PART II

8 Strategies for Good Practice

There are four key aspects to addressing inequalities in health and social care and achieving cultural competence:

- Recognising and valuing diversity.
- Auditing systems and processes within an organisation.
- Creating a more inclusive organisational culture.
- Challenging individual attitudes and behaviour.

These aspects can be translated into very practical approaches to good practice within the health and social care sector. The list which follows is by no means exhaustive.

8.1 Mainstreaming

8.1.1 Mainstreaming has been defined by the Department of Health as a:

'… means of automatically considering the race equality dimension of everything that is done. Getting there involves staff with the skills, knowledge, expertise and attitudes to do this so that they take responsibility for this as part of their professional practice.' (Alexander, 1999)

8.1.2 Mainstreaming racial equality into the core of an organisation's work contrasts with the notion of 'special provision' whereby services are established specifically for the use of black and minority ethnic groups but not integrated into core funding, planning and service development. Such special provision can be offered from within a Trust, for example the post of Chinese community development worker with the elderly supported by the South and East Belfast Health and Social Services Trust [see also 8.3.2]. However in Northern Ireland at present the provision is more likely to be based within a black and minority ethnic organisation, for example, the project with older people in the Indian Community Centre or the health project for Traveller women run by Belfast Travellers Education

and Development Group [see also 8.4.2]. Appendix A gives further information on lawful positive action measures permitted under the Order.

8.1.3 These projects tend to be innovative, flexible and go some way to meeting needs. However, pilot projects usually access only short-term funding - with the exception of a permanent interpreter's post funded by the Eastern Health and Social Services Board and based in the Chinese Welfare Association [CWA]. The services – and the staff employed to provide them – are therefore vulnerable to financial cuts and lack a sense of permanency or a strategic approach. They may have very limited opportunities for personal or professional development and lack the status of those working in mainstream services.

8.1.4 A mainstreamed approach enables multi-agency working and a more holistic approach to health. Boards and Trusts could, for example, in considering the health issues of Travellers, build links with the NI Housing Executive and Housing Associations in order to be able to highlight the importance to health of a continuing programme of site provision, which will include clean water supply and adequate sanitation and appropriate waste disposal services. In this way, multi-agency approaches help to ensure that in the long list of competing issues, black and minority ethnic health issues do not get 'lost' or become lower priority, as there are a number of voices involved in the debate.

GOOD PRACTICE:

- Commitment and leadership at senior levels to introducing more mainstreamed service provision is essential in order to take into account local diversity in all policies and planning processes. Making connections and building up links with other statutory agencies as well as community and voluntary organisations is the first step. Good practice models established in other regions and countries can be shared and adopted rather than starting from scratch and 'reinventing the wheel' which is both time-consuming and costly.
- Locally, the Health Action Zone initiative run by the North and West Belfast Health and Social Services Trust provides opportunities for interagency working, sharing resources and is inclusive of the Traveller community. The interpreter's post mentioned at 8.1.3 is another innovative and sustainable model which is regularly evaluated and is based on a strong partnership approach between Board and community or voluntary organisation.
- Mainstream provision should always complement, not compete with, direct service provision offered within the black and minority ethnic community and voluntary sector.

8.2 Assessing Need of Local Populations

8.2.1 The 2001 Census of Population was the first Northern Ireland Census to contain a question on ethnicity. The profiling available from this should help identify black and minority ethnic families and individuals within individual Board and Trust areas. The next step is to find ways of engaging with these communities in order to begin to assess unmet needs. This exercise, which should be on-going and developmental, will be a means to an end of providing more effective services. It is important that the findings lead to action and bring about change so that communities see the process as beneficial in itself.

8.2.2 Ways of seeking views of black and minority ethnic service users might include:

- Talking to individuals and families, for example in hospitals, nursing homes or clinics.
- Holding public meetings to which community representatives are invited.
- Visiting local community centres and black and minority ethnic organisations.
- Utilising potential of local community workers and lay health workers in order to 'map' the work undertaken locally as a route to identifying unmet needs.
- Setting up equality liaison panels, patient participation groups or black and minority ethnic liaison committees.

The current lack of baseline data for black and minority ethnic communities requires designated needs assessments. However it is also important that a mainstreamed approach is adopted in order to address multiple identity issues, for example the needs of older people or those with a physical disability and also from a black and minority ethnic background.

8.2.3 It is important to remember that the majority of black and minority ethnic community organisations operate on a voluntary basis and so should not be expected to put aside more immediate demands to act as voluntary consultants to statutory agencies. Anyone using these communities' considerable expertise should offer to cover the cost of distributing papers, hiring venues, childcare arrangements and travel so that individuals and volunteers do not end up out of pocket. Nor should assumptions be made about individuals representing community views. Those arranging consultation sessions should try to ensure that the representatives chosen are recognised and respected spokespeople who can give collective views with some authority. Black and minority ethnic organisations will also need to be resourced if they are to continue to organise training for their communities in order to ensure that participants are informed and enabled to participate more effectively in consultation exercises.

GOOD PRACTICE:

- In any needs assessment exercise consultation must mean more than simply seeking the opinion of the community; any user involvement should also give the community power to influence and make decisions about their own needs. Health and social care professionals' views of where the biggest gaps in service lie may not always coincide with users' views of this. It is also important to build in a mechanism for reporting back on how views and comments were incorporated into new policies and practice as well as assessing the impact of any new initiatives or policies.

- The strength of needs assessments is that they can help bridge any gap regarding baseline data and help develop an action plan, with measurable targets and outcomes for Trusts and Boards.

8.3 Community Consultations and Partnerships

8.3.1 It is difficult for any public body to deliver appropriate services on its own. It is therefore essential to start making links and developing partnerships, particularly with the community and voluntary sector, a valuable resource offering a wealth of knowledge and expertise. Bodies such as the Community Development and Health Network (NI) and Belfast Healthy Cities have shown considerable commitment to engaging with black and minority ethnic groups in developing their health plans and policies in culturally sensitive ways. Commissioning from the sector may also sometimes be an appropriate course of action.

8.3.2 Some Trusts have established black and minority ethnic liaison groups to develop and lead on the implementation of service provision. The South and East Belfast Health and Social Services Trust has developed a multi-agency and multi-disciplinary approach in order to meet the needs of the black and minority ethnic communities in its area. Members of these communities are on the liaison group and examples of good practice which have ensued include:

- A Chinese community development worker based in the Chinese Welfare Association to meet the needs of older people more effectively.
- A bilingual Community Development Worker focusing on black and minority ethnic issues based in the Trust team.
- Cultural Diversity days for staff celebrating black and minority ethnic cultures and traditions.
- Conferences organised in partnership with the black and minority ethnic voluntary and community sector.
- Anti-Racism and cultural awareness training for staff.
- A communications project developing appropriate translated information and resources.

