Devon County Council

AGE Concern Exeter

A Question of Fairness

An enquiry into the health and social care needs of Muslim elders in Exeter

Report

connections
social work consultancy

A QUESTION OF FAIRNESS

An enquiry into the health and social care needs of Muslim elders in Exeter

The Islamic Centre of the South West, Devon County Council Social Services Directorate, Age Concern Exeter, Connections Independent Social Work Agency

Compiled by Fiona Hutton, MA (Cantab)

Forward by Kauser Ahmed, LLM

Preface by Brenda Laker and Julie Cornwell

The Study Team

Brenda Laker

Current post: Policy and Projects Manager (Equalities) working as a member of the Strategic Policy and Planning Team of Devon Social Services Directorate.

Brenda's current responsibilities include working within the Social Services Directorate to promote implementation of Equalities legislation. This involves ensuring that Devon County Council's strategy and policies comply with the Race Relations (Amendment) 2000 Act, Disability Discrimination Act 1995, Sexual Orientation Regulations, Religion and Belief Regulations, Sex Discrimination Act and impending Age Discrimination Regulation 2006.

Working with members drawn from across the County Council's directorates, she represents the Social Services Directorate on the Devon County Chief Executive's Corporate Equality Steering Group.

Her responsibilities have involved her in a number of research projects across Devon, collating impressions and data which are indicating a range of unmet needs within minority ethnic groups, such as those experienced by the mentally ill and young people, as well as elders.

Kauser Ahmed

A qualified teacher with a background in legal practice, Kauser has a passionate belief in all equality issues and has always been involved in community work, primarily with issues concerning bme women and children.

Kauser has lived in Devon since 1991, working as a teacher in the largest comprehensive school in Britain and then becoming a freelance trainer. She works with the Islamic Centre in a voluntary capacity and is involved with a range of organisations both voluntary and public.

Kauser is a co-founder of the Olive Tree project based at the Islamic Centre, which organises educational, social and health related events not only for the Muslim community but also for the Chinese community.

As a mother of two boys with special needs, Kauser ensures that she has enough energy to devote to them and the rest of her family by going running and reading.

Fiona Hutton

Current posts: Neighbourhood Day Care Co-ordinator, Age Concern Exeter and freelance trainer and researcher.

The Neighbourhood Day Care service of Age Concern Exeter offers approximately 300 individualised day services a month in the homes of Host Carers to older residents of Exeter experiencing sensory loss or mental health difficulties, and/or a mild to moderate dementia illness.

Fiona also delivers training on Inclusive Caring, the Person Centred approach to Dementia Care and, as part of Devon County Social Services Training Pool, the Protection of Vulnerable Adults from Abuse.

Professionally trained as a Social and Medical Anthropologist and Integrative Counsellor , Fiona has completed research for the Alzheimers' Society, BBC Radio 3 Nightlines, the House of Commons Leisure, Media and Sport Committee, Age Concern Exeter, the Royal Albert Memorial Museum, the Tasmanian Aboriginal Council and Intjartnama Aboriginal Rehab Outstation.

Julie Cornwell

Julie Cornwell is a founding partner in Connections Social Work Consultancy, an organisation that specialises in assessment and training.

Julie has been a social worker for almost twenty years and has worked as a practitioner and manager. She became involved in A Question of Fairness via her role as Practice Teacher.

Connection as an organisation is committed to promoting equality and challenging discrimination.

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Foreword

Background to the Muslim Community within Exeter and Devon

The Muslim community within Devon comprises 0.21% of the population, the majority of whom (0.77%) reside within Exeter. The remainder are scattered through the county.

The community itself goes back many decades, and the link between the Muslim world and the south- west dates back centuries through the sea faring traditions of the South- West. In more recent times, the presence of a large specialist Middle East Studies and Islamic studies Department at Exeter University has resulted in students from Muslim countries coming to study and in many instances finding jobs, marrying locally and settling down in Devon.

There is a significant Bengali community comprising mainly of restaurateurs who have been in Exeter for over 30 years. Many professionals such as Doctors started to arrive in the 1960' and 1970s, filling hard to fill posts in less popular rural areas and district hospitals.

The diversity of the community has also been affected by the turmoil of world politics. In the 1991, the first Gulf war resulted in many Iraqi students at the university seeking political asylum and settling in Exeter. Earlier, the Iranian revolution of 1978 had resulted in exactly the same scenario with regard to Iranian students.

The war in former Yugoslavia led many Bosnian Muslims to come to Britain (some being evacuated by the U.N) and many were dispersed to Exeter, this was followed by Kosovans in the mid to late 1990's and recently there has been an influx of Afghan and Iraqi and Turkish Kurds into the city under the government's dispersal scheme.

There is a steady growth of the Muslim community in line with the general increase of the BME communities in Devon as evidenced by the 2001 census figures. This is in part due to children growing up and establishing their own families within the county and with BME communities confident enough to move for a 'better quality of life' from metropolitan cities.

The Muslim community is culturally very diverse. There are over 15 languages spoken and over 30 countries are represented in the ethnic origins of the members of the community.

The religious and spiritual needs are met by the Mosque and Islamic Centre in York Road Exeter. The Islamic Centre serves the needs of Muslims from Devon, Cornwall and parts of Dorset, Somerset and Avon, a huge catchment area. During important religious festivals such as the two Eids up to 700 people attend services.

Torquay has a small house which is used as a mosque and Muslims in North Devon are informally using a few rooms in a terrace house for Friday prayers.

The Islamic centre in Exeter started as one room for the purposes of prayers in 15 York Road. Donations and fund raising led to buying of the whole of 15 York road, then 14 York Road and in 1998 bought present buildings from Devon Education Department.

It is a testament to the Centre that different denominations of the Islamic faith are welcomed e.g. Shias and that there is an ethos of inclusion and acceptance. The main Friday sermon or Khutba is delivered in English as that is the common language for the worshippers.

The Islamic Centre is also a unique resource for Devon. Schools and Colleges regularly visit the Centre and members of the Islamic Centre visit schools and colleges in turn to give talks on Islam or to take part in citizenship classes and discussions. The educational links of the Islamic Centre have contributed enormously to the positive relationship that the wider community has with the Islamic community in Devon.

The Islamic Centre has been very supportive of The Olive Tree Project, a learning and social initiative tackling the language and learning needs of the community especially women and which has also worked with the Chinese community and their learning and social needs. An IT centre has just been established with the aid of Exeter City Council which has been a widely used and welcome resource.

Kauser Ahmed, LLM

April 2004

Preface

This project has been a labour of love, sometimes frustration, sometimes exasperation but most of all it has been a journey towards understanding. It is by no means finished but hopefully we are some way along the road. The individuals involved have all contributed time, expertise in different areas and a huge amount of enthusiasm.

