



Engaging ethnic minorities with multiple needs

Client: Big Lottery Fund
Fulfilling Lives: Supporting people with multiple needs programme

Project: National Expert Citizens Group (NECG)

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This paper provides the findings from research undertaken by four peer researchers across the Nottingham, Manchester and West Yorkshire projects of the Big Lottery Fund's Fulfilling Lives: Supporting people with multiple needs programme. It also includes the views from BME members of the National Experts Citizen's Group (NECG).

Introduction

The NECG is a network of individuals who have lived experience of multiple and complex needs (MCN). MCN is defined as having experience of two or more of homelessness, substance misuse, mental ill health and offending behaviour. Individuals who attend the NECG come from one of the 12 funded project areas of the Big Lottery Fund's Fulfilling Lives: Supporting people with multiple needs programme. The group meets quarterly and chooses what they want to focus on. The current focus of the group is *'how to engage the disengaged'*. Volunteers from the group chose to conduct a peer research programme to further understand how Fulfilling Lives projects were addressing equality and diversity specifically in regards to ethnic minorities. Ten of the twelve projects participated in the research during the months of November 2016 to January 2017. A larger group of NECG members worked together to identify why ethnic minorities (in their experience) were disengaged with services and how this could be overcome. This paper outlines the key findings from both the research and the expert's lived experience.



Why don't BME groups engage with services?

There are a number of reasons why individuals from ethnic minorities with MCN do not engage with services. The core issues listed below come from the direct experiences of NECG members.

Please note: that the majority of NECG members and the peer researchers have **not** been direct beneficiaries of the programme. Further, the views expressed are not based on a specific singular service or geographical location (members of the NECG live across England).

Fear is a common cited reason for not engaging with services. There are a number of fears that can be experienced, most of which revolve around a lack of understanding – either by the individual or the service. The NECG experts felt that services lack an understanding of specific cultural behaviours; for example, individuals can be viewed as aggressive when they are expressing their views passionately or clothing, hairstyles and volume of speech can lead to negative stereotypes. The group spoke about feeling pre-judged on their ethnicity or religion when trying to access services – they felt there were assumptions made about how an individual would behave based on these judgements.

From an individual's perspective, they fear what will happen to them if they access services, particularly mental health. Experts spoke of how community members warn people to not go to a mental health service because 'you will be sectioned and they will treat you badly'. BME groups often have strong community ties and networks so if someone has a negative experience, word of mouth acts as a powerful agent to ensure the community is aware. These negative experiences create a **lack of trust** in services and a belief that they will not be treated fairly or with respect. The peer researchers termed this as 'racial neglect'.

Due to strong community ties and identities BME groups are more likely to trust members of their own community when seeking support, advice and help. However, there are a number of issues within communities which also act as a barrier; the most significant being the **stigma** around multiple needs. The level of stigma is considered to be so high that there is fear that a religious leader or trusted confidante may tell their family or the wider community which would bring **shame**. Due to the stigma, and shame associated with it, there is considered to be a lack of awareness and knowledge within BME communities to accurately identify when someone has a need, particularly in regards to mental ill health. In turn, there are considered to be **a lack of safe spaces to discuss issues and recovery pathways** without feeling judged and being able to say what you think or need – this is also a significant issue for those who are already on their own recovery journeys who would like a safe space to talk about the problems affecting BME people with MCN. Cumulatively the whole impact of stigma and shame means there are **few, if any, role models** individuals can look up to who have 'recovered' or 'survived' MCN.



Practical reasons why BME groups may not engage with services revolve around knowledge and poverty. Individuals **may not be aware of available services** and those who are may not be able to access them. Access can be prohibitive for BME groups for the reasons listed above, but also because an individual may have **no recourse to public funds**, or because BME groups tend to be **situated on the peripheries of towns/cities and services tend to be centrally located**.

The final cited issue was **poor use of language/terminology**. Experts provided examples of staff in services using words and phrases that they find offensive for e.g. ‘coloured’.

BME engagement on the Fulfilling Lives: Supporting people with multiple needs programme

The peer researchers felt that the number of BME beneficiaries on the Fulfilling Lives programme is low. They felt that one reason for the low numbers was because projects rely on referrals to their service from existing services. The peer researchers believe that these referral organisations do not work with BME individuals (for many reasons, please see above) and therefore, adequate numbers are not referred into the programme. In addition, experts mentioned that some BME specific services don’t want to refer to clients into Fulfilling Lives because they do not trust that the mainstream services will meet their needs. So, how many BME beneficiaries are engaged on the programme?