8.3.3 The Ulster Hospitals and Community Trust runs ante-natal and parent-craft classes with women from black and minority ethnic groups within the Trust's maternity outpatients department. The classes are run with the help of interpreters when necessary.

8.3.4 It is important that such initiatives are as inclusive as possible, ensuring that small groups without paid staff or representatives, and who may not be members of larger umbrella organisations, also have a voice in the process. Often individual health and social care needs can be greater where there is no apparent community infrastructure.

GOOD PRACTICE:

- Boards and Trusts should consider more involvement of black and minority ethnic community and voluntary organisations in the process of developing health strategy and purchasing intentions. A more informal style of working with black and minority ethnic organisations could be used, including undertaking visits, workshops or focus groups and the development of appropriate forums rather than relying on paper-based communication.

- Local models of good practice which incorporate both community consultation and strategic partnerships include the Sure Start Programme in South Belfast which employs a Chinese worker to link with Chinese families who have children in the 0-4 age group. Sure Start aims to improve health by supporting parents in caring for children and promoting their health and development – particularly those who are disadvantaged.

- Healthy Living Centres are also based around local partnerships which promote an holistic view of health, recognising social, economic and environmental influences and focusing on preventive health care. Black and minority ethnic groups fed into proposals in both Belfast and Craigavon, each underpinned by the principles of inclusion and equality of access.

8.4 Capacity Building

8.4.1 Many black and minority ethnic community and voluntary organisations are unfamiliar with changing NHS policies and practice and may have little knowledge about who they should approach to secure support. However, many undertake valuable work which contributes toward achieving health improvements for their communities. With others, raising awareness of the potential for health improvements is a prerequisite if they are to participate effectively in national and local strategies. One of the key difficulties communities say they face is that, while health agencies talk of 'partnership' arrangements with the community and voluntary sector, in many areas the development work has not taken place for this to be a reality.

8.4.2 Relatively recent examples of innovative work building the capacity of individuals from the black and minority ethnic communities includes the training and employment of community based minority ethnic staff, for example:

- Belfast Travellers' Education and Development Group, in partnership with the DHSSPS, has developed a joint initiative preparing Traveller women to become lay health workers.

- Barnardos, in partnership with the Chinese Welfare Association, initiated the Chinese Lay Health Project in September 1994, a project founded on community development principles. This is the only health project in Northern Ireland which focuses specifically on minority ethnic health issues. It currently employs two Chinese lay health workers to work in Belfast and Craigavon. Three staff have successfully completed social work courses, sponsored by Barnardos.

8.4.3 In August 1999 the DHSS set out its view of the way forward in community development in the Community Development Working Group Report entitled Mainstreaming Community Development in the Health and Personal Social Services. This renewed the Department's commitment in this area and recommended that Boards and Trusts develop community development strategies which impact on all aspects of their activity.

GOOD PRACTICE:

- Community development and capacity building should be accepted as an integral part of working in partnership. Boards and Trusts can play an important role in strengthening the infrastructure of the black and minority ethnic community and voluntary sector through resourcing and capacity building, for example, by the creation of specific health posts. These might include community development workers, lay health workers, link workers and/or interpreters with responsibilities for the particular community in question. Such workers should not be expected to go beyond their duties and perform a wider role for which they are not trained.

- Consideration should also be given to lengthening the term of contracts to ensure greater sustainability and develop capacity of both individual staff and organisations so that they are more capable of influencing health policy and practice. Health agencies should build in performance indicators and monitoring and evaluation systems in order to take into account changing health needs and priorities.

8.5 Training

8.5.1 Training for staff employed within the health and social services is generally very limited with regard to black and minority ethnic issues. Participants may therefore infer that these issues remain marginal to the mainstream areas with which health workers are expected to concern themselves. Courses can also teach one set of norms and values without encouraging students to understand and respect that others are equally valid. Such courses can therefore fail to equip workers with the specific skills or information they need to work effectively with black and minority ethnic patients.

8.5.2 Cultural awareness training provides information on the customs, habits and lifestyles of different cultures, religious or minority ethnic groups. It is often oriented to a health care environment, for example customs about death, birth and diet. However it is a somewhat limited model of training and it can reinforce stereotypes such as:

- Minority ethnic groups behave in similar ways.
- Aspects of cultures are static and do not change.
- Staff trained in 'cultural' knowledge means that the health service is now culturally competent.

8.5.3 It is unrealistic for everyone to know everything about different cultures. Access to background information (see Appendix D) and developing the skills to ask appropriate questions is potentially more useful.

8.5.4 Anti-discriminatory training focuses more on actions than attitudes, and the use of policies and processes to address issues of direct and indirect discrimination as well as institutional racism. This training can be provided by a number of the agencies mentioned in Section 10.

GOOD PRACTICE:

- Boards and Trusts should consider the implementation of a comprehensive training programme on anti-discriminatory practice for '*all* employees' in order to underpin this Guide.

- Courses should be designed to address diversity in values and beliefs. They should equip participants with the skills to look critically at their own cultural values as well as considering different family and support systems, different possible expectations in the use of health services, the position of minority ethnic groups in society and the likely implications for health care needs. Consideration should be given to using black and minority ethnic trainers from the community and voluntary sectors where possible when delivering racial awareness training.

- Such training should be built into all training courses in health and social care and should be part of both the induction of new staff as well as ongoing in-service programmes. Outcomes should also be continually monitored and re-evaluated in order to accommodate changing needs.

8.6 Monitoring

8.6.1 Monitoring of service provision, as well as in employment, helps to ensure that there are no unintentional barriers to accessing health and social services because of a person's specific need or background. Monitoring can be helpful in the following ways:

- It helps the provider get to know the local community.
- It indicates a commitment to equality in both employment and service delivery.
- It raises awareness of gaps in services.
- It improves access to services.
- It helps guide service provision toward the specific health and social care needs of a variety of black and minority ethnic groups, therefore developing priorities and targeting resources more effectively.
- It enables better targeted health promotion and prevention programmes.
- It measures outcomes.
- It can assist in developing and implementing Equality Schemes as required under Section 75 of the NI Act (see Appendix B).

8.6.2 Given that employers in Northern Ireland have had experience of monitoring on the basis of religious affiliation, perceived religious affiliation and gender, the extension of monitoring to include ethnicity should prove less burdensome and costly than would otherwise be the case. It is recognised that racial monitoring within service provision is a relatively new area which may require the use of more detailed categories. Advice and assistance should be sought from both the Equality Commission and the Department in developing this work.

GOOD PRACTICE:

- Decide what information it is important to collect, how feasible it is to collect it and, most importantly, how the data will be used. As well as ethnic origin, questions commonly asked include: religious and cultural needs, language needs, advocacy needs, specific health beliefs and use of other health care systems. Given the relatively small numbers of black and minority ethnic people in certain Trusts, it may be more useful in these areas to consider qualitative data.