The project started with a number of questions:

- Why don't older Islamic people use the existing resources?
- Do they know about Social Services and, more importantly, do they know what they do?
- What about Age Concern?
- Would a dedicated day centre be acceptable?
- If it were, what would it look like?
- What would be the main obstacles to overcome?

and can be traced to a number of events coalescing:

- The setting up of the Olive Tree Project to teach women English.
- The appointment of the Policy and Projects Manager (Equalities) in the Social Services Directorate of Devon County Council.
- The Race Relations (Amendment) Act 2000.
- A meeting between the Services Manager, Age Concern Exeter and the Education Liaison Officer of the Islamic Centre.
- Julie?

Political Realities

The biggest challenge to the study, which had a significant impact in terms of the study having to be placed 'on hold' and the elders becoming suspicious, was the invasion of Bagdad. The invasion and its impact cannot be under-estimated. For some the fact that the 'study' was on hold proved difficult. Here we had a partnership with five different bodies with a different outlook, some time led, others results led, and a community trying to come to terms with the government's decision to invade Iraq. It was not an easy time.

As the war progressed, and eventually ended, we were able to pick up and complete the questionnaires, and decide on a community consultation day – which again was announced by the Imam at Friday prayers.

The project started within the context of world upheaval in respect of the events of nine eleven, and subsequently the start of the Iraqi war. More locally, the activity of the British National Party in Devon focussed our minds on the dual vulnerability of the older Islamic community. This was borne out in the course of conducting interviews when a number of individuals referred to fear of walking the streets. Suspicion was certainly an issue with some participants voicing reluctance to be involved and some preferring to be interviewed as a group.

The Germination of the Idea

Contact was made by the Policy and Projects Manager with the Islamic Centre. Initially this was a difficult task as little information was known about the Muslim community in Exeter – none of the statutory agencies were able to assist. The community appeared 'hidden' to the organisations.

Over a period of months the relationship between Education Liaison Officer of the Islamic Centre (Kauser Ahmed) and the Projects Manager (Brenda Laker) grew, and eventually the positive relationship provided the opportunity to discuss issues which were of concern to the community. Women from the Olive Tree Project spoke about issues which were of concern to them and their families.

A concern of many was growing old. Needs of Muslim older persons had been identified by the community and were not hidden. The challenge was to look at these needs and present them to the organisations in order to get them listening.

At a meeting in April of 2001, the Services Manager of Age Concern Exeter and Kauser agreed that accommodating the religious responsibilities of Muslim elders, such as prayers and dietary requirements, at Age Concern's Cowick Street premises would be very difficult. Despite this, there was commitment to working towards a solution to the problem of low take up of services for older people amongst the Islamic community.

It was decided to pursue possibilities through their joint membership of the Building Bridges group, which was meeting to consider the provision of mental health services to potential users from black and minority ethnic communities in Devon.

In August the following year, Kauser, Brenda and a representative of Age Concern Exeter, Fiona Hutton, visited Fairfield House, an independent social and health care facility contracted by Avon County Council Social Services Directorate to provide culturally specific services to Muslim and other minority ethnic elders in Bath.

Inspired by this example, the Islamic Centre expressed a wish to apply to the Community Fund for the funding necessary for a similar facility.

It became clear that evidence was required to support such an application and that this could become the platform for a more systematic study into the health and social care needs of Muslim elders in Exeter. From the start it was assumed that the community would play a key role in the identification of these needs.

Challenges

The study was now taking shape, and was supported by Social Services, Age Concern Exeter, and the Muslim Community through Kauser and the Imam's wife, Fatima Seid. Following several meetings it was agreed that the study should take the form of a quesionnaire and a community consultation session. The Imam assisted by announcing at Friday prayers that the study was going to take place.

The biggest challenge which faced the participants was the fact that there was no one to undertake the study. There was no capacity. None of the statutory organisations had individuals working within the community or had any contacts that could assist. The Strategic Health Authority were contacted but advised that this was a marginal issue and not a priority. It looked as though the study had ended before it began!

However, the Projects Manager contacted the University of Plymouth and proposed the idea of the study being part of two students' Diploma in Social Work placement – and that the placement would take place at the Islamic Centre. In fact a unique placement as this had not been attempted before.

All parties supported this idea, and were pleased that this meant the study could progress. Several meetings ensued to ensure that there was clarity of purpose, a that the requirement of the study would be met – and at the same time this would form part of the students assessment and their learning needs would be met.

Two students were identified who were interested in working with the Muslim community, and who were prepared to work with interpreters, and work as part of a study team. Following the identification of the two students – the two Placement Supervisors were introduced to the study team, one of whom is still with us and is a study team member.

We now had a study team comprising the two Plymouth University second year students, Education Liaison Officer (Islamic Centre), Age Concern Exeter, Connections Independent Social Work Agency, and Policy and Projects Manager Social Services.

The next task was the structure of the questionnaire.

The Questionnaire

Preparing the questionnaire that was to be used as a consultation tool proved difficult and there were a number of re-writes. The breadth of information required made the use of additional questions crucial, information gathered through discussion proved just as enlightening as the answers to prescribed questions.

It was decided to use a joint health and social services questionnaire formerly known as the 'shared assessment schedule'. The questionnaire proved to be a difficult area and an example of how cultural issues can be misunderstood and overlooked. The study team very soon realised that the shared assessment schedule needed re-writing in order to be translated through an interpreter and to ensure that issues were not overlooked. The two second year social work students both reflected on the need to abandon assumptions and to be prepared for the unexpected. Whilst the Islamic community is joined by a shared religion, there is a huge diversity of race and culture represented within Exeter and what maybe acceptable to one may be completely unacceptable to another. Indeed a lot of time was spent on re-writing the questionnaire and testing it out.

Involving the community

All members of the study team interviewed persons from the Muslim community and questionnaires were completed. Interpreters assisted with some interviews. The style and venue of the interview was determined by the individuals themselves, eg two men, a group of men, two or four women, individuals, at their home, or at the Islamic Centre.

The community consultation day followed after – and approximately two hundred persons attended.

Conclusion

Analysing the information that was gathered proved full of surprises, in particular the complex health needs that were identified and the high percentage of individuals experiencing mental health difficulties, depression and a sense of isolation. If we have learnt one thing it is the need to put aside preconceived ideas – do not assume that because someone is Muslim, female and over sixty that she has no interest in East Enders.!

You have here before you the results of the study. The study team and the community perceive this as the beginning. The challenge for all of us is to listen and take this forward.

Brenda Laker, Policy and Projects Manager,
Devon Social Services Directorate

Julie Cornwell, Director
Connections Independent Social Work Agency

Introduction

During the summer of 2002 the Policy and Projects Manager for Equalities, Brenda Laker, met with members of the Olive Tree Project Trust, a community group based at the Islamic Centre in Exeter, and others to look at the health and social care needs of the Islamic community.

Members of the community had drawn the attention of a number of service providers to, amongst other things, their perceived need for a culturally-specific day service for older people; a focal point for the provision of information, advice, social support and recreational opportunities.

A working group comprising representatives of Devon County Council Social Services Department (DCC SSD), the Islamic Centre of the South West, Age Concern Exeter (ACE), and Connections Social Work Agency agreed to research their claim. Drawing on the testimony of respondents to a questionnaire, *Removing the Barriers,* and two community consultation events, the working group conclude that the evidence amassed and presented in this report supports their claim.