The table below illustrates the percentage of BME beneficiaries in each project area as of the end of quarter 4 2016. It compares the percentage against the total BME population¹ as derived from the Census 2011 results. As the table illustrates, half the funded projects are working with the proportion of BME beneficiaries we would expect (less than 5% difference to the total BME population in the local area). Bristol is working with a greater proportion of BME beneficiaries than the total BME population in their local area. However, it is the project areas with the largest BME populations who are working with smaller than expected proportions of BME beneficiaries. Interestingly, it is experts from these areas who are most likely to express concern over the low proportions of BME beneficiaries on their local project; and who wanted to conduct the peer research and focus the NECG activity on improving the engagement of BME groups.

¹ For this illustration BME population has been calculated as any ethnicity which is **not** White British (English, Northern Irish, Scottish & Welsh).

	BME beneficiaries (%)	BME Population: Census 2011 (%)	Difference
Birmingham	29.4%	46.9%	17.5%
Blackpool	3.1%	6.3%	3.2%
Bristol	30.8%	22.1%	-8.7%
Brighton, Eastbourne & Hastings	12.7%	16.3%	3.6%
Camden & Islington	46.2%	54.2%	8.0%
Lambeth, Lewisham & Southwark	32.6%	60.0%	27.4%
Liverpool	10.9%	15.2%	4.3%
Manchester	20.0%	40.7%	20.7%
Newcastle & Gateshead	8.5%	13.0%	4.5%
Nottingham	19.0%	34.6%	15.6%
Stoke on Trent	10.0%	13.6%	3.6%
West Yorkshire	17.8%	21.6%	3.8%

When interviewing staff from the projects, the peer researchers found that although each project has an equality and diversity plan² in place, most projects did not have diverse workforces or volunteer bases. For example, when questioned, some services said that they had a diverse workforce because they employ women. For the peer researchers, diversity must include BME staff and they consider that this contributes to the lack of engagement by potential BME beneficiaries. In addition, NECG members commented on the low number of BME individuals in the experts' groups at both the national level and in local partnerships. Consequently, they feel this impacts on engagement as there are insufficient peers and role models for potential beneficiaries.

When questioned about the low numbers of BME individuals (from volunteers to staff) the following were the cited reasons for not placing an emphasis on BME inclusion:

- *Not having enough capacity (staff, budget)*
- *Not knowing how to actively engage individuals from BME groups*
- *Having numerous priorities to meet at the same time*
- *Reliance on referral/partner agencies to identify BME individuals*
- *Not feeling there are adequate numbers of BME individuals living in their local area.*

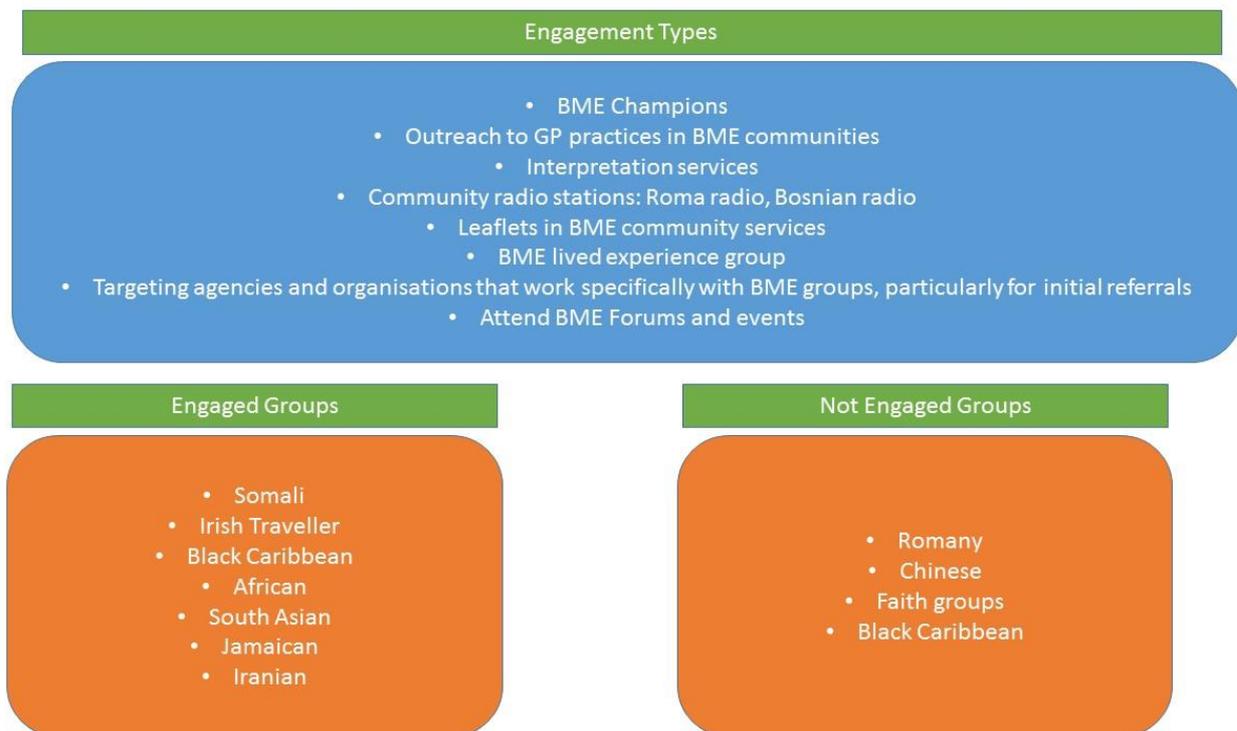
² These are a requirement by the funder – The Big Lottery Fund.