- Any monitoring procedures should be agreed with black and minority ethnic representatives to prevent any suspicion or resentment about why the information is being collected. Employees and service users should be clearly informed about the reasons for monitoring, given guidance notes on how to respond to questions and given an assurance of confidentiality.

- All staff within the organisation should be briefed/trained on the monitoring policy and guidance notes to ensure a standardised approach.

8.7 Service Delivery

8.7.1 Health and social service policies determine the way in which services are organised and also how staff work within institutions. There are a number of ways in which existing policies may indirectly (and often unintentionally) result in black and minority ethnic patients receiving less favourable treatment, for example:

- Arrangements for dietary and religious needs.
- Interpreting and communication needs.
- Registration, medical records and appointments.
- Hospital care.
- Maternity and childcare provision.
- Employment and training.

8.7.2 The most appropriate way to ensure equity of treatment for black and minority ethnic individuals and communities is to consult with support organisations and umbrella groups within a Board or Trust area.

GOOD PRACTICE:

- Equal opportunities policies should include the core values which will underpin services and provide a clear, explicit guide for action.
- Core values (such as those included in these guidelines) might state that different people have different requirements; everyone is entitled to fair access and appropriate health care services, regardless of numbers, location etc; appropriate services should be designed in partnership with the sectors; communication as a key to service delivery and so on.
- Any policies should be developed in partnership with the black and minority ethnic sector.

8.7.3 The guidelines which follow will enable initial steps to be taken in developing good practice within health and social care policies. Particular emphasis has been placed on the needs of patients while hospitalised as this is where individuals often feel at their most vulnerable. It is again recommended that these guidelines should be part of any induction programme for all new staff and circulated to existing staff through in-service training.

8.7.4 Further guidance and support can be obtained from the Equality Commission NI or relevant black and minority ethnic support organisations. Please also refer to the contact list contained in Section 10 of this guide.

8.8 Dietary Needs

Many black and minority ethnic patients are unable to eat food from the standard hospital or day centre menu, either for religious reasons or because they are simply unused to a western diet. Clearly hospitals and other institutions have an obligation to provide appropriate

choices of meals for patients. Good practice includes:

- Procedures to record information relating to diet and cultural and religious requirements on patient and nursing records.
- Menus available in community languages with details of ingredients if requested.
- Relatives should be free to bring in food from home and adequate storage and heating facilities (within appropriate health and safety guidelines & in consultation with hospital staff) for such food should be provided.
- Training for dieticians and catering staff in assessing and delivering appropriate diets.

8.9 Religious Needs

Most hospitals set aside a room for use by Christian patients for prayer or worship. There may be nowhere for patients of other faiths to pray in private or simply to seek additional comfort and support. Good practice includes:

- The provision of a non-denominational quiet room for prayer or contemplation.
- Accessible list of religious leaders to be contacted on request or as part of the care of terminally ill or dying patients (see Section 10).
- Written information about access to religious and spiritual support translated into community languages.
- Provision in maternity services for staff to cater for religious requirements and ceremonies relating to childbirth.
- In the event of a death, consultation with the patient's carers regarding their preferences in relation to the preparation of the body and other religious requirements. Privacy and space for families to spend time together or to perform religious ceremonies should be allowed.
- Religious items, including religious and wedding jewellery to be treated with respect and not removed without the consent of the patient or their next of kin.
- Staff awareness of festivals, celebrations and holy days as these may affect procedures such as discharge.

8.10 Communication Needs

Service users whose first language is not English can be at a major disadvantage in getting access to health care. At the same time language is only one of the potential barriers to effective communication. Professionals and patients each bring their own expectations to any interaction.

Below are examples of ways in which some of the barriers to communication might be tackled. Please also refer to Section 9 with regard to working with interpreters.

- Trained interpreters for those community languages where there is sufficient demand and in particular for important discussions such as taking a medical history, discussing treatment options and obtaining informed consent.
- Register of hospital staff who speak less frequently needed languages for use in emergency situations within the hospital in question.
- Language point card to help front line staff identify the language a patient speaks.
- Training for health and social care workers in the most effective use of interpreters.
- Recruitment of lay health workers and link workers who speak one or more of the community languages.
- Hospital and clinic signs in English and in the most commonly used community languages.
- Well-translated leaflets on important health topics and on topics of special relevance to people who are unfamiliar with NHS provision e.g. how it works, what to bring into hospital for an inpatient stay, how to get the help needed, how to choose and change your GP and patients' rights. Decisions on which leaflets to translate should be taken in consultation with the black and minority ethnic communities.
- Leaflets and other materials written in plain English or produced in audio-visual form so that they can be understood by everyone.

- Training for staff particularly those on reception, as the first point of contact, to improve their own communication skills, including an opportunity to examine their own expectations of black and minority ethnic patients.
- Posters and leaflets etc reflecting the diversity of the population so that members of all groups realise that the service is there for them.
- Communication strategy to publicise the interpreting service and its availability to staff, patients, carers and black and minority ethnic community organisations.
- Recording and monitoring of the language and/or dialect of patients who do not speak English.

8.11 Registration, Medical Records and Appointments

Some black and minority ethnic groups have naming systems which differ from the British naming system on which NHS records are based, for example, the Chinese, Indian, Pakistani and Turkish communities. Experience has shown that patients from these groups are often subject to embarrassment, delays and confusion when attending clinics and surgery appointments and serious mistakes can occur over drugs and treatment. Examples of good practice include:

- Training receptionists, medical records staff and ward clerks in how to record names and how to avoid entering mistakes.
- Training for nursing staff and GPs in the different naming systems and how to address people correctly and politely.
- To improve continuity of care of nomadic Traveller families, health providers should be encouraged to issue patient-held family health records.
- Local Development Schemes allowing GPs additional time to spend with nomadic Travellers should be encouraged and if possible extended to other black and minority ethnic groups.

- Mechanisms to allow Travellers access to local GPs on a temporary basis, without necessitating new applications. Current system can be both difficult and time-consuming and potentially lead to Travellers accessing medical care only through the accident and emergency units of local hospitals.
- Consideration given to introducing clear, pictorial or colour-coded instructions on medication.

8.12 Hospital Care

Admission to hospital can be a stressful experience for anyone, but particularly so for people who have difficulties with language or who may have had negative experiences in the past. Some refugees and asylum seekers may have particular fears about medical examination and treatment if for example they have been subjected to physical or sexual abuse at the hands of medical staff in their country of origin. It should be noted that some women from black and minority ethnic communities will face multiple disadvantage and therefore cultural and religious requirements should be considered alongside gender-specific requirements.

