.

There has also been close partnership working with ESOL classes that are run from Wishing Well's centres. Wishing Well staff noticed that people attending the classes were not staying on to take part in any of the other activities taking place at the centre. Although it would have been easy to assume these people 'didn't want to engage' or preferred to 'keep themselves to themselves', Wishing Well decided to find out why. Having spoken to the students, they discovered that they thought the activities weren't for them, that they weren't entitled to take part. Staff began to address these issues by inviting the students along to specific engagement events, such as a 'pamper night' they were holding to attract new clients. As a result, many students are now actively engaged with a number of the activities run by the project.

Information & Engagement

Staff at the project recognise the need to get information out to diverse communities and actively engage. As one member of staff put it "I find the easiest way to go about it is just to turn up and talk to people....sing about what goes on in the community and welcome them". This is done in a number of ways, for example by attending local GP clinics and talking to people from BME backgrounds about Wishing Well's services; by giving information to schools to be passed on to parents; and by holding information events. For example, Wishing Well worked with local Health Visitors to arrange a presentation to BME mothers and babies on the summer play activities that would be running that year. As a result of this session, the mothers regularly attended the play sessions, making friends and connections with other BME and White British mothers. At the end of the six weekly sessions, the mothers decided to hold a 'bring and share' event, where each brought in traditional dishes

from their own culture and shared them with each other. This resulted in a continued link with Wishing Well for a number of these women, some of whom went on to attend courses at the project.

The staff at Wishing Well acknowledge that there is still much to do in terms of spreading the word among BME communities about their services, breaking down barriers and delivering culturally competent services. However, by reaching out to and including people from BME communities in the work that they do, Wishing Well have already created a solid foundation on which to continue to build trust and engage a diverse range of service users.

5.6 Consultation

When designing services, consultation with BME communities is key to ensuring that the services being developed are accessible to all.

5.6.1 Findings

- None of the service providers said they had specifically consulted with BME communities when designing their services.

- Many said the only consultation they carry out is with existing service users.

- Some providers described how they design their services according to what commissioners are looking for and carry out little if any consultation regarding this. With regard to BME consultation as part of the commissioning process, one provider described how "We like to make sure that what we're proposing is consistent with their [the commissioning agency's] service direction and I guess we rather lazily assume if there's a BME dimension they would raise it with us".

5.6.2 Recommendations

- Cheshire East Council must ensure that as part of the commissioning process they ensure service providers have consulted with BME communities and that the services they are proposing take account of the findings from these consultations.

- Consultation with a diverse range of communities must become an integral part of providers' service development process. The services they provide must be culturally appropriate and consultation is an important way of ensuring this is the case.

- Providers should consult with BME communities using the networks provided by organisations like CHAWREC and by soliciting feedback from BME service users.

- Service providers need to be aware that health and social issues may be understood and viewed differently by people from different cultures. It is very important that any service planning and delivery reflect this.

5.7 Policies and procedures

The existence and application of policies and practice guidelines relating to working with people from BME groups is essential to ensuring equity in service delivery. This goes beyond simply having an equality and diversity statement or policy, towards a much more practical set of guidelines that outline how staff are expected to engage with BME communities, develop and implement cultural competence skills, provide services that are accessible to people of all backgrounds and so on.

5.7.1   Findings

- Most service providers described having an equality and diversity statement or policy, but none described policy and practice guidelines for working with people from BME groups.

- The majority of providers who said they had an equality and diversity policy said it was not an active document, but once read as a new member of staff remained on the shelf.

5.7.2 Recommendations

- Cheshire East Council must make the existence and application of policy and practice guidelines a requirement for any organisation seeking to be commissioned to deliver services.

- Service providers must develop these policy and practice guidelines and ensure they remain relevant, are updated when new services are developed and are consistently applied by all members of staff. The guidelines should be developed in accordance with the recommendations contained under each heading in this document.

6. BME Focus Groups and Interviews with Service Users

The following findings come from the interviews with service users from BME backgrounds and from the focus groups. They have been grouped to reflect the themes that emerged from these discussions.

6.1 Finding out about services

- The service users from BME backgrounds who were interviewed both said that they had been referred to the service by another agency. Had it not been for this referral, they said they would not have known that the service existed. Neither of them were aware of any of the other services offered under the Early Intervention and Prevention umbrella.

- The focus group participants (none of whom were service users) said they were not aware of any of the services available with regards to Early Intervention and Prevention. Some of the participants were interested in a number of the services offered, but had not heard of them before.

- Some participants said that they did not feel the services were for them, either because they were not relevant to them at that particular time or because they felt that these types of services might not be available to people who had moved to the UK from abroad.

- There was a strong desire from participants for more information about services to be available in places that they frequent (e.g. schools, community centres, shops, faith centres) or for service providers to visit their clubs and events with information. They would also welcome being invited along to any awareness raising events that take place.

- There was also a strong desire for information about services to be made available in the main languages spoken locally.

- Most participants described how they gained a lot of information about the availability of services from informal sources, such as friends and family, in shops, cafes, or from trusted community sources.

- A number of participants described how they also use social media to get information about what is happening in their local community.

6.2 Experience of using services

- Both the service users who were interviewed said their experiences with their providers had been very positive and they did not feel that their ethnicity had made any difference to the way in which they received the service. Both said they did not have any particular

religious or cultural requirements, neither did they require translation or interpreting services.

- In the focus groups, some participants said that when accessing services in general they had received what they thought to be a good service and had positive experiences. However, others described how they did not always feel they received a very warm reception from service providers and sometimes felt they might be regarded as a nuisance, particularly if they required an interpreter.

