Equality and diversity issues within Family Intervention Projects – some observations on advice in publications, and from Key Workers

Karamat Iqbal, Forward Partnership, December 2009

Foreword

Karamat Iqbal, Diversity Consultant was commissioned by the then DCSF to:

1. ***To note some key points, selectively, from advice in a range of publications on equality issues in service provision, for readers to consider any implications for Family Intervention Projects.***
2. ***To interview informally Key Workers from Family Intervention Projects and report some of their experiences of equality and diversity issues within Family Intervention Projects***

Background information about the consultant can be found at http://www.forwardpartnership.org.uk/.

Note that this report, and the report from which it was drawn, were not subject to the rigorous criteria required by the Department, e.g., from a literature review process, questionnaire design or sampling stratification for interviews. The objectives of the work were (a) to use the insights and expertise of the Forward Partnership, and Karamat Iqbal, selectively to raise a set of issues from advice contained in past publications – issues that could be of interest to Key Workers and others in agencies that work with families with multiple problems; (b) again selectively, to report on some of the observations made by Key Workers during informal semi-structured interviews. The purpose of the report, therefore, is to be a 'prompt for practice'; food for thought on equality and diversity issues for practitioners to discuss and consider as they go about the planning and delivery of services.

We hope the report makes interesting reading for colleagues in the field and elsewhere.

Note that the findings in the report do not reflect Government policy or the views of the Department for Education.

1) PUBLICATIONS ON EQUALITY OF SERVICE PROVISION AND SOME ISSUES RAISED FOR CONSIDERATION BY FAMILY INTERVENTION PROJECTS AND SERVICES

Introduction

In order to provide equality of service provision, it is essential to understand barriers that can be faced by disadvantaged groups such as BME (black and minority ethnic) communities, as well as understanding how to deliver services to diverse customers. A number of key reports and documents (Katz et al[1], National Audit Office[2], DES[3], BRAP[4] and Shelter[5]) have provided helpful advice in this respect. Some key findings – key in the view of the author - are included below, firstly as a list of barriers and secondly, methods to promote equality in service provision.

Barriers to service provision

Service users can face a number of barriers when accessing services. Four such barrier types are listed below:

Physical and practical barriers: lack of knowledge of how the service would be able to help; lack of transport; geographical location of services.

Social barriers: institutions and structures that may focus on individual characteristics, like gender and ethnicity. For example, research[6] has found that the majority of parenting services are framed around mothers, thus pointing to a need for specific efforts to be made to engage fathers.

Cultural barriers: intervention programmes may veer towards a cultural norm, white and middle class, that could disadvantage non-white service users and those from lower socio-economic groups. . Katz et al[7], in their study of parenting programmes, point out that most such programmes originated from "white middle class values which do not automatically recognise different cultural attitudes towards child rearing".

---

[1] Katz I et al *Barriers to inclusion and successful engagement of parents in mainstream services,* Joseph Rowntree Foundation 2007

[2] National Audit Office *Delivering public services to a diverse society 2004*

[3]DES *Improving services to meet the needs of minority ethnic children and families 2006*

[4] Birmingham Race Action Partnership: *Drug treatment and prevention services in Birmingham- a culturally competent approach* 2002

[5] Shelter: The advice gap 2007

[6] Daniel B and Taylor J Engaging with Fathers (2001)

[7] Katz I, La Placa V, Hunter S: *Barriers to inclusion and successful engagement of parents in mainstream services Joseph Rowntree Foundation 2007*

Shelter [8] noted out that there can be a perception amongst BME communities that their cultural needs would not be understood or acknowledged. The report also pointed to a feeling of discomfort amongst communities when seeking advice from outside people. "Generally, this seemed to be because seeking advice and help with a problem was seen as a sign of weakness and there was a strong desire among many communities to be independent".

Linguistic barriers: these exist especially, though not exclusively, for people for whom English is their additional language. Even though agencies sometimes provide translated materials this may not be of use if service users are not literate in their first language. For example, it has been estimated that approximately a third of Pakistanis in the UK are Kashmiris, many of whom are not literate in their country's national language, Urdu[9].