In addition to religious and catering requirements (see above), it is also possible that black and minority ethnic patients may have preferences in personal hygiene and good practice which might include:

- The provision of full-length, long-sleeved gowns with adequate ties; full-length dressing gowns should also be made available.
- People for whom modesty is a particular issue should, when possible, have access to staff of the same sex.
- Both showers and baths should be provided on all wards.
- Hand basins should be available in the lavatories.
- The preferences and needs of dependent patients in relation to modesty, personal hygiene and hair care should be identified and met.
- People's cultural obligations in relation to visiting should be acknowledged and accommodated when possible. For example, in hospitals where there are large numbers of visitors due to patients

having extended families, opening times may be a more appropriate system.

8.13 Maternity and Childcare Provision

The time surrounding pregnancy and childbirth is one when women are particularly vulnerable, both emotionally and physically. This may also be the first time that some women have had to come into close contact with large health and social care organisations. In addition, many parents may have approaches, practices and priorities in child-rearing which are different from those of the child health practitioner, but which are nonetheless equally valid. Specific examples of good practice should include:

- Sensitivity in teaching hospitals, for example, in making it possible for patients to request that only female medical students be allowed to observe an examination.
- Ante-natal classes run by bilingual health workers, or with the aid of an interpreter, for women whose mother tongue is not English (see 8.3.3 above). This might include a few intensive lessons to teach them the English they will need during their stay in hospital.
- Basic information and instruction sheets should be translated and circulated.
- Health education programmes should highlight the importance of both ante-natal and post-natal care.
- Training for staff in using culturally unbiased developmental tests which take into account environmental differences for children from different social groups.
- Support to meet the particular needs of mothers and children from black and minority ethnic groups, eg bilingual mother and toddler groups, appropriate childminding provision, play groups and day nurseries and support groups for women of different communities where they can relax and speak their own language.
- Active recruitment of minority health workers who share the cultures, values and backgrounds of local black and minority ethnic groups.
- Training in relevant cultural and religious needs for those named ante-natal midwives who are assigned to black and minority ethnic mothers.

8.14 Employment Issues

- **Staff training** (see Section 8.5)
- **Training and employment of more black and minority staff** (see Section 8.4) in order to establish models of minority ethnic participation – particularly in areas of health promotion and prevention.
- **Positive Action**

  Positive action is allowed under the law in order to establish equal access or as redress for past discrimination. The aim of positive action is to ensure equality of opportunity. However the particular difficulty in Northern Ireland with regard to the positive action provisions in the Race Relations (NI) Order 1997 (see Appendix A) is that statistical information about the extent of black and minority ethnic participation in the workplace has only recently become available in some, but not all, organisations. This may prevent employers and training providers from assessing the applicability of positive action provisions. This makes ethnic monitoring (Section 8.6) even more important.

  Please refer to the Equality Commission's Code of Practice for Employers for the Elimination of Racial Discrimination and the Promotion of Equality of Opportunity in Employment or seek further advice and assistance with regard to positive action measures directly from the Commission.

GOOD PRACTICE:

- Specific measures to meet the special needs of black and minority ethnic individuals, such as language training, literacy skills or English as a Second Language.

- Specific courses for black and minority ethnic individuals under-represented in particular jobs. This could, for example, take the form of a management skills development programme for potential managers.

- Employers may also support training for people who are not their employees but who are from racial groups which are under-represented in particular work across Northern Ireland or a region of Northern Ireland:

  – directly, by providing or funding training in particular skills, perhaps with other employers or training organisations; or
  – indirectly, by providing work experience placements for trainees being trained by other organisations.

For further help and guidance, please refer to the Code of Practice for Employers on the Elimination of Racial Discrimination or contact the Equality Commission NI.

9 Interpreting Issues and Communication

9.1.1 The Race Relations (NI) Order 1997 places a legal duty on the way in which establishments provide their services. The legal duty to provide services without discrimination includes the duty to ensure that services accessible to the majority community are also accessible to members of a black and minority ethnic group. The need to communicate in languages other than English is often implicit rather than explicit. Nevertheless, failing to provide interpreting facilities in relation to service provision, when it is known that there is a language barrier, could be construed as unlawful racial discrimination.

9.1.2 In addition, Section 75 of the Northern Ireland Act 1998 imposes a duty on public authorities to have due regard to the need to promote equality of opportunity on grounds of race and due regard to the desirability of promoting good relations between different racial groups.

9.1.3 Providing an interpreting facility within the health and social care sectors:

- Improves communication.
- Reduces language and cultural barriers.
- Reduces the scope for wrong diagnosis and treatment.
- Enables patients to make choices.
- Increases patient satisfaction and reduces repeat visits.

9.1.4 A Regional Health and Social Services Interpreting Service for Black and Minority Ethnic Communities Project **"More than words"**, is currently underway. It is intended that this regional initiative will significantly improve access to health and social services by black and minority ethnic communities who do not speak English either as a first or competent second language. It will establish and deliver a programme of basic, advanced and specialist accredited interpreting training; establish a centrally co-ordinated register of on-call trained health and social services interpreters; identify interpreting and translation needs within the health and social services sector and develop standard glossaries of medical health and social services terms.

The Eastern Health and Social Services Board (EHSSB) has been commissioned to manage and deliver the project with the DHSSPS' Evaluation and Equality Unit overseeing the Project.

Regional Health & Social Services Interpreting Service,
"More Than Words"
Foyle Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH
Tel: 028 90 563794
Fax: 028 90 563752
Minicom: 02890563795
Contact: Colin Dickenson, Project Manager
email: *CDickenson@ehssb.n-i.nhs.uk*

9.2 What is an Interpreter's Role?

9.2.1 The main aim of the community interpreter is to assist clients from the community with which they work to get the best possible service from whatever agency they are dealing with. The starting point for this is good communication between the client and the professionals providing the service. Within the black and minority ethnic sector, there are a number of posts where interpreting plays a major role.

9.2.2 Interpreters' posts: Interpreters are employed full-time, part-time or on a voluntary or sessional basis to facilitate linguistic communication. It is sometimes argued that interpreters offering word-for-word interpreting do not always provide the most appropriate service in health matters. The patient may not understand the implications of what is being said and feel vulnerable and powerless, whilst the professional often requires advice on the appropriateness of treatment and care with regard to the person's religious and cultural needs; a role beyond that of an interpreter.

9.2.3 Lay health workers or Linkworkers act as more of a bridge between clients and professionals. They can offer befriending and information

to the client and, through their knowledge of the community, can offer cultural information to the professionals. They therefore become involved in the development of more appropriate and accessible services through feedback to the agencies.

9.2.4 The role of Health Advocates is to empower clients to articulate their own expectations and health needs by facilitating communication, advising them on their rights and providing them with information on the availability of health services, including the different options available to them. They are able to challenge discriminatory practice and help providers identify local need, gaps in local service provision and other inadequacies of the service.

