

HEALTH ACTION  
TYNE & WEAR

# Health Action Zone (Area for Special Action)

**Addressing Inequalities for Black & Ethnic  
Minority Communities in Newcastle**

**2000-2002**

HEALTH ACTION  
TYNE & WEAR

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**Shehla Naqvi**  
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The Acute Trust (*RVI, Freeman & General*)  
Primary Care Group West  
HAZ Race Network  
Health Partnership  
Newcastle Healthy City Project  
Newcastle University  
Newcastle & North Tyneside Health Authority  
Race HimP Group  
MAP (*Multi Agency Panel on Racial Harassment*)

## Thank you and appreciation for all their hard work:

### **Stella Carmichael**

Project back bone and organiser extraordinaire! Currently working on a unique piece of research to look at ethnic monitoring within the Acute Trust regionally. Heartfelt appreciation for her commitment.

### **Philip Crowley**

Previous Chair of the Race ASA. Dedicated support for Black and ethnic minority health concerns city wide through Community Action on Health. Much respected advocate of race equality issues within the ASA partnership.

### **Community Action on Health team**

Respect and appreciation for their continued and grounded support to: Ann McNulty, Rachel Parsons, Ross Cowan & Rob Errington. The Race ASA work would not have been possible without this dynamic and integrative city wide partnership.

### **Chairs of the 5 Race Task groups**

For their dedicated support and co-ordinating skills:

Steve Page (Acute Trust), Chair of the Ethnic Monitoring & Audit Group

Nora Phipps (NCVS), Chair of the Health Information & Advocacy Group

Shamshad Iqbal (HIV Prevention), Chair of the Race & Mental Health Task Group

Denise Briddon (Interpreting Service), Chair of the Race Equality Training Group

Eugene Milne (Health Authority), Chair of the Coronary Heart & Diabetes Group

### **Historical Context**

Development of the 'Race Area for Special Action' group has been a key priority for HAZ since the development worker was appointed in March 2000. The genesis of this work was the old 'Race & Health Forum' for Newcastle & North Tyneside. The group is now re structured into 5 priority areas as a dynamic determination of Black & ethnic minority health priorities and membership to help raise the profile of health inequalities. The work has been commended by independent University evaluation as an excellent example of partnership working. It is a privilege to see such a strong, diverse and evolving network of local people.

### **Historical legacy**

Race discrimination has played an important role in the disproportionate social exclusion experienced by people from ethnic minority communities. In the North east, high levels of morbidity and inequalities of access to appropriate health and social care have distinguished the particular experiences of Black people. The following excerpts are taken from Newcastle's Racial Harassment Support Group West (funded by the Home Office), The Sainsbury Centre for Mental Health and from the Governments 'Social Exclusion and Neighbourhood Renewal' strategy:

- People from ethnic minority communities are disproportionately represented in deprived urban areas. 56% live in the 44 most deprived local authorities in Britain.
- These communities are more likely than the rest of the population to be poor. 28% of the general population live in households that have incomes of less than half the national average; but this is

the case for 34% of Chinese people, over 40% of African–Caribbean and Indian people, and over 80% of Pakistani and Bangladeshi people.

- The latter two groups are 5 times more likely to be diagnosed with coronary heart disease and diabetes than white people.
- 40% of Pakistani and Bangladeshi communities are over represented in poor and overcrowded housing conditions.
- Racial harassment is endemic in the North East, The RHSG Project in West Newcastle receives on average 4-5 referrals a week. It saw a 67% increase in reported racist incidents in 2000. The vast majority of case work in collaboration with the police and Crime Reduction Strategy, focused on crises referrals from refugees and asylum seekers.
- Visits by the Mental Health Act Commission to 104 mental health and disability units across the U.K found two thirds of the wards used the patients' family relatives as interpreters. Three quarters of the units had no policies on dealing with racial harassment, and 59% of patients had reported repeat incidents of racial victimisation.
- The unemployment rate for all ethnic minorities in spring 2000 was 13% compared with 6.9% for white men. Black men from countries other than Africa or the Caribbean have the highest unemployment rate at 26.6%. Bangladeshi men are next at 20.4%. The unemployment rate for white women was 4.7% while the rate for all ethnic minority women was 12.3%.