So in terms of black minority ethnic groups, they're very small and because of our caseload...having one client can make the statistic look great....closing one case from someone who is from a black minority group can skew us back hugely.

How are Fulfilling Lives projects engaging BME groups?

Where there is engagement with BME beneficiaries this has occurred in a number of different ways across projects and different areas see the engagement of different groups. The figure below illustrates the types of engagement activities applied across the programme and the groups that areas are able to engage and not able to engage.



As the figure shows, there are a variety of engagement approaches but most of them deal with actively engaging a targeted BME community. Engaged and disengaged groups vary by area and the engagement is often contingent on having a positive relationship with the local community.

There are some good examples³ of how some projects are applying the aforementioned approaches and tackling the engagement issues listed above. These are provided below.

³ Please note these are specific examples provided by the peer researchers from their fieldwork. It may be the case that other project areas also employ such approaches too.



1. **Providing BME champions to raise awareness and overcome stigma.** In West Yorkshire's Finding Independence (Wyfi) project they engage a BME engagement worker, as well as BME community champions and service champions; the former is a fixed-term post that was built into the original business plan for the project and the latter two are volunteer positions for individuals with lived experience. The BME community champions raise awareness of Wyfi and MCN; they take a pledge on what they want to focus on and are supported to deliver this as part of their personal development plan. The champions work in their local communities to raise awareness of multiple needs to break down the stigma. As a member of their community, and by virtue of having lived experience, they provide a role model pathway into existing services. They provide potential beneficiaries with an individual who they can relate to, who understands their cultural and religious identity as well as their multiple needs. An example of work that one champion was particularly proud of was the increase in enquiries to the project following an interview they conducted with the BBC for a local news story.
2. **Working in a culturally aware manner.** Opportunity Nottingham has a culturally specific delivery partner that their project works with – AWAAZ⁴. This partner specialises in working with BME communities and provides a specific outreach worker to the project as well as running cultural competency training. AWAAZ's cultural competency training is different to cultural awareness training. Cultural awareness focuses predominately on tangible things you can see or hear such as clothing, food, symbols, language etc. It is about identifying the symbolic and, as the peer researchers state, the superficial. Cultural competency focuses more on identity and things that cannot be seen. It is designed to help you understand identity and how that impacts on engagement and access to services; it is because of this focus that peer researchers feel this is more appropriate than cultural awareness training. For example, they talk about the need to build trust with communities and the best way to do this is to understand their identity. For Muslim communities it is important to dress appropriately and address the right people in the right way if there is to be a successful partnership brokered.
3. **Focused Outreach.** Most Fulfilling Lives projects undertake outreach to engage beneficiaries; however the difference with a culturally specific outreach worker is *where* they will conduct their work. In Liverpool, outreach workers visit religious buildings, community centres and cultural events to engage beneficiaries; they also go to GP surgeries in wards with high densities of BME groups. The project has also successfully engaged an Imam who will be assisting them in community engagement.
4. **Providing positive peers.** In Manchester, one core group (the core group is Inspiring Change Manchester's expert citizen group) member set up a BME lived experience panel. The hope is to develop individuals to act as positive role models to others and ensure that the views and opinions of BME communities are considered in the work undertaken by the local project.

