THE DILEMMAS OF PROVIDING WELFARE IN AN ETHNICALLY DIVERSE STATE: SEEKING RECONCILIATION IN THE ROLE OF A 'REFLEXIVE PRACTITIONER'

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ABSTRACT

Despite an increasing commitment to tackle disadvantage and discrimination, welfare states in the West struggle to provide accessible and appropriate health and social care to people of minority ethnic populations. This paper analyses the dilemmas of welfare provision in an ethnically diverse state by drawing on empirical findings from a qualitative study exploring the perceptions and experiences of family life and social support for people of Pakistani origin living in the UK, and its interface with state as a site of potentially competing and conflicting sets of social values. We conclude by suggesting that a notion of 'reflexive practitioner' is fundamental to generating a critical insight that can deal with the tensions posed by diversity for a welfare state.

Key words: Ethnicity; citizenship and governance; family relationships; health and social care

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Minority ethnic populations living in the UK experience an ongoing struggle to realise their citizenship rights (Coffey, 2004). As in most Western democracies, these struggles occur against a backdrop of socio-economic disadvantage and social exclusion, in which the needs of minority ethnic communities are either ignored or misrepresented (Atkin, 2004). In the wake of the Macpherson Report (1999), there has been a flurry of national and local initiatives attempting to address these problems, as well as legal provision placing a statutory responsibility on public organisations to promote diversity and tackle institutional racism (Commission for Racial Equality, 2004). Such initiatives are facilitated by a broader international shift in ideas about governance in which the State, by promoting active citizenship, recognises a plurality of interests, fostered through networks and partnerships (see Boddy and Parkinson, 2004).

Despite a willingness on the part of the British State to tackle discrimination, public organisations not only struggle to reconcile key ideas - such as institutional racism and community cohesion - within a policy framework (Ratcliffe, 2004) but often lack a political strategy to initiate change (cf. Kymlicka, 2001). Diversity management, however, continues to inform the emerging machinery of State governance (see Kelly, 2002), a multi-dimensional idea based on common themes (Barry, 2001). These include an emphasis on a shared national identity and an inclusive society, facilitated by tackling inequalities and social exclusion, in a way that recognises the multi-cultural nature of British society (see Home Office, 2004 and for a more

international perspective, see Downing and Husband, 2005). The complexity of this, however, can be illustrated by the constantly changing demographic profile of the UK, where 40 per cent of so called 'ethnic minorities' are born in the UK. This reminds us of the changing global context within which competing claims to ethnicity, nationality and citizenship are located (see Castles and Miller, 1998); and the main dilemmas of welfare provision in an ethnically diverse society.

We acknowledge that there is a depressing familiarity to many of the issues raised by this paper. This familiarity, however, might be part of the problem, particularly since long standing problems remain only partially resolved, often waiting to be rediscovered in different guises (Bhavnani *et al*, 2005). Familiarity does not necessarily equate with more responsive welfare provision: knowing about difficulties is not the same as doing something about them. Stereotypes of minority ethnic families who 'look after their own' have long been discredited by empirical research (see Atkin, 2004). However, these ideas persistently surface in the perceptions and attitudes of many practitioners, as reflected in the patterns of referral to various secondary care services. Why do such myths persist, and how can we formulate meaningful solutions to ensure they do not disadvantage minority ethnic populations? As Charles Taylor (1994) reminds us, Western social democracies, in responding to multiculturalism, need to move beyond the 'politics of recognition' - where policy debates confuse 'focusing' on need with 'responding' to need - to the 'politics of difference', in which an acceptance of difference is reconciled with a political intent to ensure such difference does not become a basis of

inequalities. To an extent, our paper addresses some of the difficulties in facilitating a 'politics of difference'.

This paper summarises the challenges of providing culturally appropriate health and social care to minority ethnic communities living in the UK. It draws on examples from wider literature on how health and social care professionals interpret and respond to difference; and empirical findings from a larger qualitative study exploring the perceptions and experiences of family life of young people of Pakistani origin, their parents and grandparents, living in the UK and its interface with state. In examining the relationship between family, community and state as potentially competing sites of values, the paper highlights the complexity of social contexts within which families of Pakistani origin might challenge the legitimacy of service intervention and the underlying default values, thus jeopardising the 'welfare intent' of state. We conclude by outlining the potential role of a 'reflexive practitioner', who is able to respond to the complexity of biographical contexts within which health and social care needs are located and negotiated, without relying on over-simplified generalisations of homogenised religious or ethnic groups.