A report published in January 2001 by Angela Ishmael of the Industrial Society (supported by the TUC) finds: 'equal opportunities rhetoric has failed in practice...in the 30 years since the Race Relations Act, the position of Black people in the Labour market has substantially deteriorated'.

According to 'future (demographic) trends' published this month by One North East, the ethnic minority population will increase in the next 40 years from 5% to 17%. The 2001 census will provide a clearer picture of new groups such as asylum seekers. We have approximately 3,000 Refugees and asylum seekers residing in Newcastle & North Tyneside. (Source, NERF) In total, Denise Briddon who co-ordinates the city's Translation Interpreting scheme serves over 65 community languages, with an increasing demand to supply health organisations.

Primary Care Trusts, Health Authorities and Mental Health Trusts and Social Care Bodies are required to become accountable to local and increasingly diverse communities in light of new NHS 'equality' requirements through 'Macpherson' 1998, 'Vital Connection' 2000, 'Positively Diverse' 2000, and the new amendments to the Race Relations Act 2001.

This paper outlines the work of the Race Area for Special Action:  
addressing inequalities in health for Black and ethnic minority communities.

## PCG West Race Equality Audit

A Race Equality Strategy provides a framework for action placing equality at the heart of a primary care agenda. This piece of work has received national recognition in its philosophy of providing an accountable interface with primary care provision and local people. As a project, it is now integrated within PCG Investment plan.

The wards of Newcastle West PCG cover a broad spectrum of diverse and heterogeneous ethnic minority communities. Approximately 60% of the city's total Black and ethnic minority population live here, ranging from the predominant South Asian to Middle Eastern, and recently emerging asylum seekers and refugees. Evidence has shown that the vast majority of these communities are concentrated in the most economically deprived wards of Newcastle, here they experience distinct health inequalities and some of the poorest health outcomes within primary care. These include for example, higher mortality rates from Ischaemic heart disease within South Indian groups, lack of access to therapeutic mental health services (Crowley 1996). Health problems are compounded by racial harassment, economic deprivation and social isolation. (City Council: RHSG 1994-99, MAP 2000, Crime & Disorder Reduction Strategy 1999-2000)

PCG West Race Equality Strategy evolved through recognition of the need to develop sustainable and equitable partnerships between primary care and local communities. This interface between people and policy can influence health strategies, reduce health inequalities and determine the effectiveness of health planning. Elements of this include:

- Base line Audit of equality indicators
- Systematic Ethnic Monitoring
- Appropriate information systems
- I.T software
- Multi disciplinary race equality training
- Patient evaluation

Primary Care Groups are now asked to outline how equity translates into good practice. The concept of equitable health care is part of the NHS agenda (Vital Connection 2000). The principle of 'equal treatment for people with equal needs' (Harrison & Hunter 1994) must be made relevant to a localised agenda relating particularly to a heterogeneous population group in the West.

Developing partnerships with local initiatives is the key to understanding the reasons for social exclusion and addressing appropriate solutions in education and social regeneration. A sustainable partnership can use its leverage to make a real difference to the life opportunities and health of its local communities, especially 'hard to reach' groups such as international student families, refugees and asylum seekers.

Since 1995, NHS Trusts have been required to record the ethnicity of all patients. In order to devise a care model that considers a patients' cultural and communication needs, it is necessary to accurately and consistently record information on ethnicity, language, dialect and religion.

Establishing a firm baseline of local population and the ensuing analysis of that data (not just based on individual G.P patient lists) is an essential first step for West PCG in addressing health inequalities. (See Crowley 1999) It is fundamental for two reasons: to measure progress by setting meaningful targets, and to determine whether PCG policies are reflected in good practice.

The Acheson report (1999) outlined specific recommendations for Black and ethnic minority groups:

- To focus on development and implementation of policies aimed at reducing socio-economic inequalities.
- The development of services which are sensitive to the needs of ethnic minorities and which promote greater awareness of health risks.
- That the needs of ethnic minority people specifically considered in assessment, resource allocation, health care planning and provision.

Measurement through audit (both qualitative and quantitative), and ethnic monitoring provides a structure to underpin action, monitor improvements and outline deficits in health service provision.

The amended Race Relations Act (Jan 2000) echoes the Macpherson Report (1998) in recommending a statutory duty on public bodies to promote race equality and address institutionalised racism.