⁴ <http://www.awaaznottingham.org.uk/>



Key lessons learned about engagement by funded projects

Towards the end of their interviews, peer researchers asked project staff what were the key lessons they had learned about engaging BME communities. All interviewees agreed that it is vitally important to engage and work with the communities from which an individual is from in order to obtain trust and secure positive engagement. Due to this, it has been detrimental to further engagement if that individual no longer works with the project – it is difficult to recruit adequate numbers of representatives to sustain community engagement.

Another reflection, was that at the start of the programme projects actively networked with agencies and partners to raise awareness of the programme. With hindsight, it was felt that further thought and attention should have been given to engaging organisations ‘not on the radar’ or in the mainstream to ensure that diversity was embedded from the outset.

For those that have engaged well with BME communities, it has been important to note that they do not refer to multiple and complex needs as MCN – they may be addressing or working with such issues but not identifying them in the same terms as mainstream services. For example (as mentioned earlier in regards to terminology) mental health is more likely to be referred to as emotional wellbeing or dealing with emotions. Each community is likely to refer to MCN in a different way and part of the reason for not acknowledging the terms in the same way as services do is due to the stigma associated with it.

When considering how to raise awareness of MCN in communities how can you teach a community to recognise chaos? Sometimes there are no visible signs to the community so what tools and language could be used to identify the issue(s)? Equally, what tools and language, if used, would disengage an individual? One project has addressed the language barrier issues by working with local student volunteers.

What individuals with lived experience would like to see occur

Reflecting on the research and their personal experiences the expert citizens and peer researchers had a number of suggestions of how services should engage BME groups.

1. Ensure diversity is pervasive across the organisation from board members to volunteers. BME experts by experience and peer mentors would be seen as key to engaging new beneficiaries. To address the lack of representation of BME staff experts suggest advertising opportunities in BME communities, especially targeting volunteering and job fairs in these locations;
2. All staff and volunteers should receive training on Equality and Diversity so everyone is aware of what it is and how it relates to their role;



3. Cultural competency training would provide greater insight and understanding into BME groups to help sustain engagement and build trust with beneficiaries;
4. Outreach needs to be conducted within BME communities not on the streets or via existing services;
5. An MCN awareness raising campaign/service for BME communities should be conducted. Experts have said that social media has helped to begin to address this and reduce stigma amongst younger generations. Another suggestion was to run an event in the community, related to entertainment they relate to (food being a core suggestion) and use it as an avenue to raise awareness and empower speakers from within the community to talk about the issue;
6. In order to further address stigma within communities consider terminology changes – for example, instead of saying ‘mental health’ use phrases such as ‘emotional wellbeing’, ‘managing emotions’ e.t.c.;
7. Provide access to interpreters and promotion of services in different languages;
8. As services review or reconfigure their spending/operational plans they should take on a specialist view on engagement with BME and disengaged communities. Someone within the service needs to be given a specific portfolio to address this rather than it being left open for all to do it (as this inevitably leads to no-one doing it). By employing a specialist worker there will be greater focus, commitment and resources allocated towards achieving the set targets. If a service/organisation does not operate in a high density BME area the post can cover engagement with other minority and disengaged communities; and
9. Any approach to engaging disengaged communities must take a long term view. Short term posts and targets do not provide time to embed partnerships and systems which will not allow them to maximise the potential of the investment made. Further, quick fixes/short term roles will not engender trust with mainstream initiatives and can be more damaging than if no engagement had been made at all.

Conclusions

There are ultimately three types of barriers which stop BME groups engaging with services:

1. Barriers inherent in communities e.g. stigma, shame, lack of knowledge/awareness
2. Institutionalised barriers in services e.g. current approaches not understanding and reflecting identity to garner trust
3. Practical barriers e.g. knowledge of services, no recourse to public funds and poverty.

These barriers can begin to be reduced and tackled by forming positive relationships/partnerships with the BME communities. Creating a pathway for beneficiaries from community based assets to mainstream services is viewed, by those with lived experience, to be the key to engagement. A community based asset might be a BME champion, an outreach worker or a member of the community with training and awareness of MCN and the services available. It provides an individual with someone they can relate to and identify with from an area of trust – be it shared language, religion or culture. Trust, being the ultimate requirement for successful engagement as stated in other Fulfilling Lives publications:



<http://mcnevaluation.co.uk/wpfb-file/fulfilling-lives-multiple-needs-evaluation-annual-report-2016-pdf/>

<http://mcnevaluation.co.uk/wpfb-file/the-role-of-specialist-womens-workers-sep-case-study-pdf/>