Delivering 'equal' services to diverse customers

It is important to address the above barriers which can be faced by many service users, but especially by BME communities. However, removing such barriers alone may not be enough; more could be done in the form of '*positive action'*. It is also essential to be clear that equality does not mean '*sameness'.*

'Equalities in service delivery is not about providing the same service to all, nor is it about treating all people in the same way. It is about adapting the service to meet the diverse needs of different groups of people. There is no ***'standard'*** *service user with* ***'standard'*** *needs.'* City of Salford[10]

'All children and their families are entitled to equal access to services which do not discriminate on the grounds of religion, ethnic origin, linguistic background, culture, gender, disability, or sexual orientation. However, this does not mean that all children and their families will receive an identical service but rather that services will recognise and respect their particular differences and meet their particular needs.' Bradford District Parenting Strategy 2007

This point is reinforced by Barry[11], who uses the analogy of all soldiers being issued with size 8 boots, pointing out that those who are a smaller or larger size would be treated unfairly.

Following are some of the components which go towards providing equality of service provision:

Needs assessment: To gather adequate information on the needs and make-up of the customer base, including identifying different service delivery needs. Needs should also be

[8] Op cit

[9] http://www.leeds.ac.uk/writingbritishasiancities/assets/papers/WBAC001.pdf

[10] http://www.salford.gov.uk/servicedelivery.htm downloaded 26 11 09

[11] http://politics.as.nyu.edu/docs/IO/4758/barry.pdf downloaded 26 11 09

identified across equality strands, such as ethnic minority women or Muslim men. Only reliable data should be used and should include grassroots sources wherever possible as they are more likely to be current, and also especially able to provide qualitative information.

In a needs assessment process, it has to be borne in mind that sometimes there can be a view taken by 'community leaders' who wish to present a 'perfect' image of their community (*we don't have a problem with ....; we can take care of our own problems*); and service providers who may not attach sufficient weight to why some sections of a community are not provided services (*they don't have a problem with .....; they can take care of their own problems*). Chantler[12] and Fountain[13] point out that there is greater likelihood of such 'denial' of need where community leaders feel a sense of shame, for example in accepting drug problem or domestic violence; meanwhile the needs go on being ignored. The view is supported by Izzidien's [14] research into domestic violence affecting Asian women.

At a wider level of need, Modood et al[15] provide a comprehensive picture of BME communities in the UK. This included a number of chapters, which are likely to be of interest to FIPs, e.g. people, families and households; income and standards of living, neighbourhoods and housing, and culture and identity. More recently, reports from the SEU[16] have provided information on the particular disadvantages faced by BME families. A useful paper on parenting was also produced by REU[17], which included sections on family life, challenges facing BME families, and support parents have requested.

In addition to the above, there is occasional and local research which sometimes points to problems and issues within the BME communities which were not there at all before, or were not as common. These include incidence of lone parent families, marriage break-up, alcohol and drug abuse, gang violence or multiple family members ending up in prison.

Working with BME community: To establish regular channels of communication with a wide range of stakeholders to engage them in the design, implementation and subsequent evaluation of services to meet the needs of diverse customers. However, Johnson[18] points out that the building of trust can be a very slow process and recommends that the community is informed of the service being promoted. The workers learn about the community and its diversity and use is made of satellite venues. Taking a 'community

[12] Chantler K: *An analysis of present drug service delivery to black communities in Greater Manchester BWDF 1998;*

[13] Fountain et al *Black and minority ethnic communities in England- a review of the literature on drug use and related service provision University of Central Lancashire 2003*

[14] Izzidien S *I can't tell people whats happening at home* NSPCC 2008

[15] Modood T et al E*thnic minorities in Britain* PSI 1997

[16] SEU *Minority ethnic issues in social exclusion and neighbourhood renewal* 2000; *Breaking the cycle* 2004

[17] Bignall T and Butt J *Parenting* REU 2001

[18] Johnson M *Alcohol issues and the South Asian and African Caribbean communities, http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0028.pdf downloaded 22 November 2009*

development' approach can also be a way of empowering service users, some of whom may have the potential to become role models and peer mentors for others. The AMBER project sighted by Page and Whitting[19] was an example where parents of school children go on to work with more parents. Views of existing and previous service users should also be elicited in order to make service improvements.