Staff training and professional development is integral to the effective implementation of West Primary Care Group's Race Equality Strategy. Recognition for staff support to develop specific competencies to enable them to work in a progressively multi ethnic environment, (eg. Using bilingual link workers, interpreters, technical support etc). These competencies must be properly valued and remunerated with a premium on joint planning with service users and staff to help determine training needs and establish an integrated communication strategy.

Strategic aims for the amendments to the Race Relation Act 2001 include the following:

- 'to recruit, develop and retain a workforce that is able to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of individuals and groups'.
- 'to ensure the NHS uses it's influence and resources as an employer to make a difference to the life opportunities and the health of it's local community, especially those who are shut out or disadvantaged'.
- All NHS organisations will publish an annual 'Equality Statement' to outline indicators for staff, users and partners in relation to how the organisation has implemented national and local equality priorities.

### **Focus for PCG West RES:**

#### Phase 1. Baseline Audit

- Audit of existing manual information systems.
- Audit of existing computerised information systems
- Documentation of patients' ethnicity, language, religion and special needs.
- How is the above information used?
- Health information within practices targetted for Black & Ethnic minorities
- Staff awareness of information/resources for Black communities?
- Do staff refer patients to community resources/ projects?
- Audit of referral to secondary care services.
- Audit of referral to specialist services within Primary Care eg. Complementary/ Physiotherapy, Counselling, Welfare Rights.
- Staffing composition within primary care teams.
- Audit of in-house services eg. benefits welfare/ counselling
- Take up of Interpreting service during and out of hours?
- Are independent interpreters offered/ made available at consultation?
- Extent of use of interpreting service: eg. antenatal, health clinic?

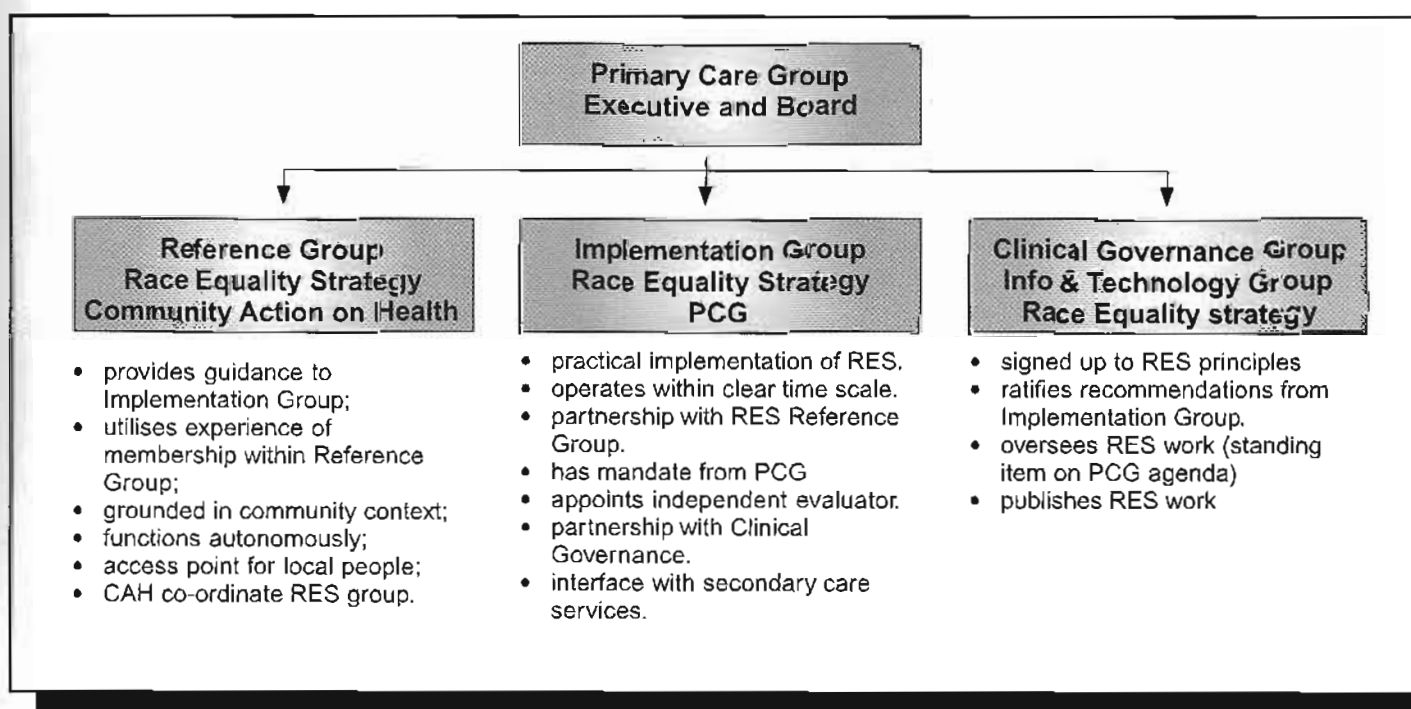
- Practice policy and profile of Interpreter use.
- Are secondary care services aware that interpretation is needed for referred patients?
- Is the practice leaflet available in community languages?
- Number of home visits.
- Length of consultation for Black & Ethnic Minority patients
- Staff Questionnaire: level of skills/awareness, equality training, support needs in response to Black & Ethnic Minority patients?