The group further argues that ring-fenced funding for such an facility should be committed by the statutory sectors at the earliest opportunity. Making use of existing community networks and groups is recommended by the government as fundamental to implementing its Social Inclusion policies.[1]

Over the last few years a raft of legislation has been introduced by this government with the clear intention of profoundly improving the health status and social and educational opportunities of black and minority ethnic people. Added to this, initiatives aimed at improving services to older people more generally have, without exception, made specific reference the importance of counterbalancing the double disadvantage experienced by ethnic elders.

[1] Social Inclusion Strategy for Exeter 2003-2006

A spirit of co-operation already exists between the relevant voluntary groups in Exeter, as does a site of culturally specific community activity. The combination offers a cost-effective opportunity for Exeter to take significant steps in redressing the inequalities that have been shown to overshadow the lives of some of our older citizens.

Aims

There is a breadth to the aims of this report that may seem disproportionate to its size. As a piece of joint agency work its aspirations include those of all its stakeholders. The aims are:

- to provide a platform for Exeter's Muslim elders to convey their unmet social and health care needs to relevant agencies.
- to consider, in the context of statutory obligations and local recommendations, a designated day service for Exeter's Muslim and other minority ethnic elders.

Objectives

The report's objectives reflect the working group's desire to provide an accessible overview of issues deserving further study. They include:

- clarifying government requirements
- presenting quantitative data on the current health and social care needs of Exeter's Muslim elder population
- presenting qualitative evidence of the community's desire for designated day opportunities.

Context

Britain has a long tradition of studying health inequalities dating back to the seventeenth century. Pioneer demographers analysing Bills of Mortality and, later, death certificates highlighted mortality trends by occupational social class. And yet, despite more than three hundred years of investigation, research focusing on ethnic inequalities in health is only relatively recent, and remains ad hoc and localised[2].

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[2] Evandrou, 2000

Analysis has tended to focus on mortality rates by country of birth, rather than on morbidity and ethnicity. Questions on ethnicity, and also on limiting long-term illness, appeared on the Census for the first time in 1991, and those included in the 2001 Census provide background data for the Local Trends section of this report.

Between the years 1991-96, a combined sample of 139,800 cases self-reported their health status to the General Household Survey. Of these, 12,368 were ethnic minority respondents. Two surveys in 1991 and 1994 on the health and lifestyles of ethnic minority groups in England, carried out by what is now the Health Development Agency, strengthened the evidence base, although both only include individuals up to the age of 75.

The Fourth National Study of Ethnic Minorities 1994 and the *Health Survey for England 1999* have also boosted the pool of knowledge. Even so, a lack of sufficiently large samples within national surveys has hampered more detailed work.

Sources

The data used in this report is compiled from a series of consultation exercises carried out in Exeter during 2002 and 2003. They are:

- Building Bridges, Finding Paths – information share day
- Removing the Barriers – questionnaire
- The Islamic Centre of the South West consultation event

Following the McPherson Report (1999) and the Acheson Inquiry (1998), tackling ethnic inequalities in health and social care services has been affirmed a priority area for the statutory sector. Legislation and best practice are considered in Part Three, where we draw attention to relevant sections of:

- The Race Relations Amendment Act (2000)
- The Chronically Sick and Disabled Persons Act 1970
- The National Service Framework for Older People
- The Social Inclusion Strategy.

Part One – Demographic Trends

The Health of Muslim Elders in the UK

There are approximately two hundred and fifty thousand people aged sixty or over belonging to ethnic minorities in Britain. The proportion of older people is set to increase over the next fifteen years, however, as increasing numbers of those currently aged between 45 and 59 reach retirement age.[3]

This situation will be compounded by increasing incidents of chronic ill-health in those approaching retirement[4]. To confuse the picture still further, there are different rates of ageing for different ethnic groups, with some populations ageing faster than others.

Black and minority ethnic (bme) populations are the highest users of primary health services, yet report the worst health outcomes.[5] Many argue that inappropriate social care is a significant contributory factor. Reasons for this include:

- language barriers
- insufficient knowledge of social and public services
- low expectations
- negative experience of retirement
- poor mental and physical health
- professional assumptions that their family will provide care
- inadequate support from their family
- ‘colour-blind’ approach to service provision and assessment
- racism at individual and institutional levels
- a lack of consultation with bme communities in service planning and delivery
- geographical isolation, social exclusion and poor outreach.

[3] Census 1991
[4] Bhalla and Blakemore, 1981
[5] Pharoah, 1995

The Department for Transport, Local Government and the Regions

The Department for Transport, Local Government and the Regions' guide *Reflecting the Needs and Concerns of Black and Minority Ethnic Communities in Supporting People* (May 2002) paints a bleak picture citing high incidence of unemployment and low incomes, poor quality accommodation in deprived neighbourhoods and high crime rates.

Evidence further suggests that there are significant variations both between and within minority ethnic groups in terms of socio-economic status and access to material and social resources[6].

Pakistani and Bangladeshi women, many of whom have extensive responsibilities caring for children as well as older husbands and extended family, are reported to be the worst off, although men from these regions of the Indian sub-continent are also shown to be significantly disadvantaged.[7]

For these communities, whose health and social support needs are, in part, a result of their poverty, the likelihood that they will be able to meet those needs is reduced further. Accessing information and advice, aids to living, domiciliary help, and transport is compromised by language difficulties, isolation, and financial constraint.

Analysis of both the General Household Survey (GHS) and the Health Survey for England 1999 (HSE99) showed that a higher proportion of people from some ethnic minorities, particularly Pakistan and Bangladesh, report a ***limiting long-standing illness*** (LLSI) compared to the white majority population. Amongst women aged 60-74, 36% of white women report a LLSI compared to 75% of Pakistani and Bangladeshi women and 51% of Indian women. Similar relative patterns of LLSI by age have also been shown by Carlton and Wallace using 1991 Census data.

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[6] Ibid
[7] DTLR, 2002

Ethnic differences are similarly evident in both the GHS and HSE99 for self-reported ***acute ill-health***. Ethnic minority elders report an illness or injury that has restricted their activity in the last two weeks more than twice as frequently as white elders and show a 'reverse' gender differential amongst older Pakistani and Bangladeshi respondents, with a higher proportion of men reporting acute ill-health than women.[8]

This picture is replicated in the *Census 2001* data for Exeter, although rigorous comparison is limited as some categories of analysis are based on ethnicity, and some on religion.

Exeter's Muslim population has coalesced around individuals from Africa, Continental Europe, and East Asia as well as the South Asian countries. These geographic identities can be roughly equated to the 'ethnic groups' used by the *Census* to classify Occupancy Rates, for example. Conversely, the Health Status of the county's population is differentiated by 'religion'.