Working with family members: many BME service users operate in a family context. This can either be in an extended family or 'nuclear with extended family nearby' as Fernandez[20] found in Camden. In terms of service providers, Johnson[21] found that all of them cited the need to work with family members in addressing alcohol issues in a BME context. Involvement by the wider family was also recommended by the DoH[22], in their work with family's problems arising out of drug abuse; the work was undertaken with BME communities in Birmingham. Barn et al [23] in their report on the use of family group conferences with BME families also stress the involvement of wider family and elders.

Cultural competence: This was described by the NASW[24] in the US as an *"ongoing process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, sexes, ethnic backgrounds, religions, sexual orientations, abilities and other diversity factors in a manner that recognizes, affirms and values the worth of individuals, families, and communities and protects and preserves the dignity of each".*

Barn[25] states that "understanding the culture of the families was important as culture was an interface through which families' requirements could be explored and their needs respectively addressed".

Such cultural competence can be a particular necessity for people working in 'sensitive' areas of service provision. So they know, for example, when a client is unnecessarily referring to their racial or religious origin in order to take advantage in a given situation. It can also help them guard against fear of unjustifiable accusations of being racist as, according to Garnham QC during the Climbie case "such fear can stop people acting when otherwise they would". Such fear was also sighted in the Tyra Henry and Sukina child abuse cases.

---

[19] Page J and Whitting G: *Engaging effectively with black and minority ethnic parents in children's and parental services DCSF 2007*

[20] Fernandez J *The role of the family in a Bengali community in Camden, London with substance use patterns* Islington PCT http://www.britsoc.co.uk/user_doc/05BSAConfFernandezJeff.pdf downloaded 1 December 2009

[21] Op cit

[22] Department of Health *Good practice in working with family members affected by drug problems* http://dmri.lshtm.ac.uk/docs/orford.pdf downloaded 1 December 2009

[23] Barn R, Chaitali D, Sawyer A *Family Group Conferences and Black and minority Ethnic Families* Families Rights Group 2009

[24] NASW Standards in cultural competence http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf downloaded 7 December 2009

[25] Op cit

Diversity within ethnic minority communities: It is important to recognise the diversity which exists across as well as within cultures and communities. The latter can be between generations, or based on education levels or length of time they have spent in the UK. There can also be different levels of bi-culturalism. Just because two individuals or families have their origins in the same country does not mean they will have identical needs. Both Shelter [26] and JRF[27] support the importance of recognising diversity within minority groups.

Diverse workforce: A diverse staff team can be a very effective way of providing insights into service delivery needs of diverse groups. Butt[28] talked about the positive impact employing BME workers can have on the services received by BME communities. However, there are occasional situations where it may not be advisable to match service users to staff of their own ethnic group. The service users may be worried about confidentiality[29] i.e. that talking to a member of their own community would cause their problems to become known by the rest of their community. This can be so where particularly sensitive issues and problems are concerned, which could give rise to shame[30]. However, it has to be recognised that no two BME workers or service users are the same and the situation is forever changing.

Super worker syndrome: According to Subhra and Chauhan[31], a 'super black worker' was: *"supposed to or expected to do everything; training, counselling, outreach work, public relations, anti-racist organisational and policy development as well as delivery or generic services to white clients.... This experience contributed to dissatisfaction, low morale and services being spread very thinly"*

There can be a danger in BME workers being expected to know everything about BME communities and solve all problems associated with them. This can especially be the case where there is a single or a small number of BME workers.

A similar point was made by Fountain[32], referring to BME drugs workers:

"It seems that...drug workers of some sort- if they are bilingual- might function as useful go-betweens helping children liaise with their parents. However, they would have to be young enough to be trusted by the drug users and old enough to be trusted by the parents. They

[26] Op cit

[27] http://www.bradfordobservatory.com/consultation/Community%20Reports/MinoritieswithinMinorities.pdf

[28] Butt J *Same service or equal service* DoH 1994

[29] Johnson M *Alcohol issues and the South Asian and African Caribbean communities, http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0028.pdf downloaded 22 November 2009; also,* Fountain et al *Black and minority ethnic communities in England- a review of the literature on drug use and related service provision University of Central Lancashire 2003*

[30] Cowburn M *Black and minority ethnic sex offenders Sheffield Hallam University 2008*

[31] Subhra G and Chauhan V

[32] Op cit

would have to be liberal enough to keep quiet about the clients' drug use, yet sufficiently religious and respected in the minority ethnic community to win the respect of elders".