## Phase 2. Software Implementation

- Identify 'change agents' and advocates eg. IM&T, Practice Managers, Caldicott Guardian, Public Health Nurse (inequalities in health)
- Identifying software systems to complement EMIS, Read codes & 'Vision in practice systems' across 15 practice sites, including new coding guidelines for 'active problems'
- Incorporate data collection for:
  - Ethnic monitoring, language support needs, disability, being a carer, NSF targets: Mental Health, Ischaemic heart disease, Diabetes, Cancer (palliative care access), Maternity Services, access to secondary care services, chronic illness, DNA's for outpatient appointments, Number of DNA's or late arrivals for G.P surgeries.
- Training support for staff

## Objectives

- To ensure equitable access to health and social care for Black and Ethnic minority communities including refugees and asylum seekers.
- Establish an audit of existing race equality measures within practices
- To implement an integrated programme of ethnic monitoring across PCG West
- Ensure provision of appropriate information.
- To contribute to multi disciplinary race equality training based on the needs and experiences of staff and patients.
- To implement a programme of software for each practice base to record ethnicity and health priorities



Ethnic monitoring is vital to identifying current service use and gaps in service access. It helps monitor any response to those gaps, can identify prevalence of illness, changing patterns of disease and monitor the effects of intervention programmes on these. Pilot studies have shown that most patients are in fact willing to provide this data, particularly if they understand why the information is being sought (Horton 1994)

1. The working group established by the Race ASA is comprised of Acute Trusts, Primary Care, Social Services, Disability Area for Special Action and Community Action on Health (North & West), and the health visitor for asylum seekers and refugees. Following a series of meetings and a half day workshop facilitated by Brian Collier from the NHS Executive, our focus is to implement CRE Audit guidelines and NHS Equality requirements regarding ethnic monitoring and access both from a service delivery and staffing perspective. So far all the key partners are engaging with the process of historically what has and hasn't worked, and devising action plans which will be drawn together this year.
2. Stella Carmichael has completed collation of ethnic monitoring information from all key hospital providers in Newcastle. A report is now available that sets out clear recommendations for ethnic monitoring within Health Services. Copies are available from Stella on tel: (0191) 2616358

## **RACE ASA Task Group Key recommendations:**

### **1. Ethnic Monitoring & Audit**

- Ensure that ethnic monitoring takes place.
- Through training, ethnic monitoring must be part of an overall strategy to improve service provision for Black people.

### **2. Coronary Heart Disease & Diabetes:**

- Better information for communities, including targeted campaigns, increasing understanding of service provision, investigations, medication and results.
- Support the need for race equality/ awareness training.

### **3. Health Information & Advocacy:**

- Increased access to health information
- Specific support for health advocacy to meet the needs of Black communities

### **5. Race Equality Training**

- Needs to be integral to the PCT and Mental Health Trust – staff induction and CPD programmes
- Needs to be integrated with audit and ethnic monitoring awareness
- Need for continuous monitoring and evaluation

### **4. Mental Health**

- Ethnic monitoring
- Improved access.
- Training focusing on race equality principles within mental health provision.