The Health of Muslim Elders in Exeter

The GHS uses three indicators of self-reported health status: ***chronic ill-health***, distinguishing between the experience of a limiting and non-limiting long-standing illness; ***acute ill-health***, referring to an illness or injury in the last two weeks; and ***general health*** status over the last year. Devon's *Census 2001* provides figures for long-term illness and general ill-health only as follows:

WITH LIMITING LONG-TERM ILLNESS AND/OR GENERAL ILL-HEALTH - ALL

	Muslim, Hindu, Sikh	**All Others**
Aged 50-64	**33.7% (32)**	26.8%
Aged 65+	36.8% (14)	**50.8%**

[8] Evandrou, 2000

WITH LIMITING LONG-TERM ILLNESS AND/OR GENERAL ILL-HEALTH – MALES

	Muslim, Hindu, Sikh	All Others
Aged 50-64	**38.6% (22)**	28.6%
Aged 65+	37.9% (11)	**48.7%**

WITH LIMITING LONG-TERM ILLNESS AND/OR GENERAL ILL-HEALTH –FEMALES

	Muslim, Hindu, Sikh	All Others
Aged 50-64	**26.3% (10)**	25.1%
Aged 65+	33.3% (3)	**55.8%**

It has traditionally been argued that the relatively small numbers of minority ethnic elders in Exeter do not justify specialist services, a claim it is hard to maintain in light of more recent figures. Forty-six people who described themselves on the *Census 2001* as Muslim, Hindu or Sikh were suffering at the time from either a limiting long-term illness or general ill-health.

Causes of Health Inequalities

Nationally, self-assessments of general health produce similar results. Higher levels of general ill-health are reported by older people from minority ethnic communities irrespective of the measure of morbidity investigated. Consistency has been shown across a range of indicators, pointing to substantial inequalities in health for many ethnic groups.

Four factors are generally associated with ethnic inequalities in health:

- firstly, differences in ***health related behaviour*** (such as diet and propensity to exercise);
- secondly, attributes which have a ***genetic*** component (for example, sickle cell anaemia and diabetes);
- thirdly, differences in the ***material environment***, including living arrangements, financial resources and other indicators of standard of living; and
- fourthly, the consequences of direct and indirect ***racism***.[9]

Two of these, ***health related behaviour*** and ***material environment***, appear as significant contributory factors to the relative poor health of the questionnaire respondents.

In 1998, when the Government commissioned an *Independent Inquiry into Inequalities in Health*, chaired by Sir Donald Acheson, its aim was "to review the evidence and identify priorities for action". The report which followed highlighted the role of socio-economic factors in health inequalities.

The *Census 1991* shows Exeter's non-white population to have been 1,314, a figure which had increased to 2,644 by the time of the *Census 2001*. Based on consistent growth rates, a conservative estimate would predict a black and minority ethnic population of over 3,000 living in Exeter city today, well over double that of twelve years ago. By comparison, the country as a whole showed an increase of 25% in Black and Ethnic minority residents over the same period.

Material Environment

Detrimental material environment, in the form of sub-standard accommodation, has been identified in the Devon *Census 2001* by levels of overcrowding and lack of central heating[10].

[9] Ibid
[10] The occupancy rating assumes that every household requires a minimum of 2 common rooms (excluding bathrooms).

CENTRAL HEATING AND OCCUPANCY RATING EXETER 2001

	White	**Non-White**
All	103,664	1,963[11]
Overcrowded (O/C)	8,662	386
No central heating (NCH)	19,621	335
O/C & NCH as % of All	**27.3%**	**36.8%**

The figures show that sub-standard housing is experienced by 36.8% of the non-white population, compared with 27.3% in the white population.

Health Related Behaviour

Patterns of health related behaviour that are emerging for Exeter's elder Muslim population are considered in the following section of the report; Consultation.

[11] *Census 2001* statistics on ethnicity give a figure of 2,644 for Exeter.

PART TWO - CONSULTATION

Building Bridges, Finding Paths: full day consultation event

14th February 2002

The first consultation event addressing health and social care issues for Exeter's bme communities was staged by the Building Bridges group as an opportunity for service providers to hear what problems existed first hand. In the morning a programme of talks by practitioners from a range of disciplines, sharing examples of good practice, gave a broad picture of existing specialist services (the Clock Tower general practice, Chinese medicine, Asylum Seekers and Refugees Group), as well as initiatives aiming to make mainstream services more culturally competent.

Later in the day, service users from some of Exeter's ethnic groups described their experiences of insensitivity and discrimination in service delivery. Common themes included:

- communication problems
- lack of information
- lack of understanding of culture
- inability to access services

Visit to Fairfield House, Bath

August 2002

Looking for a model against which to assess the requests and recommendations of the Muslim community in Exeter, the working group looked round for an appropriate example of good practice in the West Country. Culturally distinct centres in Plymouth and Bristol were ruled out as the bme populations were thought to be so large and urbanised as to make comparison meaningless. A likely facility in Bath was eventually identified. Fairfield House was started with four clients.

Donated in perpetuity by the Emperor Haile Selasi to Bath's bme communities, Fairfield House currently provides culturally specific activities, food, advice, and companionship to up to one hundred ethnic elders a week. These services are commissioned by the local Social Services Directorate, augmented by specialist clinics developed by their NHS Partnership Trust.

The total budget for the year is approximately £50,000, of which £36,000 is found by Social Services who purchase a block booking of up to 60 places a week over two days. This pays for a part-time co-ordinator, three part-time workers for each of the three cultural groups catered for, kitchen staff and cleaning. Health clinics are funded separately, as are specialist classes.

Removing the Barriers: questionnaire

Summer 2003

With the intention of exposing a more detailed picture of the support needs of the older people who maintain contact with Exeter's Mosque, the working group designed a questionnaire, *Removing the Barriers; meeting the needs of minority ethnic elders in Exeter*. These were completed by 20 older Muslims with the help of two Social Services student practitioners.

Respondents were asked to describe their domestic arrangements, health and personal care needs, leisure activities, unmet social needs, and awareness of current services. They were also asked to comment on their priorities should a designated day opportunity be made available to them.

Respondents were aged between 52 and 70, divided equally between men and women. Almost all lived with other family members and were dependent on informal carers for part of their daily living routines.

Health Status

Although only 68.7% described themselves as being in poor health, over 80% were regularly taking medication. Mobility problems were common and transport problems universal and yet, despite this, 87.5% of respondents regularly attend the clinic of at least one health professional (dentist, chiropodist, optician, etc) for preventative treatment and health checks.

Health Related Behaviour

The same number, although not necessarily the same respondents, take regular exercise, although a common complaint was that walking was all they felt was available to them, religious and cultural sensitivities making most activities provided by Exeter's municipal sport and leisure centres difficult to access.

Agency Awareness

There was little awareness of existing service provision for older people within either the statutory or voluntary sectors, even though 60% of respondents (and, there again, not the same 60%) confirmed they "had heard of" either DCC Social Services Department or Age Concern Exeter.