9.2.5 For the purposes of the following sections we will focus on the role of Interpreter only.

9.3 The dangers of using untrained/unskilled interpreters

9.3.1 Black and minority ethnic individuals who are unfamiliar with the health service in this country often find themselves in particularly stressful situations with regard to their health, for example, the first time in hospital or house calls from the health visitor. This additional stress and fear can inhibit them from using the simple English they may already know. The patient and professional will probably be able to 'get by' in these circumstances but the quality of service is clearly impaired.

9.3.2 "Someone is usually there to help". In most situations a child or other relative is relied upon to interpret. An assumption is being made that any bi-lingual person can interpret in any given situation.

The practice of using children disregards the harmful effects it may have on the child. Children may often be able to interpret in very general terms but their linguistic competence in both languages is almost certainly inadequate when technical or specialist language and concepts are used. In addition, the situation may involve a particularly disturbing matter (such as abuse in the home) or may require the child

to ask intimate or embarrassing questions of his/her parent; in this instance the child may reword the question totally in order to minimise the embarrassment factor.

Situations like these can mean that the parent becomes dependent on the child, involving a role reversal. The child is also unlikely to be mature enough to handle this new role of gaining power and knowledge over their parents.

On a practical level, the child may regularly be kept away from school, for it will not only be on matters of health that the child is required to interpret, and this can affect educational progress as well as lead to conflict and resentment in the home.

"They think we don't mind. Of course we do. And of course we would very much like the hospital to provide someone who could interpret for us. There are many things my son should not know at his age and they ask him all these questions to ask me and explain to him all these things. And he knows I am embarrassed, and of course some of the things I cannot tell him, even if I think they are really important, like some pains that I get, or bleeding. But I am not going to tell a boy of his age; I am worried about how all this will affect him later. But what else can I do when it is left up to me?"
(Romanian woman)

9.3.3 Using other relatives or friends also gives rise to difficulties. A personal relationship between patient and 'interpreter' can prevent impartiality and client confidentiality. The 'interpreter' may withhold important information - for example, a woman who is depressed because of her marriage may not be able to get to the root of the trouble if her husband is acting as interpreter. Since the patient is known to them, the 'interpreter' may report what they think they ought to say, rather than what was actually said. Moreover, it may turn out that the relative/friend has only a little more English than the patient. The situation can create an unwelcome sense of dependency and undermine the position of the patient.

9.3.4 "We usually use a member of the hospital or health centre staff". Some professionals claim that interpreters are not necessary since they can access someone on their own staff who speaks the relevant language. However, although this is preferable to using friends or relatives, it is generally not good practice (except in emergency situations) since these members of staff were employed to do a particular job, not to act as interpreters.

Bilingual staff may resent being put in such a situation but feel obliged to comply. In addition, a conflict of interest might arise. Interpreters who are seen by the patient as spokespersons for the service-provider may be viewed with mistrust. The staff may feel pressure from both sides as a result. It is also important to remember that the member of staff may come from a completely different background and have nothing in common with patients from the local black and minority ethnic community. A Hindu doctor from South India and a Muslim women from the rural Punjab may both be perceived as 'Asian' yet have nothing else in common, not even language.

9.3.5 Additional shortcomings of using untrained interpreters include:

- No assurance of competence of individual in language(s) he/she claims to speak.
- No obligation to maintain honesty, confidentiality, trust or impartiality.
- Possible misuse of power.
- Imposition of subjective views, often with the good intention of being 'helpful'.
- Time offered may be extremely limited.

9.4 Where can we access an Interpreter?

9.4.1 The public authority should take the initiative, and the responsibility, to provide an interpreter when requested or required.

9.4.2 Full-time/part-time interpreters based in Health Boards or Trusts. *There are none in Northern Ireland at the time of going to print.*

9.4.3 Full-time/part-time interpreters based in black and minority ethnic community centres. *As of January 2002, there were six in the Chinese community and two in the Asian community. One position is fully funded by a Health Board and the others are all part-funded by Boards and/or Trusts. Two are full-time and six are part-time.*

9.4.4 Centralised, independent, multi-agency interpreting service. *This is not available in Northern Ireland.*

9.4.5 Regional health interpreting service with a register of sessional interpreters. *An initiative is currently underway, underway - The "More than Words" project referred to in para 9.1.4.*

9.4.6 Telephone interpreting: National telephone interpreting services are already used by a number of Health Trusts. However, while useful for emergencies and for less common languages, these can be expensive services which are not ideal as the main or only means of inter-cultural communication. A number of black and minority ethnic community organisations also offer telephone support.

9.4.7 Sessional interpreters from either black and minority ethnic community centres or commercial interpreting agencies.

9.4.8 Other bi-lingual staff, both paid and unpaid, based in black and minority ethnic community centres, such as community workers or administrative staff may be available in an emergency.

9.4.9 A list of black and minority ethnic organisations and other agencies providing interpreting facilities is included in Section 10. Most of these community and voluntary organisations have to levy charges for interpreting and translation and this should be clarified with them at the outset.

9.5 What can a professional expect of an interpreter?

Reasonably	**Unreasonably**
- to be proficient in both languages	- to be a linguistic expert
- to be able to interpret accurately	- to speak the same language as the client simply because they both appear to be of the same ethnic origin
- to respect confidentiality	- to be familiar with all agency jargon & detailed procedures
- to be impartial	- to initiate or lead discussion
- to be mature, patient and even tempered	- to take on the professional's work
	- to wait around for hours
- to ensure both parties feel included at all times	- to advise the client or try to solve their problems
- to show evidence of experience and/or qualifications	- to provide the service free of charge

9.6 Interpreter's Responsibilities

- To make communication between client and professional as effective as possible.
- To respect confidentiality.
- To interrupt the interview if there is the need for explanation or clarification.
- To remain impartial throughout interview.
- To encourage the client not to withhold information with regard to health.

- At same time, to respect the right of the client to withhold information.
- To make sure all information is transferred accurately.
- To make sure that both parties understand why he/she was talking to the other for a long time, that is, not to let either the professional or the patient feel left out.
- Not to misuse his/her power over the two who cannot communicate directly.

- Not to take responsibility for specialised information, but ensure that the professional does.

9.7 Interpreter's Rights

- To be treated and respected as a professional.
- To ask for the time to do things properly before, during and after the interview excluding emergency situations.
- To be an interpreter, not a doctor, social/community worker, secretary etc.
- To get support, particularly when cases are particularly distressing or difficult, if possible.
- To stop the interview if demands are too great, if it is felt that it is beyond his/her capacity or beyond the boundaries of the interpreter's role.
- Not to interpret, but rather to withdraw the service if discriminatory attitudes or behaviour are demonstrated and to report immediately to his/her line manager.
- Not to be expected to be an 'expert' on medical or cultural issues.
- To get training.
- To get paid.