## Tackling racial harassment :

Facts: In the city of Newcastle, every 11 minutes there is another victim of racial harassment.

**Source:**

Section 95 statistics on Race and the Criminal Justice System, 2000

- Reported racist incidents increased nationally by 107% last year.
- Nationally there were 47,814 racist incidents recorded in 1999 - 2000, compared to 23,049 in the previous 12 months.
- In Northumberland there were 1,159 racist incidents reported in 1999 - 2000, compared to 623 in the previous 12 months.
- In western Newcastle there were 386 racist incidents reported in 1999 - 2000, an increase of 67% on the previous 12 months.

**Source:**

Section 95 Statistics on Race and Criminal Justice System, 2000. Figures for England and Wales only.

- 1 person in 15 of western Newcastle's Black and ethnic minority communities becomes a victim of racial harassment.

**Source:**

Section 95 statistics on Race and the Criminal Justice System, 2000 Special Investigation Unit annual figures, 2000.

Tyne and Wear Black Housing Project census figures, 1998.

- 47,814 racial incidents were recorded by police forces nationally last year. Yet only 1 incident in 3 was reported.

**Source:**

Metropolitan Police Force estimates 66% under reporting locally.

- Between 60% and 66% of racially motivated crime goes unreported every year.

**Source:**

Policy Studies Institute (Brown 1984) estimated 60% under-reporting nationally.

'Hidden from View' (Chahal 1982) estimated 62% under-reporting regionally.

Metropolitan Police Force estimates 66% under-reporting locally.

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A detailed training strategy to tackle racial harassment in the heart of the New Deal for Communities Area has been drawn up through the work of the Racial Harassment Strategy Group West, it is being supported by the City Council Equalities Group with funding agreed through SRBV. The aim of this training is to build capacity within local communities to engage with democratic processes and to address the social impact of harassment and crime. This work has arisen from the extensive case work experience of the West's Racial Harassment Support Group and the Black Mental Health Forum. A training pack will be produced following a 'training the trainers programme'.

*For further information, please contact Desmond Hill: Case worker for Newcastle West Racial Harassment Project on 0191 2733250*

## Coronary Heart Disease & Diabetes

Collaborative partnership with Dr Jane Skinner, Consultant Community Cardiologist leading on a Health Improvement Plan for coronary heart, diabetes and IHD, Dawn Scott, public health nurse working for PCG to examine deficits in community access for Black communities, appropriate treatment and promotion, and Eugene Milne who chairs the city wide integrative and umbrella task group for this area.

There is a real need to promote more joined up and pro active intervention at a primary and community level with 'at risk' groups and wider families/ carers. Educational awareness and the re visiting of research focus groups is firmly on the agenda to look at creative and strategic means of addressing the interface between community service provision and proactive access to treatment. This is an exciting area of work. The Race ASA group aims to integrate developments in line with the ethnic monitoring, health information and race equality training proposals.

### Recommendations

1. Ethnic monitoring of Coronary Care Unit
  - " " of Cardiac Surgery
  - " " access to Diabetes care
2. Better information and equitable dissemination
3. Collate and analyse perceptions within primary care
4. Develop screening policy for ethnic groups
5. Need for specific race equality training
6. Improve access to interpreting and translation
7. Encourage recruitment of multi-lingual health workers

### Race Equality Training:

Race Equality training is fundamental to meeting key NHS equality indicators and is distinct from cultural awareness or multicultural training. An appreciation of 'diversity' is an important and positive recognition, but not to the extent where the nature of racism in our society and in our public institutions is denied. The traditional multicultural penchant to celebrate and exoticize diversity, ignores the power structures and social practices that produce racism.

Cultural awareness' training is the one adopted in many health organisations. It seeks to address problems that Black communities experience in accessing services by exploring the different cultural norms in different communities and focuses on issues of religion, diet, dress and family organisation. The problem with this is that the norms are complex and diverse and do not lend themselves to neat summaries in 1-2 hour training sessions. So in the end result, certain stereotypes are reinforced and no effort is made to look at aspects of how a service is delivered in order to explore why Black communities are not accessing it.