Support for minority workers: Bearing in mind the above syndrome and possible isolation, such workers can and do sometimes have additional needs for supervision and support. One way this can be provided is through the involvement of 'external consultant supervisors'[33]. The 'supervisor' is external to the organisation and places the needs of the worker centre stage in the supervisory relationship.

According to Subhra and Chauhan[34], "*for the black worker the external supervisor facility countered the isolation, 'sole worker syndrome', stress and lack of culturally appropriate supervision"*. Opportunities to belong to particular networks and fora such as BME Workers Support Group is another way of receiving such support.

Language issues: In providing services to BME communities there has to be an acceptance that some service users will need the help of interpreters in order to access the services required. Some who are literate in their first language may also benefit from written material.

When working with different generations, it is important to remember that younger family members who have been educated in the UK may need information in English, while older and other members, new to the UK, may need information in their first language. Fountain[35] warned that some BME service users could feel patronised if information is provided in their first language instead of English, so it's best to provide a choice i.e. English and their other language.

Some communication issues can arise through the use of children as interpreters where there is no or insufficient provision of trained adult interpreters. With the exception of emergencies and brief situations involving non-sensitive and straightforward information, this should be discouraged as it can lead to problems such as:

- Role reversal: The child becomes the adult and the parent the child.
- Selective interpreting: The child may edit information according to what suits him or to avoid embarrassment to the parent.
- Limitation of expertise*:* No matter what a child may say, there are always likely to be limitations in their linguistic expertise.
- Confidentiality*:* The parent may omit certain information from the child because they may not want the child to know about it; children may also not understand the meaning of confidentiality.

Capacity building of BME communities: The BME voluntary community sector faces all the challenges faced by the mainstream voluntary community sector. In addition, it can face

[33] Marken M and, Payne M *Enabling and Ensuring- supervision in practice National Youth Bureau 1987*

[34] Op cit

[35] Op cit

challenges arising out of being smaller or younger. According to Fountain[36], it is essential to '*capacity-build*[37]' the sector in the recognition that often smaller community based provision can be a good way of meeting diverse customer needs. However, the author did accept that in certain limited situations users do not wish to access services from their own communities for fear of people finding out about their problems and needs.

Barn et al[38] also stated that, "*the cultural competence of BME community-based organisations is an asset in engaging these (BME) families and mainstream organisations would do well to form meaningful partnerships with them*". Later, the point is reiterated when it is said that. *"given the well evidenced shortcomings of statutory services to provide accessible services for the BME communities, (the) model of embedding services in community settings provides a framework for addressing these shortcomings'*.

Resource allocation: Although resources in the form of funding alone do not lead to equality in service provision, their lack and short-term nature can often be a formula for failure. There can be significant cost involved in engaging with previously under-represented service users and their representatives, especially in the early stages of such effort, and budgets must take account of such cost.

Piloting specific services: Sometimes community based projects which have a principal (but not exclusive) focus on ethnic minority communities can be more effective than larger centralised initiatives. However, while such separate provision can be successful in reaching ethnic minority users, steps need to be taken to ensure that it is not second best and also that it does not become a substitute for mainstream provision.

Partnership between mainstream and community organisations: Sometimes the best way of improving access for under-represented service users is through a partnership between mainstream service providers and community based organisations, from within the same communities as those service users. A good example of this is provided by the model of partnership between Family Rights Group and BME communities, as documented by Barn et al[39]. In summary they achieved their aims by:

- Negotiating an agreement with the community based organisation, making clear the responsibilities of each organisation.
- Providing the community based organisation with initial and on-going consultancy support.
- Providing training to staff and volunteers.

[36] Op cit

[37] 'Capacity building' is a term used to describe activities and investment which improves the knowledge, skills and behaviour of individuals as well as structures and processes within organisations in order to increase their sustainability

[38] Op cit

[39] Op cit

- Providing continuing contact between the Family Rights Group policy adviser and the community based projects in order to aid the sustainability of the service.