9.8 How to work well with an interpreter

- Clarify the method of payment early in order to prevent any confusion or embarrassment.
- Give adequate notice of the interview.
- Ensure the interpreter and patient speak the same language and dialect.
- Match the gender of the interpreter and patient if appropriate.
- Always treat the interpreter as a professional.
- Do not expect the interpreter to be an 'expert' on cultural matters.
- Avoid making false assumptions or generalisations about either the interpreter or patient.
- Respect the interpreter's independence and impartiality.
- Allow time for the interpreter to establish rapport with the

patient and to clarify his/her role.

- Try to speak to the patient, addressing them directly, not the interpreter.
- Speak in clear sentences with pauses in between for interpretation.
- Avoid jargon, abbreviations, specialist terminology and colloquialisms if possible.
- Check that the patient has understood fully and whether they want to ask anything else while interpreter is present.
- Allow time for post-interview discussion with the interpreter on his/her own, particularly after distressing situations.

9.9 Improving Communication in General

9.9.1 There will be times when an interpreter cannot be accessed and in these situations it is very important for health professionals to think about how they put their message across.

9.9.2 Non-verbal signals: Health workers and patients may misinterpret each other's intention if the non-verbal signals they use are based on different conventions. Many of these conventions are culture-based and largely unconscious. It is important that assumptions and judgements are not made without checking them out first.

At one point I was interpreting in a health centre. The doctor asked me "Why won't these people look me in the eye? Are they afraid of doctors?" It was difficult to explain to her that for our people it's just being respectful, looking down. I think she wanted me to tell people to stop doing it because it irritated her, but I felt it would have made things worse – people would get very embarrassed because they would think it was rude not to look down (Vietnamese interpreter)

9.9.3 Conventions of courtesy: words and gestures associated with politeness and good manners also vary from culture to culture. For example in many Asian languages, the words please and thank you are not normally used except on very formal occasions. Gratitude and polite requests are expressed in other ways through forms of address, etc. Understanding such differences can help avoid misunderstanding and resentment.

9.9.4 Simplifying communication: there are many ways to improve the process, including:

- Speak clearly and slowly but do not raise your voice.
- Use simple English and avoid using idioms such as 'spend a penny' and 'red tape'.
- Avoid using pidgin English which can be patronising and ambiguous.
- Get the patient's name right and try to pronounce it correctly.
- Always check back to make sure the patient understands and avoid questions which require only 'yes' answers. This is often the first word that one learns in a second language but can easily hold a variety of meanings.

9.10 Training

It should be noted that the way in which health and social care workers present advice or instructions has a significant effect on how much patients remember and whether they act on the information received. Health workers and others are increasingly aware of the importance of communication in health care; the issues referred to above can be built into in-service cultural awareness and anti-racism training in order to more effectively bridge the language and cultural gaps in service provision. Health staff will also benefit greatly from training in how to make the most effective use of interpreting resources. Agencies providing training are included in Section 10. Unfortunately none of the following organisations can provide textphone facilities.

9.11 The DHSSPS will ensure that contact details are updated on the website(s) once they have been informed of any changes by Organisations listed. Any change of contact details should be forwarded in writing to Strategic Planning Branch, C4.22 Castle Buildings Stormont Belfast BT4 3SJ.

10 Black and Minority Ethnic Communities in Northern Ireland

Contact list for interpreters, religious/spiritual leaders and training

Contact name:	Sunita Patra
Organisation:	Indian Community Centre
Address:	86 Clifton Street BELFAST BT13 1AB
Telephone Number:	02890 249746
Fax Number:	02890 278922
E-mail:	Info@iccbelfast.org.uk

Opening Times:	9am-5pm only	Evenings ✓	After 10pm ✓

Nature of work/service:

- Community Development
- Hindu temple used as a base for religious events

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No

If yes which languages are offered?

- Hindi
- Punjabi
- Kannad

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓ Hindu priest	No

TRAINING

Can training be accessed through you?	Yes ✓	No

If yes, which kind? (anti-racism, cultural awareness etc)

- Anti-racism
- Cultural awareness
- Indian cookery classes

Contact name:	Mrs A.S. Khan
Organisation:	Al-Nisa Muslim Women's Group
Address:	c/o 46 Mount Eden Park BELFAST BT9 6RB
Telephone Number:	02890 228135
Fax Number:	02890 228135
E-mail:	

Opening Times:	9am-5pm only ✓	Evenings ✓	After 10pm

Nature of work/service:
- Community work
- Language classes (English, Urdu, Arabic)
- Social activities/cultural events
- Capacity building

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No

If yes which languages are offered?
- Urdu
- Arabic
- French

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓	No

TRAINING

Can training be accessed through you?	Yes ✓	No

If yes, which kind? (anti-racism, cultural awareness etc)
- Cultural awareness (Muslim culture and tradition)
- Training pack and fact sheets on health, education, policing and social services

Contact name:	Jamal Iweida
Organisation:	Belfast Islamic Centre
Address:	38 Wellington Park BELFAST BT9 6DN
Telephone Number:	02890 664465
Fax Number:	02890 913148
E-mail:	jamaliweida@hotmail.com

Opening Times:	9am-5pm only ✓	Evenings ✓	After 10pm

Nature of work/service:

- Religious, cultural, social, educational training
- Interpretation, translation, presentations
- Women's and young people's activities
- Information centre

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No

If yes which languages are offered?

- Arabic
- Urdu
- Bengali
- Malay

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓	No

TRAINING

Can training be accessed through you?	Yes ✓	No

If yes, which kind? (anti-racism, cultural awareness etc)

- Religious and cultural awareness
- Anti-racism (anti-Islamophobia)
- Contemporary Islam and Muslims in NI

Contact name:	Paul Yam
Organisation:	Wah Hep Chinese Community Association
Address:	Brownlow Health Centre 1 Legahory Centre Brownlow Craigavon BT65 5BE
Telephone Number:	02838 341143
Fax Number:	02838 345983
E-mail:	

Opening Times:	9am-5pm only ✓	Evenings	After 10pm

Nature of work/service:
- Community development
- Family support
- Youth work
- Interpreter services
- After school club
- Chinese school
- Adult English classes
- Chinese festivals
- Summer activities – family outings and classes, workshops etc

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No

If yes which languages are offered?
- Chinese
- Cantonese
- Limited service in Mandarin and Hakka

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes	No ✓

TRAINING

Can training be accessed through you?	Yes ✓	No

If yes, which kind? (anti-racism, cultural awareness etc)
- Anti-racism
- Cultural awareness

Contact name:	Anna Manwah Lo
Organisation:	Chinese Welfare Association
Address:	133 –135 University Street BELFAST BT7 1HP
Telephone Number:	02890 288277
Fax Number:	02890 288278
E-mail:	cwa.anna@cinni.org

Opening Times:	9am-5pm only ✓	Evenings ✓	After 10pm ✓

Nature of work/service:

- Community development – Regional Chinese Community Forum, after schools club, older peoples group, youth group, Derry Sai Pak Chinese Community Association, Oi Kwan women's group, English classes
- Direct services – welfare rights and immigration advice, interpreting and translation, racial incident monitoring
- Community relations – working with other statutory and voluntary organisations
- Cultural awareness and anti-racism training
- Multi-cultural and cross community project management

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No

If yes which languages are offered?