It is comfortable to spend training time in examining the 'unusual' way that different communities go about their business but if the purpose of the training is to ensure that we have services that deliver to the needs of Black communities then we have to go further. We have to explore how attitudes prevalent in society may affect how staff deal with people. We need to explore ways of redesigning services so that Black communities feel comfortable accessing them and we need to ensure that as a result of training we have a workforce and an institution delivering an action plan to remedy the

deficiencies in service access and delivery.

## Why Race Equality training?

Education about cultural difference does not in itself prevent discrimination. People need clear guidelines and indicators.

Race equality training takes multiculturalism further by:

- Looking deeper at the inherent power dynamics of how institutionalised racism operates.
- Examines how racism discriminates against Black people in our society.
- Provides a practical framework and quality assurance indicators for action in tackling discrimination within organisations.
- Identifies and addresses the experiences of Black employees and service users.
- Locates race equality within a wider context of equity in service provision.
- We need to work towards capacity building in recruiting, training up, mentoring and ultimately sustaining (!) people to deliver this from within the region rather than recruiting consultants
- Training needs to be relevant to peoples experiences and the local context as well as new NHS legislative frameworks.
- Training can be both didactic and experiential looking at group/ individual processes, as the contents can be personally challenging.
- Our experience has shown that few examples (if any) of race training in Newcastle have provided a supportive and containing infrastructure for participants to feel safe enough to contribute honestly and reflectively.
- The SRB V model provides a debriefing and a consultative structure for the trainers as well as a peer support group for participants which is facilitated professionally with expertise in humanistic/group dynamics.
- Training needs to be pro actively integral to mainstream Equity and Equality induction and professional competency/development programmes.
- Training needs to be recurrent, updated regularly, be part of the process of staff appraisal.
- Outcomes implemented in the aftermath of training need to be evaluated externally and by service users

### **Positive indicators of progress need to include the following components:**

- Systems in place for ethnic monitoring and audit of service uptake with emerging evidence of increased Black uptake of services
- Review of existing equality policies.
- Systems to address and encourage a responsive interface with user representation.
- Review of information materials.
- Review of staffing composition that reflects the community

1. NVTS : The Northumbria Vocational Training scheme for G.P's extends across Tyne & Wear from Berwick to Teeside. Keen to develop a core module focusing on 'race equality awareness', through the support of Community Action on Health, this has now provided some useful tools to enable G.P's to reflect on their practices in how they assess Black and ethnic minority communities, myths, historical facts, inequalities in health etc. The training has been successfully evaluated and piloted. In the next phase, it will focus on registrar training and complement the work of the RES for PCG West.
2. A discussion paper for Stakeholders

The task group has paved the ground to launch a discussion paper as a progressive model based on our collective experiences of race and health community development. In the prevailing climate of health and social care trust configuration, the task group proposes that race equality training needs to be integral to mainstream professional development and induction programmes. A stakeholder event targetting human resource and chief executive personnel will take place as a Race ASA consultation event in November

Ratnam Jayaratnam, Consultant Public Health Medicine underlines the importance of training around the issue of race for health care staff: 'Ethnocentrism, assuming that everyone thinks and behaves the way oneself does, or stereotyping, attributing the same characteristics to all those in one group, are other obstacles which are needed to be overcome if appropriate, flexible and effective health care is to be provided to all users'

### 3. Acute Trust ward staff training

A series of training sessions focusing on Black and ethnic minority patient care and health inequalities have been developed with the Acute Trust nurse induction programme.

Briefing seminars on the rationale and implementation of ethnic monitoring have been beneficial to help the Trust develop a robust culture of regular analysis through the ASA working group of ethnicity analysis by site, clinical speciality and admission method.

## **RACE ASA Partnership:**

**Acute Trust  
Audit & Ethnic Monitoring task group  
Equal Opportunities working group  
Ethnic monitoring training  
Race equality training  
Disability ASA  
Refugees & Asylum Seekers  
Race HimP**

**Primary Care  
Clinical Governance  
Information Management & Technology  
Community Action on Health  
NHS Executive  
Newcastle Healthy City Project  
NVTs**