Representing difference and responding to diversity

Two intertwined themes underpin the tensions of the 'politics of difference' and run through our analysis and discussion. The Welfare State faces pragmatic challenges in *representing difference* and *responding to diversity*. This is reflected in provision for health, social care, housing, education, employment as well as broader legal provisions defining the democratic rights

and duties of citizens in relation to those of the State (Law, 1996). Policies and practices related to health and social care inevitably involve moral judgements about social life and relationships - rather than reflecting *rational* choices in a (Weberian) value-neutral sense of the term (see Eliaeson, 2002) - posing a philosophical dilemma of choice. Hence, in any multiethnic and multicultural society, both Western and non-Western, there is bound to be some tension between the use of default social and legal values, often representing a dominant majority, and acceptance of these by people of different ethnic groups (Bauman, 1992).

For pragmatic and less visible ideological reasons, institutions representing the State tend to engage with people of minority ethnic communities as conglomerates and stereotypes of a culture, religion or ethnic group, rather than as citizens in their own right who negotiate their multiple identities within specific social and political contexts (Das, 1995). Politically and economically marginalised minority ethnic groups often unwittingly reinforce this process, as they redefine themselves as an 'imagined' moral community (cf Anderson 1991), homogenising and celebrating their difference and uniqueness, in attempts to secure their claims to substantive citizenship rights (Knott, 1991). We need to deconstruct this process in a way that informs the basis of reflexive practice, enabling professionals to respond to the needs of people from minority ethnic populations without recourse to homogenised notions of culture, religion or community.

The critical emphasis of current literature on ethnicity in Britain has successfully highlighted the negative consequences of socio-economic deprivation, racism, marginalisation, and inequities in access to health and social care (Mason, 2003) as well as to employment, housing and social security benefits (Owusu-Bempah, 2001; Craig, 2002; Craig *et al*, 2005). However, constantly highlighting the negative consequences and inequities of service provision, at times, creates the antithetical situation of contributing little to advances in thinking and practice (Levick, 1992); 'condemning everything' and 'proposing nothing' (see Bauman, 1992). Hence, despite a good deal of evidence outlining the processes and outcomes of discrimination and disadvantage, policy and practice has been less successful in translating these insights into improvements in service delivery (Bhavnani *et al*, 2005).

Current modes of representing difference have the unintended consequence of reinforcing dominant ethnocentric values and stereotypes of 'ethnic communities' (Atkin, 2004). One of the implications of such stereotypes is that health and social care needs of people from minority ethnic communities' are blamed on their 'deviant' cultural practices rather than life circumstances or socio-economic background. Some professionals, for example, attribute higher incidence of thalassaemia and congenital problems in South Asian children to consanguineous marriage rather than genetic predisposition within a population (see Ahmad *et al*, 2000). In other cases, the boundaries between ethnocentrism and racism are breached in therapeutic situations leading to a denial of choice. Young people of African-Caribbean origin suffering pain related to sickle cell disorders might be denied effective pain

relief due to the mistaken perception that they are more likely to get addicted to pain-killers than other patients (see Anionwu and Atkin, 2001). The recent recognition of discriminatory treatment received by Black and African-Caribbean men in the mental health services offers another reminder of a similar set of essentialist constructions of race and ethnicity (see Bhui *et al,* 2004).

Various reports have reiterated concerns about the quality of social support services provided to black and minority ethnic communities (see Butt and Mirza, 1996, for a review of family support services, and more recently, Qureshi *et al*, 2000). Lack of awareness and understanding about minority ethnic cultures and pathologisation of family values and practices, and the impact this has on the quality of health and social care received is well documented (Atkin and Rollings, 1996; Atkin and Ahmad, 2000). We know, for example, that Black families are likely to be over-represented in the child protection system due to issues of poverty as well as discriminatory and racist assumptions underpinning social work assessments (Chand, 2000). This is yet another reminder that a focus on culture deflects attention away from structural issues of inequality and forms of institutional cultures and racisms that sustain such forms of discrimination (see Gunaratnam, 1997).