Benefit Uptake

Of particular concern to the working group was the discovery that 62.5% of respondents were in receipt of no benefits. Given the high incidence of chronic ill-health in those under 65, and of poverty expressed by those over 65, it would seem that assessing eligibility to benefits might be a priority.

Personal Care

Equally disturbing was the discovery that 56.3% described difficulty in performing their own personal care, a need that in some instances was completely unmet. Religious injunctions made the situation particularly difficult where the care was performed by family members of the opposite gender.

The following table shows the main quantitative distinctions as a percentage of the total respondents.

Main categories from questionnaire Removing the Barriers

Benefits	Receiving	37.5%	Not receiving	62.5%
Mobility	Poor	62.5%	Good	37.5%
Medication	Taking	81.3%	Not taking	18.7%
Regularly Using Private Health Professionals	Yes	87.5%	No	12.5%

Health Status	Poor	68.8%	Fair	6%	Good	24.2%
Personal Care	Needs help	56.3%	Doesn't need help	34.7%	Didn't answer	7%
Outings	Would like	56.3%	Would not like	23.7%	Didn't answer	20%
Exercise (walking)	Does do	87.5%	Doesn't do	5.5%	Didn't answer	7%
Social Services	Know of	60%	Don't know of	33%	Didn't answer	7%
Age Concern Exeter	Know of	60%	Don't know of	33%	Didn't answer	7%
Muslim Elders Drop-In Centre	Would like	93.8%	Wouldn't like	0%	Didn't answer	6.2%

Designated Day Provision

As can be seen from the figures, there was unambiguous enthusiasm for the idea of a culturally specific day opportunity. Suggestions for activities and services that would be either pleasurable or useful ranged across a wide spectrum, with most citing meeting other people and companionship as their primary concern. Health, benefits and other forms of advice were also universally presented as reasons to attend such a facility.

The following is a selection of the comments that were received on this proposal:

I would like activities at the centre, and information.

I am interested in health care.

I would like to see people giving talks; on politics, Exeter and history.

Other religions could come to the house and preach.

I think a drop-in centre is a good idea to reduce isolation and depression and give people something to do. I believed depression was a self-inflicted thing that you could talk yourself out of until I came depressed.

I'd like to write stories.

health and benefits would be good, and social events – but I would have to feel comfortable.

I would like to socialise with my friends.

I would like to make friendships with people of my age.

Newspapers and magazines, lectures on current or historical topics, provision of food.

Chat to people, get information on health care and benefits, have lunch, a massage, trips out.

A place of security and safety.

Islamic Centre of the South West – consultation event

5th October 2003

Benefiting from three weeks of announcements at community learning groups, and to worshippers prior to Friday's Jumah prayers, a consultation event arranged by the Islamic Centre with help from Devon County Council Social Services and Age Concern Exeter one Sunday afternoon was attended by around 200 people.

Half of these were particularly concerned with issues affecting older people and elected to spend the time discussing:

- Day Care
- Health advice
- Social and educational opportunities
- Transport

Transport

Above all else, a desire emerged for the provision of transport to facilities and events already existing at the Islamic Centre and elsewhere. The point was made that some were unable to attend even the consultation event because they had been unable to get there.

Health was felt to be regularly compromised for older people. What was particularly frustrating was being unable to access health services because there was no-one to help them negotiate what transport was available.

Day Opportunities

As with the questionnaire respondents, everybody felt a growing need for provision of culturally specific social and advice opportunities. Combating isolation was considered a priority, along with advice on health, benefits, and housing.

Considerable unmet need was shown to exist and Age Concern Exeter were able to follow up a number of immediate housing and benefits enquiries. The community generally felt that there was no point in pursuing a solution to many problems. Experience had undermined expectations of understanding complicated instructions or explanations when delivered in a language other than one's own.

The technical language of medical diagnosis and treatment were also reported to cause problems and anxiety. There were occasions, the working group were told, when primary age children and grandchildren, acting as translators, accompanied older members of their families to GPs surgeries.

A culturally specific day service was seen as a potential source of the support older people felt was currently denied them, frequently leading to isolation, depression and ill-health.

Multi-Ethnic Devon –A Rural Handbook

Summer 2003

After three years of systematic consultation across the county, Sam Magne and the Links Team published a handbook designed to promote issues of importance to all those considering the relevance of cultural diversity to their service. One hundred and seventy minority ethnic respondents answered a range of questions on their experiences of living in rural Devon.

Although some of the issues raised are particular to living in a rural or remote area, some are not. In particular, problems of '***identity***' (Chapter 4) and those associated with '***isolation and belonging'*** (Chapter 5) are shared by those living in the more urban environments of Exeter city.

For one hundred and fifty of the hundred and seventy respondents multiple layers of isolation applied (highest isolation score 10 out of a possible 14), with ethnicity adding at least one compounding layer to a variety of other social disadvantages. Of fifty-four languages spoken by participants, for example, thirty-nine of these were first languages.

PART THREE – GOVERNMENT & AGENCY RESPONSES

The Race Relations (Amendment) Act 2000

Sir William Macpherson's report of the Inquiry into the racist murder of Stephen Lawrence resulted in profound changes to the race equality legislation, demonstrated by a shift to a pro-active approach. Under the new legislation local authorities have a general duty to promote racial equality by aiming to:

- eliminate unlawful racial discrimination
- promote equality of opportunity, and
- promote good relations between people of different racial groups.

Devon County Council (DCC) has declared that it intends to pursue this aim by:

> *by making race equality a central part of the way the County Council works, by putting it at the centre of policy making, service delivery (including contracted services), employment practice, regulation and enforcement.*[12]

In May 2001 the Council published a Policy on Racial Equality, since incorporated into its Racial Equality Scheme. Of particular pertinence to this research is the assurance it gives that:

> *use of services is monitored by ethnicity to ensure equality of access and the data used to develop services which are appropriate to the needs of the whole community;*

Section Eight of the DCC Race Equality Scheme, Access to Information and Services, includes the same proposal:

> *8.2 The Council intends that all of its services are fully accessible to all parts of the community. Equality impact assessments (see section 5) should highlight any factors, which indirectly discriminate by*

[12] Devon County Council Race Equality Scheme, May 2002

making a particular service less available to particular groups and recommend appropriate action.

Chronically Sick and Disabled Person's Act 1970

Section 2 (1) of this Act addresses the types and range of services that should be available to those assessed as in need. These include: provision of practical assistance in the home; provision of recreational facilities outside the home or assistance to take advantage of educational facilities; provision of assistance with works for adaptation in the home; provision of meals.[13]

Parity in the distribution of these provisions was addressed by the Right Honourable John Reid, Secretary of State for Health, in a speech he gave last November on Equity in Access to Healthcare, where he set out his approach to providing equality for health service users from vulnerable and minority groups. He was particularly condemnatory of the "one-size-fits-all" attitude and argued for more differentiation in services[14].

The same level of healthcare services, he told us, was not currently received by some groups, despite similar health characteristics. He confirmed that additional funding is to be made available to Primary Care Trusts to help address these "unmet needs".