- Some participants described how their experiences with some providers had been so negative that it had prevented them going back to that provider and had made it less likely for them to engage with other services. Negative experiences included not being able to make themselves understood because interpreters could not be made available; staff who did not appear to make any effort to help if English was not the client's first language; not receiving a service that fitted their needs; and experiencing stereotypical assumptions from staff about them and their families.

- All participants in the focus groups who said they would benefit from interpreters did not expect an interpreter to be available immediately. They said what would be useful would be for staff to be better informed about how to go about getting an interpreter and to be able to tell them when one would be available and therefore when they should come back.

- A few of the focus group participants said that they were reluctant to approach service providers in case by receiving services they put themselves at risk of losing out on benefits, such as Tax Credits or some disability benefits. Others thought that some of the Early Intervention and Prevention services might only be available to people who are unemployed and therefore not for them.

- None of the participants said they would have any objection to being asked for their ethnic identity, particularly if it was explained to them why this information was required and how it would be used. They did say, though, that there are more and less appropriate times to be asked this. One participant, for example, had been asked before they had been given a chance to explain what they were enquiring about.

6.3 Consultation regarding services

- Both the service users who were interviewed and the majority of participants in the focus groups said they would welcome being consulted on future service development.

- None said they were currently aware of how they could contribute to future service development. One of the service users said they had completed a questionnaire about the service they received, but were not sure how the information they gave was used.

- Some participants in the focus groups were keen to stress that service providers should ensure consultation takes place more often at the 'grass roots' of BME communities. They felt that the views of educated, affluent people, or those who 'shout loudest' are more likely to be considered because they are more likely to be consulted. They felt that service providers in general could do more to engage with the wider communities.

7. Conclusions

The main findings from this research can broadly be summarised as follows:

1. The majority of Early Intervention and Prevention service providers are not aware of all the barriers faced by people from BME backgrounds when accessing services.
2. The majority of service providers are not taking steps to overcome all of these barriers. In addition, some do not see the need to do this, citing the relatively small population of people from BME backgrounds in Cheshire East to legitimise this.
3. The people from BME backgrounds spoken to were aware of the barriers faced by people from their communities. Some had experienced these barriers themselves when attempting to access services.
4. As the Commissioner, Cheshire East Council needs to take steps to ensure that the services delivered under the Early Intervention and Prevention umbrella are accessible to people from BME communities.

It was clear that the majority of service providers were concerned at the low take-up of Early Intervention and Prevention Services among people from BME backgrounds. However, it was also clear that many struggled to come up with ways in which they could improve this situation and in many cases didn't see the need as numbers were low.

Cheshire East Council must ensure that service providers are aware that engaging with BME communities is not an optional extra that they can chose to do or not do depending on whether they feel there is enough 'evidence' to warrant it. There is a moral and legal duty for each and every organisation to ensure that the services they deliver are accessible to

everyone in the communities they serve. In this context, accessible means breaking down those barriers that potentially prevent BME people from using their services.

The Equality Act 2010 places on all public bodies a general duty to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities. This means that when they provide services to the public they must consider these three separate 'arms' of the duty. The term public body is one that is defined widely as it includes bodies that are carrying out public functions; which affects voluntary sector groups taking on public service contracts and also private organisations who bid for public services. Service providers have a legal duty to offer services that are accessible and appropriate to all sectors of the community, irrespective of ethnic origin.

Prior to the Equality Act, The Stephen Lawrence Inquiry Report drew attention to the widespread existence of racism in public services and broadened the debate beyond extreme and crude forms of violent racism by including the more subtle but equally dangerous concept of 'institutional racism'. Institutional racism is described as:

> *"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviours which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people. It persists because of the failure of the organisation openly and adequately to recognise and address its existence and causes by policy, example and leadership."* (*The Stephen Lawrence Inquiry*, Macperson, 1999:28)

By failing to consider the needs of BME communities, therefore, service providers are not only failing in their duty under the Equality Act, but also potentially acting in ways that, by definition, are institutionally racist. This is not to suggest that any service providers are deliberately excluding BME service users, but that this may be the unintentional outcome of failing to provide fully accessible services.

By acting upon the recommendations in this report, Cheshire East Council and the providers they have commissioned to provide Early Intervention and Prevention Services, can ensure that they comply with the legal requirements in this area. However, more importantly, they can ensure that people from BME communities are able to access these services in the sure

knowledge that they will be equitable; will recognise and take account of barriers; and are sympathetic to difference in experiences and points of view. These must be the goals of any service that seeks to reduce social isolation and prevent crisis point being reached among members of <u>all</u> sections of the communities they serve.

Appendix: Cheshire East Population by Ethnicity, 2011

	White				Mixed Heritage				Asian/British Asian					Black/Black British			Other Ethnic Groups		Total
	British	Irish	Gypsy & Irish Traveller	Other White	White & Black Caribbean	White & Black African	White & Asian	Other	Indian	Pakistani	Bangladeshi	Chinese	Other	African	Caribbean	Other	Arab	Any Other	
Number	346,264	2,241	313	9,122	1,341	461	1,293	778	2,147	856	504	1,125	1,428	664	511	227	338	514	370,127
%	93.6%	0.6%	0.1%	2.5%	0.4%	0.1%	0.3%	0.2%	0.6%	0.2%	0.1%	0.3%	0.4%	0.2%	0.1%	0.1%	0.1%	0.1%	100.0%

Table 1: Total Population, Cheshire East 2011. Source: ONS, Census 2011

	Irish	Gypsy & Irish Traveller	Other White	Mixed Heritage	Asian	Black	Other Groups	Total BME
Number	2,241	313	9,122	3,873	6,060	1,402	852	23,863
% of BME Population	9.4%	1.3%	38.2%	16.2%	25.4%	5.9%	3.6%	100.0%

Table 2: Cheshire East BME Populations 2011. Source: ONS, Census 2011