Of particular relevance to this paper is how pathologisation of other forms of childhood and parenting that do not correspond to the white, middle class default values, become reflected in wider discussions and practices related to family support (see Husband, 1996; Chand, 2000). According to a recent

survey, young people of Pakistani origin living in England lead 'overprotected' lives and lack the 'skills to face the world independently' (Katz, 2002). 'Overprotection' and 'independence', however, need to be understood within the larger normative framework of intergenerational relationships; parental responsibilities; and notions of growing up within this community.

We shall explore some of these themes by introducing relevant findings from our research on young people of Pakistani origin and their families.

Introducing the study

The study was carried out over a three year period (2002 to 2005) in Northern England (for further details see Chattoo *et al*, 2004) in collaboration with Barnardo's. We used focus group discussions with a cross-section of professionals (whose ethnic background was not analysed), groups of parents, grandparents and young people; and in depth interviews. The material presented here is based on in -depth interviews with a purposive sample of young people, aimed to represent different socio-economic and linguistic backgrounds, and varying lengths of stay in England. We conducted 21 interviews with nine young men and 12 women aged between 11-20 years old. (We, therefore alternate between talking about children and young people). For each young person recruited to the study, we also interviewed at least one parent or grandparent. This enabled us to understand how family values and practices are perceived and negotiated between generations. We interviewed 20 parents (8 fathers and 12 mother); three grandmothers and two grandfathers; an uncle and an aunt who wanted to be included; and six

siblings to get a picture of different perspectives within the same generation in a family.

Young people were recruited largely through our networks with two local schools and various professionals and colleagues to address potential bias of overrepresentation from a particular socio-economic background. Whilst the sample reflects the diversity of language, area of origin, socio-economic backgrounds and different lengths of stay in England, only one young person attended a private school within our sample; an issue that in hindsight we should have addressed at the beginning of recruitment. A leaflet in English and Urdu was sent to each family explaining the purpose of research and how the interview would be conducted, before participants were approached. The study had a development component to enable us to look at appropriate ways of supporting these families.

All participants had a choice of being interviewed in a language they preferred and by a person of the same gender. Not surprisingly, a majority of young people and their siblings opted to be interviewed in English, using Urdu or Punjabi selectively to express particular ideas and emotions, whilst a majority of their parents and all the grandparents preferred *Urdu* or *Punjabi*. Interviews were transcribed, or translated and transcribed where appropriate. Translation aimed at capturing conceptual equivalence, preserving the use of local metaphor and contextual rather than a literal meaning (see Atkin and Chattoo, 2006).

We used a biographical approach to analysis, assuming an inter-subjective notion of self and identity. This approach is useful for locating the specificities of individual experience within wider structural processes (see Chamberlayne and King, 2000). Narratives on family life and identity of the participants were located within the broader socio-economic and political context in which participants defined and perceived themselves to be defined by significant others (see Bourdieu, 1977). Theoretically, we wanted to explore diasporic culture as a site of subjectivity and identity (cf. Hall, 1990) and how 'ethnicity' is lived and played out through embodied practices related to religion, food and dress, and choice of potential marriage partner for young people of Pakistani heritage. The main themes explored in the interviews and analysis related to: notions of family and inter-generational and intra-generational support; role of state and other agencies in providing different kinds of support; salience of ethnicity (Pakistani origin) and various markers of identity (gender, dress, language, religion, social networks, and choice of marriage partner); and continuity and change (related to each theme) between generations.

We have selected one analytical theme to provide some examples of how participants in our research perceived the relationship between family, community and state, and some detailed accounts of interaction with particular professionals. These empirical accounts have been selected purposively to support our theoretical arguments, without any intention of engaging with the range of situations and analytical propositions arising from the dataset described elsewhere (see Chattoo *et al*, 2004). All names

appearing hereafter are anonymous and to further protect anonymity we do not identify the fieldwork sites.