- Cantonese
- Hakka
- Mandarin

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓	No

TRAINING

Can training be accessed through you?	Yes ✓	No

If yes, which kind? (anti-racism, cultural awareness etc)

- Anti-racism
- Cultural awareness

Contact name:	Patrick Yu
Organisation:	Northern Ireland Council for Ethnic Minorities
Address:	3rd Floor, Ascot House 24 – 31 Shaftesbury Square BELFAST BT2 7DB
Telephone Number:	02890 238645
Fax Number:	02890 319485
E-mail:	info@nicem.org.uk

Opening Times:	9am-5pm only ✓	Evenings	After 10pm

Nature of work/service:

- Capacity building for ethnic minority community groups
- Policy and information on race equality and Section 75
- Anti-racism and anti-discrimination training
- Immigration, asylum and refugee services
- Provides accredited training for community interpreters

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No

If yes which languages are offered?

- Italian
- Hakka
- Spanish
- Urdu
- Arabic
- Cantonese
- French
- Hindi
- Polish
- Mandarin
- Portuguese
- Punjabi
- Russian

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes	No ✓

TRAINING

Can training be accessed through you?	Yes ✓	No

If yes, which kind? (anti-racism, cultural awareness etc)

- Anti-racism
- Anti-discrimination

Contact name:	
Organisation:	Multi-Cultural Resource Centre
Address:	12 Upper Crescent BELFAST BT7 1NT
Telephone Number:	02890 244639
Fax Number:	02890 329581
E-mail:	info@mcrc-ni.org

Opening Times:	9am-5pm only ✓	Evenings	After 10pm

Nature of work/service:

- Health and social well being project
- Resource library
- Active citizenship project with outreach and community development role
- Weekly drop-in for women and young children

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No

If yes which languages are offered?

- In exceptional circumstances will assist in finding interpreters in lesser used languages , eg. Laos, Hungarian and Korean

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓ Can provide referrals	No

TRAINING

Can training be accessed through you?	Yes ✓	No

If yes, which kind? (anti-racism, cultural awareness etc)

- Anti-racism and training can be arranged through MCRC
- Briefing sessions for practitioners and students can be arranged

Contact name:	Joan McGovern
Organisation:	Barnardos Chinese Health Project
Address:	100 Lisburn Road BELFAST BT9 6AG
Telephone Number:	028 90 238742
Fax Number:	028 90 681604
E-mail:	joan.mcgovern@barnardos.org.uk

Opening Times:	9am-5pm only ✓	Evenings	After 10pm

Nature of work/service:

- Bi-lingual health advocacy and support service to Chinese children and their families in Belfast and Craigavon areas
- Ongoing casework with families and links with statutory service providers ensuring equality of access and provision
- Researching need and lobbying policy makers and service providers to address identified needs

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No

If yes which languages are offered?

- Cantonese
- Mandarin

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes	No ✓

TRAINING

Can training be accessed through you?	Yes	No ✓

If yes, which kind? (anti-racism, cultural awareness etc)

Contact name:	Maria Qureshi and Rukhsar Ali
Organisation:	Al-Nur Muslim Women's Association
Address:	Moylinn House 21 Legahory Centre Brownlow Craigavon BT65 5BE
Telephone Number:	02838 346607
Fax Number:	02838 346607
E-mail:	

Opening Times:	9.30am-3.30pm only ✓	Evenings on mobile ✓ 0787 6675221	After 10pm

Nature of work/service:

- Interpreting service in the Southern Board area for Health and Social Services, Education and Social Security

INTERPRETING

Can an interpreter be accessed through you?	Yes ✓	No
If yes which languages are offered? • Urdu • Punjabi		

RELIGION

Can a religious/spiritual leader be accessed through you?	Yes ✓	No

TRAINING

Can training be accessed through you?	Yes ✓	No
If yes, which kind? (anti-racism, cultural awareness etc) • Culture and tradition • Islam and Muslims in NI		

Please note that a number of private interpreting and translation agencies offer a language service. For further advice and assistance the following organisations can also be contacted. This is not an exhaustive list.

Norma Simon
Belfast Hebrew Congregation
The Wolfson Centre
49 Somerton Road
Belfast BT15 3LH

Tel: 028 90 777974

Hare Khrishna
140 Upper Dunmurry Lane
BELFAST BT17 0HE

Tel: 028 90 620530

Sikh Community Project
163 Cavehill Road
BELFAST BT15 5NB

Tel: 028 90 284400

Pippa Cookson
Belfast Baha'i Community
442 Springfield Road
BELFAST BT12 7DW

Tel: 028 90 321752

Dr James Uhomoibhi
NI African Cultural Centre
60 Lisburn Road
BELFAST BT9 6AF

Tel: 028 90 244401

Traveller Movement NI
30 University Street
BELFAST BT7 1FZ

Tel: 028 90 202727

Paul Noonan
Belfast Travellers Education and Development Group
Unit 12-2 Blackstaff Complex
77 Springfielf Road
BELFAST BT12 7AE

Tel: 028 90 203337

Belfast Travellers Support Group
Units 1-3
77 Springfield Road
BELFAST BT12 7EA

Tel: 028 90 205330

Norman Richardson
NI Interfaith Forum
c/o Stranmillis College
Stranmillis Road
BELFAST BT9 5DY

Tel: 028 90 384328

Eva McKelvey
Northern Ireland Filipino Association
c/o NICEM
24-31 Shaftesbury Square
BELFAST BT2 7DB

Tel: 028 90 238645

Li Yuan
Mandarin Speakers Association
9 Stranmillis Road
BELFAST BT9 5AF

Tel: 028 90 687793

Anastacia Walls
Mid Ulster International Group
40 Piney Hill
MAGHERAFELT BT45 6PZ

Tel: 028 79 301995

Mr Rob
Bangladeshi Welfare Association
24 Greenwell Street
NEWTOWNARDS BT23 7LN

Tel: 028 91 810566

Margaret Boyle
Derry Travellers Support Group
Ballyarnett Park
Race Course Road
DERRY BT48 8NG

Tel: 028 71 359340

Inez Keenan
Craigavon Travellers Support Group
21 Legahory Centre
CRAIGAVON BT65 5BE

Tel: 028 38 342089

Tony Browne
Sai Pak Chinese Association
45 Clooney Terrace
LONDONDERRY BT47 6AP

Tel: 028 71 288858

Charo Lanao
Latinoamercia Unida
c/o MCRC
12 Upper Crescent
BELFAST BT7 1NT

Tel: 028 90 244639

Antrim Chinese Community Association
c/o CWA
133-135 University Street
BELFAST BT7 1HQ