## Race & Mental Health :

1. The Adult Mental Health Programme Board is keen to address inequalities in mental health provision for Black people in relation to the NSF. More directly however, regular contact with PCG West Mental Health sub group, to help raise the profile of race and mental health has proved invaluable. This is a key area where the needs of Black and ethnic minority communities have been continuously marginalised. A Race & Mental Health Task Group has been established to provide a community interface for Newcastle & North Tyneside. This group is chaired by David Chappel with Black mental health user representation. It aims to bridge the experiences of refugees and asylum seekers in the region.
2. The Hadrian Clinic have made positive links (through Nurse Lead) in relation to recruitment of bi-lingual mental health nursing staff, a plan of action following recruitment, will examine staff professional development, monitoring, staff sustainability and 'equality' training needs of the clinic.
3. Black Mental Health Millenium Research:
  - Proposal for mental health survey focusing on users/carers
  - Context for this work is post 'Mapping Exercise' Crowley 1996
  - Research duration is a four month period commencing January-April 2001
  - Supervision/ support through HAZ Race & Mental Health Task Group

### Context:

Black and ethnic minority communities in the North East experience discrimination and social exclusion from health services in the region generally, and from mental health services specifically (Diverse MIND, Black Mental Health 1997/00). Evidence shows Black and ethnic minority communities experience the poorest health outcomes within primary care (CAH 1999), and suffer the highest rate per capita of racial harassment nationally (Crime & Disorder/ Northumbria Police RIIU / Racial Harassment Support Group West 1999).

The population of ethnic minority groups has increased considerably in the last decade including new communities with distinct health and social needs eg. asylum seekers and refugees such as Afghan, Turkish and Croatian, international students (Malaysian, Turkish, Iranian etc) many of whom experience isolation, trauma, poverty and harassment (HAZ ASA April 2000).

Characteristically these communities have self referred within the Black voluntary sector for support. Workers within these organisations have limited access to specialist mental health training, receive limited supervision and have restricted professional contact with secondary and primary care interface (Crowley 1996).

There is considerable research and historical documentation of the growing and heterogeneous health needs of Black and ethnic minority communities in this region eg. Crowley 1996, Save the Children 1997, Hedges & Kai 1999. Successive consultations with the Black voluntary sector eg. Community Action on Health Conferences 1995-present, Nash 1999, Black Mental Health User Group Launch 1999 and Newcastle City Council audits eg. Social Exclusion 1998, Crime & Disorder Strategy 1999, Stephen Lawrence Inquiry recommendations (City Council 1999 – 2000), Select Committee focus on Mental Health provision 2000, have respectively

highlighted the 'quality of life' experience in particular, the mental health needs of Black people living in Newcastle.

Race and mental health has been identified as an area of concern by regeneration initiatives both locally: Sure Start, HAZ Black & Ethnic Minorities designated Area for Special Action, Newcastle West PCG mental health sub group, New Deal for Communities; and by legislative frameworks eg. Our Healthier Nation 1989, NHS National Service Framework for mental health 1999.

Mental health transcends every aspect of health, social care and urban deprivation.

Underpinning this research survey is the historical legacy of a lack of meaningful engagement with Black communities, the living reality of what it means to be Black, to experience institutionalised racism and have mental health problems.

'Inaction is not an option for any Authority irrespective of the size of it's local Black and ethnic minority population' – The Macpherson report. Also underpinning this proposed work is the shared belief (Sashidharan/ Fernando 2000) that 'sustainable partnerships will and can indeed reduce health inequalities'.

The Mental Health Programme Board have recently begun to engage with race equality by developing a working partnership with the regions only independent Black Mental Health Forum and establishing a Race and Mental Health Task Group. This qualitative survey is the first exercise of it's kind and will offer a unique and comprehensive insight since the 1996 Mapping Exercise by Philip Crowley, into the quality of life experience affecting Black and Ethnic Minority communities in Newcastle:

- the reality of living with mental health problems,
- underlying concerns affecting service user/and carers
- perceptions and aspirations in light of the newly configured Mental Health Trust
- Charting progress since the Mapping Exercise.
- Focusing on traditionally established Black communities, and refugee/asylum seekers.

**Structure:**

- 4 - 5 Focus groups of local community members with the following languages: Sylheti, Farsi, Urdu/Hindi, Punjabi, Cantonese & English
- 20+ Individual interviews with community members.
- A specific focus group for refugees and asylum seekers.