The family and the state: negotiating competing moral spaces and sustaining identities

To provide a broad overview of the findings, the views and experiences of the young people, their parents and grandparents undermined the idea of family as a cohesive normative unit of socialisation within which 'ethnicity' (i.e. notions of Pakistani origin) and cultural and religious markers of identity - such as dress, food, social networks and choice of a marriage partner - are passed on mechanically from generation to generation. Contrary to popular perceptions of 'traditional', patriarchal, Muslim family, reinforced by many professionals who took part in the focus groups, our data suggests there was no single script predefining how norms and practices were negotiated within and between generations. Biographical circumstances as well as particular family histories of migration (especially rural/urban origins and educational background) were central to these negotiations. The participants' narratives introduce a contingency and dynamic to their potential interactions with practitioners, which forecloses the possibility that a simplistic bureaucratic solution or a 'fact file' approach to an ethnic or religious group can inform culturally competent practice.

Further, the State (and services representing the State), might be perceived as a competing and at times conflicting site of moral values by parents, grandparents and young people. It is important to reiterate, however, that the

relationship between these competing moral spaces is not predefined by ethnicity or generation as a whole. State intervention and support in family life is, for example, deemed legitimate within contexts of caring, housing and social security, while in other contexts it was perceived as an infringement of parental responsibility, family or religious values as a 'disenchantment of home' (cf. Reiger, 1985). The former view emphasises how State support is a matter of rights, reflecting people's sense of citizenship through contributing to labour market, payment of taxes and national insurance. In the latter case health and social services might be seen as lacking the legitimate authority to intervene in family life and as being responsible for undermining the moral fabric of the community (see also Qureshi *et al*, 2000). We now examine these constructions of legitimacy in greater detail.

The legitimacy of State intervention

Our participants' accounts suggest a lack of trust in the so called universal, liberal values of benevolent State intervention (see also Rojeck *et al*, 1989). To this extent, welfare provision becomes a potential site of conflict, in which competing interests, seek to establish legitimacy rather than a therapeutic arena in which care is administered. In order to translate the abstract notion of the relationship between family and State into real life examples, we asked participants to reflect on an imaginary or real disagreement between parents and a young person. We introduced a vignette where a young man and woman were having a relationship disapproved by the parents, and social services intervened in the interest of the young person. A majority of young participants as well as parents agreed that the issue of disagreement between

parents and their children (young people) is best resolved through mutual negotiation between parents, the young person and possibly close kin. Parent-child relationship was not considered an area for State intervention. Parents especially emphasised this and perceived professional intervention in such matters as undermining parental authority; over-riding the more accepted, kin based networks for negotiation and reconciliation; and jeopardising the reputation of the family within the community.

The following excerpt from an interview with a grandmother, regarding her grand-daughter's former friend, illustrates these tensions. Sakina Bi emphasised that family matters and disagreements between children and parents can only be solved within the family rather than through professional intervention. Like many other parents and grandparents, she believed that social workers do not understand or appreciate these family values since they follow a 'White' world view which treats children as independent and having rights of their own. She provided the example of her grand-daughter Rubi's friend, who was 14 years old. She had a disagreement with her mother about not being allowed to 'meet' (have a relationship with) a particular boy. Sakini Bi remarked that the mother, although 'good, caring and loving', probably put 'too much pressure on her children to conform'; resulting in her daughter going 'too far' and contacting a social worker. Sakini Bi perceived this as a breach of obligation to respect parental authority and said, '… the child ought to have confided in her mother and sorted the matter out', invoking a notion of trust and negotiation.

According to Rubi's version of the story (recorded during her interview when the grandmother was not present) 'the whole affair should never have happened'. The boy was 'obviously not committed' and her friend should have returned home the same day rather than cause trouble for both the families:

> My friend was staying there for about two or three nights, then she went to Social Services where she stayed for some time. Then she wanted to go back home, 'cos she realised what mistake she had made and everything. She's going through the court case and everything … the whole thing was a mess. So, like, it wasn't only her who was affected, it was her whole family as well.