Butt and Box[40] provided a blueprint in this respect. According to them centres that worked regularly with black families had the following distinguishing features:

- Likely to have black staff working for them.
- Provision of specific services for black users.
- Outreach work targeted at black families.

[40] Butt J and Box L, *Family Centred- a study of the use of family centres by black families* REU 1998

2) KEY WORKER EXPERIENCES OF EQUALITY AND DIVERSITY WITHIN FAMILIY INTERVENTION PROJECTS – some examples of responses

In total five FIPs were visited. These included: Camden, Bradford, Stoke, Birmingham and Rochdale. The FIPs were selected by the then DCSF. All visits took place during October – November 2009.

During the visits, a number of staff were interviewed. Sometimes group discussions were supplemented by one-to-one conversations. One project was able to arrange a visit to a family in order get a better understanding of their needs. To enhance the information gathered through discussions, projects were able to provide a wide range of documents. This included, from one project, a recording of a radio programme they had participated in the day before the visit.

In addition to the visits, a questionnaire was circulated, by DCSF headquarters to all FIP projects. Five responses were received, from projects in Portsmouth, Bracknell, Harrow, Hornchurch and Peterborough.

At the outset, it was explained to staff taking part in discussions with the consultant that the information gathered would be anonymised and treated as confidential.

Note that I have not attempted in this excerpt to reflect the range of views, neither, therefore have I attempted to reach conclusions. I have used selected quotes from individuals to give readers a flavour of the kinds of experience of Key Workers - used as illustrations under selective headings (in italics) – to help Key Workers and other colleagues to consider their own experience in this context.

Ethnic and Racial Diversity within the locality of the FIP

> *We have some 80 ethnic groups in the area. How does one cater for all of them! It's a real challenge. One of our service user families got upset because the worker had not taken his shoes off when visiting. I hadn't realised it was that important; obviously it is.*
>
> *A feature of the Borough is that there is no one (or few) minority groups of significant size – large number of different non white UK groups (73 languages spoken)*
>
> *E&D desperately needs addressing; not sure who will do it. Not sure if it can be left to local level though any programme will need to address local issues*
>
> *The basics of E&D are already there in our FIP; we just need to build on it. It's not just about EO; not surface but deep level*
>
> *We also have a large BNP presence in the community. If we have services located in BNP areas, often we find the BME residents don't access them.*
>
> *The non-white population was heavily skewed towards the younger age groups.*

Ethnic and Racial Diversity in staffing

> *We feel the family were able to engage with our services because the worker was an Asian male. The cultural factors, made more complicated by mental health issues,*

would have made the chances of a non-Asian worker gaining access to the family much less likely... The project worker was able to convey some complicated information because he could communicate in a common language.

Cultural/diversity competence of FIP staff

Staff need more than superficial understanding of diversity in order to engage with families and really understand them. (For example), what does it mean when someone says: "I will beat you", "you need a kick up the ass", "over my dead body" or just shout all the time in their normal communication.

How do you respond to an ethnic minority family who wish their 14 year old to get married but within a supportive family – "how does this compare with white families who encourage their young people to have sex at an early age"; or another family who quite incidentally say they are taking their daughter to their country of origin for circumcision'

Religion is important for many of our clients; we have to learn to do things on their terms.

We deal with a range of diversities; I deal with 3 white families, one has a dual heritage child as a result of a rape.

Is it ok to say to an Asian who speaks no English to go to English classes?

What does 'culture' mean for the white working class? We and the white people we work with are learning together.

Should we see people as black or white? Some of them are just people who have parenting problems or live with challenging neighbours. They have more in common than they their differences or more than they realise.

Yes, white workers could be assertive and challenge an Asian family. But they would have to have the right intentions and enter the 'other' world and understand their language and culture.

Training would help; intensive. Needs to be on-going process, not dependent on individuals.

Staff also spoke of the need to be aware of cultural sensitivities in many communities:

'Before we go into a family we prepare ourselves; their culture, religion, race, identity, that kind of stuff. We make every effort to dress appropriately. No suits so that we don't draw attention to the family from neighbours.

If it's a Muslim family, for example, we may want to cover up- not too much flesh showing. One of my Asian colleagues put trousers under her skirt so not to offend the Asian family we were visiting.