## Health Information and Advocacy Project :

1. Exciting work is being developed with the city's only NCVS Advocacy Scheme. Both of these areas of work are key to creating equal access to health services. We all need information to enable us to access appropriate services, and improve our own health. Many of us need someone to speak up for us and ensure our voice is heard, particularly by health professionals. For both of these functions the needs of Black and minority ethnic groups are stark. There is clear evidence to suggest they experience distinct health inequalities and some of the poorest health outcomes within primary care. The group has been looking at appropriate ways of providing advocacy for the local Black and minority ethnic groups. The methods used for this are:
  - Questionnaire to local people, both those who need an interpreter and those who do not
  - Questionnaire to community organisations and health professionals
  - National visits to advocacy and interpreting providers.
  - In depth discussions with lead organisations regarding the advantages and disadvantages of providing a combined or separate advocacy and interpreting service.

2. Acute Trust - Information & resources for staff re cultural/spiritual care for Black & Ethnic Minority patients

**Task:** to review the 1989 Patient handbook for Black & Ethnic Minority communities: 'Respecting the Cultural and Religious Needs of Patients.'

- The patient must always be respected and asked as an individual: what they need?
- A handbook will provide background information to aid staff. It cannot replace the human interface between the care provider and patient.
- Basic principles around assessment for all patients regardless of race and language support. Assessments must incorporate a holistic view of the patients needs taking into account the importance of family, linguistic support where that is required and sensitivity (for example if a female would prefer to talk with a same gender staff member)
- As a matter of principle all bi-lingual patients need to be offered an interpreter.
- Need to gather population figures/breakdown of ethnicities from places such as the NERS (North East Refugee Consortium) , Tyne & Wear REC, Tyne & Wear Black Housing Project, City Council, GONE (Government Office North East). The 2001 figures. Won't be out until 2003!
- The REC's briefing document 1999 – 2000 by Dudu Sher provides excellent historical context of Black communities in the region as well as:
  - >Population trends & census analysis
  - >Religion
  - >Rites of passage
  - >Services for Death
- How can this be an effective and appropriate tool kit/reference point for sensitively assessing the care needs of patients from multi ethnic backgrounds?
- A specific room designed to meet patients spiritual needs must be provided by the chaplaincy. This could be offered for any spiritual/meditational support.
- When the handbook goes on intranet, it is vital this is reviewed and updated quarterly.
- The handbook needs to complement staff training as part of a rolling programme of care management and induction training. We also understand it will incorporate a generic equal opportunities framework which will include disability and carers.
- Existing resources and research materials need to be included as appropriate to prevent duplication of good work. These include:
  - Directory of organisations concerning health and ethnicity: Tyne & Wear REC 1999 – 2000.
  - Briefing on Ethnic Minority Communities in Tyne & Wear: Tyne & Wear REC 1999 – 2000.

- Services available in Newcastle for people from Black & Ethnic Minority Groups: City Health Trust Patient Information Centre– Dec 2000
- The handbook will begin with a clear equal opportunities statement and policy regarding the Trust's 'Duty of Care'.

The Health Information and Advocacy task group have collated examples of good practice nationally, with a view to making key recommendations for Newcastle's main health care providers. The group recognises the need to enable pro active Black advocacy recruitment and personal development. Norah Phipps is developing a system of ethnic monitoring for the NCVS service. Watch this space!

### **'Shena' Iranian Health Project:**

Following a successful 10 week pilot with Iranian families (including men) who have experienced racial harassment and social isolation, application was successfully made in conjunction with Westgate and Participation in Leisure to appoint a bi-lingual co-ordinator. The project is now fully constituted with an extensive community data base.

### **HAZ Race Evaluation:**

All HAZ areas are being evaluated as an ongoing process, including Race ASA. Following a HAZ wide initiative to examine models of evaluation, the work is led by Duduzile Sher (previous author of the REC Resource Directory) and is being supervised by Madeleine Murtagh (Research Associate at Newcastle University). A creative evaluation process has focused on partnership working within the Race ASA and our strategic objectives and community experiences to enable us to raise the profile of race equality issues/deficits in health care. The Race ASA has been cited as an area of excellence in partnership building and the work will be launched in July in Paris!

#### **Legislative Frame for HAZ Race ASA:**

- The Vital Connection
- Positively Diverse
- Macpherson
- The Race Relations Act  
(with amendments)