Rubi concluded that although her friend was back with her parents and at school, social services had to check the credibility of her parents to make sure that she was in a 'safe environment'. Her friend had lost the respect of her peers at school, her father faced charges for kidnapping the boy's brother, and the family were forced to leave town since the whole affair was within the public domain. Rubi also reflected on how the parents were blamed by the wider community for not having raised their daughter properly.

Rubi's version of the story sounds stylised, reinvigorating the adult script by her grandmother reflecting idealised notions of family, community and norms related to sexual relationships. It opens the possibility of alternate frameworks and explanations for analysing family and community as a potential site of conflict (cf. Chattoo and Ahmad, 2004), highlighting one of the

significant areas of potential tension between parents and young people. Despite the idealised Muslim values of gender segregation and location of sexuality within marital relationship, breach of norms and stories of desire are as common in the UK as in Pakistan (see Shaw, 2000).

Beyond the threat of what are perceived as morally corrupting Western values, lies potential differences in perceptions and interests between generations within a culture, and different standards for judging the behaviour of men and women. Some of the young participants, although sharing some of their parents' views about the negative influences of Western ideas, had very different opinions regarding universal features of Islam as opposed to its local and cultural underpinnings followed by their parents. For example, some of them disagreed strongly with local traditions of marrying within the *biraderi* (potentially endogamous kinship network); arguing that Islamic personal law gives both men and women the right to choose their life partner. Actual negotiations on choice of marriage partner in their families, however, revealed more complex interplay between this personal right and obligation or desire to respect and obey one's parents (for discussion on social change see Ahmad, 1996; Modood *et al*,1997).

While family values and practices varied within and across generations, respect for and obedience towards parents was defined as an obligation for children and young people. This derived its legitimacy from Islam and was treated seriously by both parents and young people. Parents perceived their duties and obligations towards children to be sanctioned by religion; to raise

them as good Muslims, give them a good education and get them married and settled in life. The only case where a 16 year old young woman disagreed with this notion of an idealised family premised on parental authority sanctioned by Islam was one where religion did not define the way of life for either parents or their two children.

This notion of parental authority poses a potential challenge to the right of state to intervene on behalf of children and young people, and the right of children and young people to seek help from services fostered by the state. This theme was further reiterated in the views of a majority of parents and grandparents, and some young people who believed that 'White' values of independence served to encourage children to disregard family values and parental authority; a process perceived by some as being reinforced through the co-educational State school system and parts of the curriculum (cf. sex education). Social workers were generally perceived by parents to represent dominant White values within which autonomy and independence from parents was encouraged as part of young people's life transition to adulthood. Majid, a father in his early 40s, a taxi driver by profession who had spent most of his adult life in England, expressed the concerns of many parents by saying:

> If children do not listen to their parents, they will become westernised and there will be no difference between them and the English community.
>
> (Later) Social Services and other organisations are the ones who *disgrace* us. *Do you understand*?

These views might not necessarily reflect the remit or intentions of professionals, but define the boundaries between home and State, the private and public, while also marking the boundaries between self (Pakistani – Muslim) and the significant 'other' (White and other non-Muslims). Dilemmas posed by professional intervention into the sanctity of family life are not, of course, restricted to this particular ethnic community (see Dominelli, 2004, on the difficulties of balancing the 'controlling' and 'caring' functions of social work). What is interesting, however, is how this tension is appropriated by participants, who take on a collective voice, as a rhetorical device for reconstituting an 'imagined' moral community (cf. Anderson, 1991) resting on family as its moral arbitrator; thus silencing differences within (such as based on gender, age and socio-economic background) and often creating or reinforcing dominant stereotypes.

Negotiating professional relationships within the context of caring

The previous section looked at an aspect of family life where State and professional interventions were perceived as infringing on family life. Interestingly, participants viewed professional mediation in conjugal discord with a greater degree of flexibility, although the extended family was still perceived as the first port of call for mediation. This might be explained partially by the fact that divorce is recognised as a legitimate solution for resolving conjugal conflict within Islamic personal law, though in practice it rarely is a matter confined to the two individuals - given the 'ripple effect' of separation on other relationships within the kin-network (see Werbner, 1997).