Tel: 028 90 288277

Coleraine Chinese Community Association
c/o CWA
133-135 University Street
BELFAST BT7 1HQ

Tel: 028 90 288277

J Porghmans
Dutch Community
3 Hillside Gardens
BANGOR BT19 6SJ

Luigi Rossetti Sorieta
La Societa Italiana
Irlanda du Nord
9 Vernon Park
BANGOR BT20 4PH

Vida Lake
Omagh Ethnic Support Group
20 Birchwood
OMAGH BT79 0ES

Tel: 028 82 426660

Maria Ellis
Women of the World
c/o 14 Foothill Road
ENNISKILLEN BT74 6AW

Sau Mei Lai
Chinese worker
Sure Start
9 Lower Crescent
BELFAST BT7 1NR

Tel: 028 90 942525

Mid Ulster Chinese
Community Association
c/o CWA
133-135 University Street
BELFAST BT7 1HQ

Tel: 028 90 288277

Sumi Ito Loughran
Japan Society of NI
19 Brianville Park
BELFAST BT14 8JZ

Tel: 028 90 710158

Satya Roberts
Multicultural Women's Group
c/o Windsor Women's Centre
136-144 Broadway
BELFAST BT12 6HY

Tel: 028 90 235451

Mr Yasin
Pakistani Community
Association
7 Casaeldona Gardens
BELFAST BT6 9RQ

Tel: 028 90 797671

Dr Panesar
Sikh Cultural Centre
Simpsons Brae
Waterside
DERRY BT47 6DL

Tel: 028 71 343523

Catherine Li
Home School Liaison Officer
South Eastern E&LB HQ
Grahamsbridge Road
DUNDONALD

Tel: 028 90 566200

Organisations working with Refugees and Asylum Seekers

Centre for Victims of Torture
96/98 Grafton Road
LONDON
NW5 3EJ
Tel: 0207 813 7777

Refugee Action Group
MCRC
9 Lower Crescent
BELFAST
BT7 1NR
Tel: 028 90 244639

Refugee One Stop Service
c/o NICEM
24-31 Shaftesbury Square
BELFAST BT 2 7DB
Tel: 028 90 238645

National Asylum Support Service
58 Howard Street
BELFAST BT1 6PD
Tel: 028 90 585971

NI Housing Executive
9th floor
32-36 Great Victoria Street
BELFAST BT2 7BA
Tel: 028 90 240588

Law Centre (NI)
124 Donegall Street
BELFAST BT1 2GY
Tel: 028 90 244401

Family Trauma Centre
1 Wellington Park
BELFAST BT9 6DJ
Tel: 028 90 204700

South & East Belfast Trust
Knockbracken Health Care Park
Saintfield Road
BELFAST BT8 8BH
Tel: 028 90 564940

Red Cross
125 University Street
BELFAST BT7 1HP
Tel: 028 90 246400

Altnagelvin Hospitals HSS Trust
Mr Tony Brown APSW
Social Services Department
Altnagelvin Area Hospital
Glenshane Road
LONDONDERRY BT47 6SB
Tel: 028 71 345171

Belfast City Hospital Trust
Miss Pat Haines
Director of Planning
Belfast City Hospital Trust
Lisburn Road
BELFAST BT9 7AB
028 90 329241

Craigavon Area Hospital Group
HSS Trust
Mrs Imelda Cullen
Head of Social Work
Craigavon Area Hospital HSS Trust
CRAIGAVON BT63 5QQ
Tel: 028 38 334444

Down Lisburn HSS Trust
Mr Alan Chard
PSW (Monitoring & Inspection)
Lisburn Health Centre
Linenhall Street
LISBURN BT28 1BH
Tel: 028 92 501309

Green Park HSS Trust
Dr Claire Armstrong
Equality Scheme Manager
Green Park Healthcare Trust
McKinney House
Musgrave Park Hospital
Stockman's Lane
BELFAST BT9 7JB
Tel: 028 90 669501

Armagh & Dungannon HSS Trust
Ms Kate Courtenay
APSW (Physical Disability Services)
Lisanally House
Lisanally Lane
ARMAGH BT61 7NQ
Tel: 028 37 522381

Causeway HSS Trust
Mr Trevor Gillen APSW
Causeway HSS Trust
8e Coleraine Road
BALLYMONEY
Co Antrim BT53 6BP
Tel: 028 25 666600

Craigavon & Banbridge Community HSS Trust
Mr George Thompson
Community Development Unit
Brownlow H&SS Centre
1 Legaory Centre
Brownlow
CRAIGAVON BT65 5BE
Tel: 028 38 831983

Foyle HSS Trust
Mr John Doherty
Director of Social Care
Riverview House
Abercorn Road
LONDONDERRY BT47 6SB
Tel: 028 71 266111

Homefirst Community HSS Trust
Mr John Fyfe
Asst Programme Manager
Pinewood Offices
101 Fry's Road
BALLYMENA BT43 7EN
Tel: 028 25 633700

Mater Hospital HSS Trust
Ms Liz Courtney
Employee Relations Officer
Mater Infirmorum Hospital
47-51 Crumlin Road
BELFAST BT14 6AB
Tel: 028 90 741211

North & West Belfast HSS Trust
Mr Tommy Boyle PSW
North & West Belfast HSS Trust
The Twins Spires Centre
Unit No 12
155 Northumberland Street
BELFAST BT13 2JS
Tel: 028 90 327156

Royal Group of Hospitals HSS Trusts
Ms Maura Muldoon
General Equality Manager
Royal Group of Hospitals
BELFAST
Tel: 028 90 263482

Sperrin Lakeland HSS Trust
Mr Godfrey Young
Community Services Manager
Community Services Department
Tyrone and Fermanagh Hospital
OMAGH BT79 0NS
Tel: 028 82 835285

United Hospitals Trust
Anne McCormill
Equality Manager
Bush House
45 Bush Road
ANTRIM BT41 2RL
Tel: 028 94 424673

Newry & Mourne HSS Trust
Mr Fergal O'Brien
Community Manager
Community Development Unit
John Mitchel Place
NEWRY
Co Down BT34 1DZ
Tel: 028 30 260505

Northern Ireland Ambulance Service HSS Trust
Mr Liam McIvor
Director of Operations NIAS
Ambulance Headquarters
Knockbracken Healthcare Park
Saintfield Road
BELFAST BT8 8SG
Tel: 028 90 400999

S & E Belfast H & SS Trust
Mrs Marie Heaney
Planner - Older People's Services
Knockbracken Health Care Park
Saintfield Road
BELFAST BT8 8BH
Tel: 028 90 790673

Ulster Community and Hospitals Trust
Mr Robert Moore
Primary Services Coordinator
UHCT
3 Church Street
NEWTOWNARDS
Co Down BT23 4AN
Tel: 028 91 816666