The Department of Transport, Local Government and the Regions

In its 2002 guide *Reflecting the Needs and Concerns of Black and Minority Ethnic Communities in Supporting People*, the Department of Transport Local Government and the Regions (DTLR) recommends accurate mapping, quantitatively and qualitatively, of the needs and existing services for black and minority ethnic communities (bme) as a pre-cursor to any expansion in either range or diversity of services.

They suggest local authorities will want to use their review and quality assurance methods to ensure agencies are culturally sensitive to both existing and arriving communities. Specialist services, they argue, are more likely to be successful at meeting legal and moral obligations if designed along multilateral lines. Cross authority co-operation in the design and delivery of specialist services should particularly be considered in the following situations:

- Where the needs of bme communities are not being met by mainstream providers currently.
- Mainstream providers lack credibility or trust.

[13] The Law in relation to the Assessment and Provision of Community Care Services, Steller, January 2003
[14] BMESpark, December 2003

- Existing mainstream services do not meet the requirements of cultural, linguistic, religious and dietary diversity.
- Bme community groups have come together and organised themselves as a provider of services to their own community.

The guide draws particular attention to the potential in funding existing community groups.

The National Service Framework for Older People

The National Service Framework for Older People (NSF) indicates that "health and social care services should recognise the greater prevalence of some illnesses among specific groups of people" and suggests that "all services should be culturally appropriate".

Bme issues are addressed in all Standards by acknowledging that multiple discrimination, cultural insensitivity in areas such as hospital food and mixed wards, propensity to stroke, and cultural bias in mental health assessments disadvantage bme users.

Person-centred care-planning and care are highlighted in Standard Two as a way of recognising and incorporating cultural and religious differences. Standard Eight also states clearly that health promotion activity should take account of differences in lifestyle and the impact of cultural and religious beliefs. Appropriate and accessible opportunities to engage in physical activity will only be created through consultation with local bme communities.

The Devon County Implementation Group and The Health Forum in their handbook *Promoting Health and Active Life in Older Age* (2002) state clearly their approach to bme elder health.

> *To ensure we are pro-active in promoting health and active life in older age it is necessary for professionals to build up expertise in research, education and training so that effective person-centred and broader community based activities can be delivered within an appropriate cultural, linguistic and anti-discriminatory framework.*

Exeter Social Inclusion Strategy Plan 2003-2006

Exeter Social, Health and Inclusion Partnership (Exeter SHIP) has responsibility for formulation, implementation and monitoring of a social inclusion strategy whose purpose is to tackle inequalities in health, social care, housing, and education and to promote community involvement in Exeter.

Objective A4 of the Strategy sets out a clear intention to:

> *promote social inclusion and integration and prevent the exclusion of vulnerable groups and their carers by* ***targeting***[15] *healthcare and other services to improve their health and well-being.*

The Strategy goes on to explain how this might be achieved by the PCT and DCC SSD working together with local stakeholders and partners to improve

> *access to healthcare, social services, learning and cultural activities for older people who are excluded, or are at risk of exclusion, to improve their quality of life.*

The objectives, arranged under five headings, include a number designed specifically to

- Develop Strong Communities
- Sustain Partnership Working.

It is expected by Exeter SHIP that projects will be supported which foster "cultural activities" and

> *the capacity building of the community and voluntary sector to enable their participation and development.*

These proposals are in line with the action plan, *Our City, Our Future*[16] where sections on reducing health inequalities, and promoting equal access to services and information reinforce the Strategy's clear intentions.

[15] Our emphasis.
[16] Exeter Vision Partnership 2003.

Summary

Research shows a multi-agency consensus that health and social care needs among Britain's bme communities remain hidden and frequently unmet. Recent consultation events in Exeter have exposed a similar picture.

The government has, through legislation and recommendations, emphasised its commitment to improving the situation for these marginalized groups. Working with existing agencies and local groups, councils and Health Trusts are clearly expected to make tangible changes to the life-style opportunities, access to information, and health status enjoyed by bme elders.

Universal access to mainstream services has to be an ideal towards which we all strive. But what if our starting point is a city whose services and facilities are predicated on the needs of a monoculture? A city which has, despite a small but constant presence, remained relatively unaware of its ethnic minority inhabitants? Such an ideal would require substantial change.

With the best will in the world, such change takes time. The story is replicated across the UK's rural counties. Change occurs, but is slower. What is easier is to utilise what already exists, support what is already there. What is needed is thinking "outside the (one-size-fits-all) box"[17].

Exeter is fortunate that groups and networks used and trusted by older bme citizens in the city are well established. Opportunity exists *today* to develop a needs-led service for older Muslim people at a site which can also provide valued spiritual comfort.

We applaud change, but it is a fact of life that older people, of whatever ethnic origin, cannot wait for long. Bearing this in mind, the Study Team strongly recommends that work begins at the earliest opportunity towards securing a better future for Exeter's Muslim older people by providing a culturally specific day opportunity at the York Road complex.

[17] From the forthcoming RD&E NHS Trust Equality and Diversity Conference, July 2004

Appendix I

REMOVING THE BARRIERS

MEETING THE NEEDS OF MINORITY ETHNIC ELDERS **IN EXETER**

This questionnaire was prepared by :

Social Services Devon.

Age Concern Exeter

Islamic Centre of the South West

Connections Consultancy.

CONFIDENTIAL

Explain carefully the purpose of the visit. Why do you need the information?
All information given is CONFIDENTIAL

1 Basic Information

Name:

Address:

Date of Birth:

Who lives in the house with you?

Do they work? (If so, where, hours, do they do shifts etc?)

2 Daily Routines

Who has responsibility for doing the following?

Food shopping

Preparing and cooking food

Cleaning

Laundry

Money - utilities and bills
pensions

Childcare

Filling in forms

Transport

Do you receive any of the following?

Income Support	DLA	Attendance Allowance	Housing Benefit
☐	☐	☐	☐

Mobility

Do you have any difficulty with any of the following?

	No difficult	Some difficult	Not able to do
Walking/moving around indoors			
Getting in and our of a chair			
Managing steps and stairs			
Walking/moving around out of doors			
Getting in/out of a car			
Using public transport			

Do you use a walking stick or a frame?

Are you registered disabled?

Hearing/sight

Do you have any eyesight difficulties?

Do you wear glasses for reading/distance?

Do you have any hearing difficulties?

Do you wear a hearing aid?

3 Health

Would you say your health is:

very good good fair poor

Do you have to see your doctor, visit the hospital or see a health worker on a regular basis?

If so,

What treatment are you having?

Are you taking any medication?

Who collects your prescription?

Is this a repeat prescription?

Do you use a medi wallet?

Do you go to:

- [ ] Chiropodist
- [ ] Physiotherapist
- [ ] Dietician
- [ ] Optician
- [ ] Dentist
- [ ] Other health professionals

Do you have any special dietary needs?
Religious/Cultural/Medical

How easy do you find it to get to these places?

Do you need an interpreter in order to use these services?