We set out with an attitude of wishing not to offend; our aim is to confront without offending. But we know some things are good or bad regardless of which culture or religion. For example, child abuse is child abuse whoever you are.

Addressing the needs of service users with poor or no English

There is a way to communicate with clients who do not speak much English, straight forward English, need for patience, no jargon.

There is a need for empowerment of clients especially when we are using interpreters, which can be disempowering.

I think we should encourage our BME clients who do not speak English to go and learn English. They need independence; English will help.

Service users with racist views and other prejudices

At the outset of the research it was pointed out that: '*these clients display a whole range of behaviours which mark them apart from mainstream society, and create barriers to accessing services. Clients' 'strong' i.e. racist views...this should be a part of the work of FIPs";* and*, "many families we work with are racist*'.

During the research, all five of the projects visited cited examples of having to work with racist clients:

'If it's a drug user, we refer; alcohol problems, we refer, but being racist, who do you refer them to? (BME Key Worker)

My client is racist but he thinks he is not. He has a BNP poster on his window. Question is: Am I there to challenge his behaviour or deal with school attendance problems?

We have a functional relationship with our clients. (Some of them may just be guilty of) clumsy uses of language such as 'coloured'. Is this serious, like some other words we may hear? Is it our job to change or challenge (clients)?

None of us are paid to take abuse!

Being confrontational is not always the way (when challenging people's prejudices)

(When asked about risk assessment one team leader responded) *'If they* (meaning clients) *have racist attitude, we have to weigh up the risk: should we send a black worker; not a question of never sending a black worker or deliberately sending one'*

We have thought about using a self-assessment form for clients so to provide a mirror for service users who are racist or homophobic

Our area has a high level of racist incidents reported; some very serious ones.

The perpetrators used to be white but now it can be any colour as can be the victims'

We had two racist families who needed someone to work with them and had two BME staff who were up for the challenge; still it was a difficult decision for me as their manager sending them to work in such a hostile environment.

One of the worst cases of racism we have dealt with came from a mixed-race Asian/White young person. He was over-reacting against Asians in order to affirm his white identity. "I saw the boy one day and he said 'Hi' to me as an Asian and I knew we had made progress".

We constantly need to remind ourselves that we are not racist ourselves though I do worry about getting 'infected'.

We are there to empower people who feel small as small can be. Our biggest challenge is to know how to affirm white clients and their identity.

We are constantly faced with situations where we have to decide what we can and cannot say or should say to people with strong prejudices.

One racist family we worked with were the only white family in their road; we had to help them to see their neighbours differently (and come to terms with diversity).

How should we respond to a 5 year old who uses the N word!

Racists are full of contradictions. I have a 9 year old (white boy) *who is racist but loves rap music.*

One 12 year old white boy we are working with; he was beaten up by Asians. He is now very racist towards them but is fine towards black people'

'Some of the racism comes from BME families against other BME families; is that still racist?

It can be difficult for white workers to challenge BME service users- "you may not fully understand their culture". Sometime white workers don't challenge BME clients – would it be seen as racist?

Other agencies don't help- a child we are working with was sent on a school trip to a mosque. Her mum did not want him to participate in prayer simulation. That is exactly what the teacher did, the child refused to participate – "I don't want to wear a silly hat"- and was excluded from school. It has undone our work with the family and the child.

Some projects have begun to develop strategies for working with clients who have strong prejudices:

There are ways to challenge the people we work with who have strong prejudices; we have to speak with them not to them; we need to hear their side of the story. We can then work with them slowly and hope to challenge and change them – "have you thought....?"

We need to have mediation and group work skills so we can challenge prejudices.

I know how to respond when someone calls me a 'Paki'; I have dealt with much worse in my life. You have to build a relationship with them, they ask you questions and you make slow progress like that.

You have to find little opportunities to have conversations to challenge their thinking like driving them to an appointment.

I am working with a racist family. They have a boy who is mixed-up with his identity. He needed to go to the dentist. So I arranged for him to go to a dentist who was a trendy Asian, with ear-rings, the lot. That did loads for the boy. He also likes Asian food so I took him to the Asian owned Pak Foods. I hope it will help. Mind you he has also called me racist names on the account of my ethnic minority origin, even though its way back (in my family history).