4 Personal Care (for interpreters to explain)

Help in everyday needs including intimate personal tasks (eg hair washing, skin care, washing, going to the toilet)

Do you need help	Washing
	Dressing
	Bathing
	Using the toilet - ask question as part of a general conversation
	Eating
	Drinking
	Taking medication

5 Leisure

How do you spend your time during the day?

Do you watch TV?

What do you like to watch?

What would you like to watch if possible?

Do you listen to the radio?

Do you like to read?

Do you talk to people on the telephone?

Do you have a particular interest that you enjoy?

How often do you go out?

Do you go on holiday?

Is there anywhere you would like to visit?

Can you go alone or do you need help?

Is there anyone you like to visit?

How often to you get to see them?

Do you take any form of exercise?

For example: Walking

Swimming

Is there anything else, given the chance, that you would like to do?

Is there anything you would like to do more often if you had someone to take you?

Do you go to a place of worship? How often?

6 Services

Do you know about Social Services?

Have you ever contacted them? If yes, what was their response?

Do you know about Age Concern Exeter?

Do you know what they do?

Have you been, or have ever considered going, to Age Concern or another day centre for older people?

If yes, what did you like?

If no, why not?

How would you feel about a drop-in centre for older people at the Islamic Centre?

If you attended a drop-in centre what would you want to do there?

Please also suggest e.g. information on health care, benefits

Is there anything you would like to say about what it is like to grow old in Exeter?

Have you any questions?

Assessment

Briefly outline any other issues that have arisen? (have you identified concerns relating to isolation etc?)

Appendix II

Consultation at the Islamic Centre 5th October 2003

The need for a consultation with the Muslim community came about after a more specific consultation with the older members of the community which had concentrated on their health and social needs. It became apparent that there were other issues of concern to the Muslim community and that a fuller consultation was needed.

These concerns encompassed all areas of activity of Devon County Council ranging from access to leisure to Transport and road safety and much in between.

The consultation day was announced to the community on three preceding Fridays after Jumah (Friday mid-day) prayers and through the community learning groups held at the centre.

There was recognition that by concentrating on the community attending the Islamic centre a sizeable number of Muslims who do not use the Centre would be excluded. This group are divided into what would be termed 'secular' Muslims and those who do not use the centre for a variety of reasons which will be discussed later. This report will focus on the findings made during the consultation.

The consultation was carried out with the help of Brenda Laker, Diversity Officer for Social services Directorate Devon County, Fiona Hutton Age Concern, Julie Cornwall, Consultant and Anderson Jones DRIVE, CVS

The consultation took place at the Islamic Centre 5th October 1p.m with approximately 110-125 participants. Lunch was provided (cooked by the Olive Tree ladies)

The plenary session identified four main topics. At the suggestion of the participants, men and women separated into separate groups, with separate groups being led by a facilitator.

The Women and children group was facilitated by Julie Cornwall and Kauser Ahmed

Issues discussed:

1. Health

2. Social exclusion due to language and transport
3. Education of children
4. Learning opportunities for women
5. Leisure provision
6. Mental health

Elderly group and Men – facilitated by Brenda Laker and Fiona Hutton

Issues discussed:

1. Day care
2. Health advice
3. social and educational facilities
4. Transport

Young people 14-25 yrs facilitated by Kauser and Anderson

Issues discussed:

1. Racism
2. job opportunities
3. leisure facilities

<u>Outcomes</u>

<u>Elderly</u>

The need for transport to bring the majority of the elderly to the facilities already existing at the Islamic centre was something that all those present stressed. It was pointed out that some people had not been able to come to the consultation because their children had not been free to bring them to the centre and they were not able to use public transport because of ill health. Fiona's suggestion that Community transport could be utilised, was welcomed. Trips to social events, shopping and access to health providers were desired.

All wanted a day centre where there would be an opportunity to socialise, have a cup of tea and snacks, obtain health and benefits advice and surf the internet!

Fiona was inundated with requests to help with benefits and it became very clear that this was an unmet need. Advice around domiciliary services and gardening assistance was also sought.

Isolation for many of the elderly Muslims is a fact of life, exacerbated by ill health. This was to a greater extent for elderly women. There is no concept of

having ‘hobbies’ and for many the religious duties provide the structure to their lives. However, all of them recognise that physical activity would improve their health. Requests for single sex gym and swimming sessions were made.

One very important request was for a pedestrian crossing on York Road. Friday prayers attract up to 400 worshippers and on special occasions such as Eid this number can be doubled. This can present a danger for both pedestrians and motorists as people often crowd on to the street.

Some of the elders wanted a ‘lollipop man’ to ease the situation and prevent anti-social behaviour.

Voices:

“It is difficult to ask for help because I think they will tell me that I have to go to old people’s home and I need to be able to make wudu (ablution) and say my prayers”

“I am worried that there will be a serious accident outside the Mosque because people do not take care when they cross and the cars come down very fast; the council do not think that we could need help like this.”

“I have lived in Exeter for thirty years and I have been very happy. It is more tolerant and peaceful than in East London where my relatives live.”

“As we become older we become like disabled people and we realise that we need help and extra support”

“We need to talk with each other. Muslims are open and we welcome people to come to the Mosque and meet us. There is a lot of misunderstanding about Muslims in the community. We all have to be willing to listen and communicate”

Women and children

The women themselves requested that the consultation take place in gender separated groups as they would feel easier in expressing themselves.

The women were very articulate and open in their discussion of the issues which they felt were of concern to them, some using interpreters to convey their views.

Education of children was of prime concern to the women. 60% of the women present (55) said that they had paid for private tuition for their children. This

was often because the parents felt that their own lack of or deficiency of a formal education could disadvantage their children. Those parents who did have higher education nevertheless felt that it was important for their children to do well as this was the key to them being successful members of the community.

Family learning projects were seen as an ideal way to allow parents to help younger children but the short term courses were seen as inadequate and sporadic to be successful.

The issue of racism within schools was a factor which was seen as holding many children back. There was a clear dissatisfaction with the authorities' dealings of incidents of racism within schools and that racism was not challenged firmly in schools especially where it was by staff. Many mothers had tried to intervene on behalf of their children but felt that they had been treated with condescension and belittled.

Alongside the emphasis on success in mainstream education was a desire for own language tuition for children. It was felt that there was a growing gap in understanding between parents and children arising from a lack of communication and a culture gap between the different generations. This was leading to a estrangement of family relationships and many mothers felt that this was a cause of why many young people especially boys, were 'going off the rails' and some were involved in what the parents regarded as 'wrong' behaviour, such as hanging out in snooker clubs, where they were more likely to partake in smoking or be tempted to drink alcohol. This was of huge concern to the mothers and led to a discussion of the recreational facilities they would like to see provided for the youth.

Another request was for family mediators to be available to liaise between parents and children, but these counsellors would need to be well informed in both the culture and religious needs of the parents and the needs of the children.

A discussion on school meals took place and the women were asked if they wanted their children to have halaal meals for school lunch. There was a straight 50% split on this. Mother's who wanted to see halaal meals provided said it was because of the poor quality of the vegetarian option. On further probing, it came out that if the vegetarian meals improved in their quality and was not simply giving extra potatoes or cheese servings, then, halaal meals would not be necessary. All expressed anxiety over the sourcing of the meat and this could become contentious.

For themselves, the women wanted vocational training, structured to fit better around the demands made on them, as mothers and wives and the requirements of their faith.

The desire to be economically independent was great and the suggestion of setting up a co-operative at the centre for sewing and cooking was welcomed.

Transport was raised as an issue for many of the women as many of them do not have access to private cars. The problems of using public transport with young children were essentially the same as for any young mothers irrespective of ethnicity! However, a lack of, or poor, English language skills resulted in a loss of confidence in using the service.

It was pointed out that many women had not been able to attend the consultation because they did not have transport. Others had come with friends and neighbours. Those suffering from ill health experienced more isolation and this resulted in high levels of depression.

Overall the health of the women was not good. In comparison to the wider community, the women suffered from a range of serious conditions. Those over the age of 40 reported diabetes, high blood pressure and angina, arthritis and depression with nearly 80% of women over 40 on medication. This is very much in keeping with national findings.

All the women wanted keep fit, swimming and the setting up of a slimming club as many of the women are overweight. The lack of women only facilities within public leisure amenities are a serious issue as Muslim women cannot access mixed gender facilities. At present Northbrook Swimming pool is available on a Sunday evening but at a greater cost then to the wider community.

Many women felt that language difficulties prevented them from accessing good health advice from professionals such as midwives and dieticians. They felt that having professionals come to the centre where there was language support would be highly beneficial. This would also give the women an opportunity to discuss other health issues, personal problems etc, but they wanted someone who would respect their confidentiality.

The women saw the establishing of a community centre which would co-ordinate social and educational activities for the community as being of paramount importance. The facilities at the Centre need to be upgraded but this was seen as essential to meeting the needs of the community and assistance would be required from outside sources as the community itself was unable to raise sufficient funds.

Voices:

"When you have children and have no car it is very difficult to go anywhere. I have to wait for my husband to come and take me out, but he works in the take away and works very long hours"

"I am very worried for my children. It is more difficult for them now because there is a bad feeling for Muslims"

"I notice that Muslim women are unfit and unhealthy and I know it is because many are too shy to go to a gym or exercise classes. We need to have only women sessions at local swimming pools, gyms and other places so that we can use the facilities \that other people use."

"I am happy to live in Exeter now. I was very lonely at first because I could not speak English and my husband came here as a refugee and he was always sad so he could not really give me support. Now, I am learning English at the Mosque (with the Olive Tree Project) and I have made friends with other women, we have a good time together"

"Our children are more like English children. They don't understand why I ask them to do certain things and show a lot of disrespect to our culture. They are very confused about their identity and I feel sad that we are growing apart."

<u>Youth</u>

About 25 young people were present but the group which was facilitated was all male.

Racism and career opportunities were of paramount importance to this group. The young men felt that their needs were not understood either by their parents and older Muslims or by the wider community. They were always being asked to walk the middle line between different cultures and although most of them managed very well it was a strain to be always having to explain themselves.

Many of the youngsters felt that there was huge rise in Islamophobia and that they felt that as Muslims they received a great deal of hostility from all sides. The media was blamed but even on a local level many of the young men gave examples of casual racism at school and even when being served in shops.

One young man cited his experience during a holiday job. His manager had called him a "f…nigger" when he had made a mistake. It was only weeks later that a college tutor had urged him to report this to the Police. (No action has yet been taken.) Racism within schools and colleges was described as being 'always there'. One particular school was singled out as being particularly bad. Bad experiences at school were suggested as reasons why many Muslim young men did badly at A' levels.

The suggestion of a youth counsellor was welcomed as was the need for good careers advice as all of the young people felt that connexions did not understand the challenges faced by them first as members of BME groups and then as Muslims.

A fascinating opinion that emerged was that the young men felt that racism against Black people had decreased as they were perceived to be more like the white community and seen as being 'cool'. Black heroes in sport and music have given them an acceptance within white Britain, whereas the linking of terrorism with Muslims has created an acceptance of racism against Muslims, whatever their ethnic background.

Voices:

"I don't have a problem with the police. I think that they are just doing their job and if you keep off drugs and stuff, they keep off you"

"I wouldn't go out late at night on my own. Once I was in Sidwell Street and a couple of lads saw me from across the road and they shouted some abuse like 'f…off Paki' I just ignored them and walked off quickly"

"My school was horrible. The teachers didn't care what I was doing. It was, like, up to you to understand things and if you didn't then hard luck. Some of the teachers were, like, trying to be nice, because they wanted to show me that they're not racist; but other teachers were really obvious. There was one teacher, if he saw me in a group with other kids, and if we were messing about, he would always pick on me and say 'I'm really surprised at you' Why? I just felt that he wanted me to be really quiet and respectful because that is what Asian kids are supposed to be"

"I think of myself as British. I was born here and I know that I will be spending the rest of my life here. I went to S…..for my holidays and that was great, but I couldn't live there."

"Yeh, I agree with that. But what really makes me mad is that some white English people think you can't be brown or black skinned and be British..."

"They think we don't want Britain to be safe or do well but that's stupid because we live here and we don't want bad things to happen to us or our friends and neighbours. It makes me really angry but sad as well."

"Respect Festival? Never heard of it. What was that all about?"

Action:

1. The impact on BME communities of transport policy as with other with low economic status is huge. Impact of reduced services and hike in prices adversely affect the quality of life of BME communities. Older members of the community and young mothers suffered adversely with any cut in services. Offering Community bus services for the Muslim community would be popular and beneficial.

2. Road safety has been ignored on York road and highlighted the need for a social centre where people could congregate to meet and converse instead of in the street, causing nuisance to other pedestrians and road users.

3. Economic growth within Devon depends on the retention of young people within the county. However, there is a perception that opportunities are limited and experiences of racism and the 'glass ceiling' have led many young people to conclude that career opportunities are greater in London, Bristol or other large cities. The Education directorate must tackle racism within schools through training both of staff and pupils. Statutory bodies with responsibility to

young people must recognise their duties to BME young people and begin to understand the challenges that they face.

4. There is an ageing population within the Muslim community with higher levels than average of ill health who will have cause to call on health and social services, yet these organisations are ill equipped to meet that challenge. There has to be recognition that although the numbers are yet small, the demographics show that appropriate provision must be planned for both in staff training and services.

Conclusion

The success of any consultation depends on the outcomes. Not all the expressed wishes and aspirations of the community can be met or addressed, but their views can inform the policies of the council and ensure that it meets its legal obligations under the Race Relations (Amendment) Act 2000.

All the participants expressed willingness to take part in citizen panels and were pleased to take part in the consultation. All however, were optimistic that their views would be taken seriously and that it would contribute to better community relations.

Kauser Ahmed, LLM, Education Liaison Officer

Islamic Centre of the South West

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