We now explore examples where State support is considered legitimate; although even here negotiating relationships with professionals remains susceptible to potential differences over notions of caring, parenting, youth and family relationships (see also Twigg and Atkin, 1994).

As suggested earlier, self perceptions of a strong (morally superior) Pakistani-Muslim family and culture might reinforce the wider, professional perceptions of a self-caring Pakistani/Muslim family. Nonetheless, given the younger age profile of the population, greater number of dependent children, higher incidence of chronic illness and disability, living in a large household or having a large kin network does not ensure the required level of family support (Katbamna *et al*, 2000). Indeed, previous cycles of material and moral obligations, existing interpersonal conflicts, as well as material resources affect the level of support available to a family within a kin network (for broader discussion, see Finch and Mason, 1993). The experiences of the participants in our sample suggest that kinship relationships (*rishtedari*) have to be recognised and maintained through reciprocity, for obligations to be realised in practice (*duniyadari*). The following example illustrates the complexity of this distinction and the social context within which professional support is negotiated.

Asif Iman, a parent in his early fifties and his wife, Hajira Bibi, lived in a predominantly working class neighbourhood with their six children including a daughter who was severely disabled. The couple remembered the time when

their house caught fire and they had to move into a council flat with nothing in the name of personal belongings. Despite a wide network of relatives including siblings (two of whom lived locally), nobody came forward to offer practical or material support. The couple believed that the Council and social care professionals who had supported them through the crisis, and provided appropriate help with their disabled daughter's care on a regular basis, were 'better than family'. According to Hajira Bibi:

> They are the people who have helped us. When we moved into this house, they gave us the hoist, the wheelchair, and slings…. They have helped us more than our relatives. If we depend on our relatives or neighbours, they may let us down. It is better to rely on the council … we have peace of mind.

This reminds us of the contrast between kinship ties as bound by an intricate dynamic of exchange and delayed reciprocity, and professional relationships that are not inherently reciprocal. Relying on professional help was ideal for this family, given their particular circumstances and lack of support from close kin network. It is likely that the couple exaggerated the lack of support from relatives to highlight longstanding conflicts – a recurrent theme of extended family life often neglected in literature – since examples of help with childcare were mentioned at one point.

Despite examples of good practice, professional intervention can lead to greater surveillance of family life (see Heaton, 2004), which is further compounded where professionals demonstrate little sensitivity and

understanding of the specific circumstances facing a family that might challenge the default professional (middle class) notions of caring, parental responsibilities and childhood. The following summary of a young carer's experience illustrates this tension. It is located within the intertwined contexts of more than a fair share of burden of chronic illness within one family, and its impact on different ways of growing up on one hand; and salience of ethnicity and identity, and negotiation of kinship obligations operating trans-nationally, on the other.

Fifteen year old Rehana lived with her paternal grandmother, parents, two older sisters and two younger siblings in a terraced house. Rehana's grandmother was suffering from cancer and needed help with her daily routine. Her father had a long standing mental health problem and had been unable to work for many years. Her mother suffered from a painful colon condition for which she had undergone surgery, resulting in a permanent colostomy bag. Both Rehana's older sisters were disabled and received regular professional help. Given the family situation, Rehana shared domestic chores to help her mother and also shared caring responsibilities towards her sisters, assuming the role of their 'second mother', whilst studying for her GCSEs. She was aware that her younger brother and younger sister did not have to share these responsibilities, and had a different childhood from hers. However, she enjoyed privileges arising from her role of acting responsible and being treated as 'someone older and with respect' by her parents and siblings. Her father let her go to town with friends and gave her a bit of extra money to spend on herself.

Rehana was quite upset by, what she perceived as, the discriminatory attitude of their social worker who, she felt, had little insight into their family life and no respect for her parents. She also felt that his attitude undermined rather than supported her role as a young carer within the family. She narrated an instance when her paternal uncle, also her mother's cousin (who lived in France), died. Her father had to rush to France and make arrangements for a burial to take place in Pakistan, while her mother left for Pakistan to support the rest of the family in their bereavement. Rehana was left in charge of the family at home, whilst her aunt (father's sister) and older cousin who lived in the neighbourhood supervised the routine. The social worker (a man of African-Caribbean origin) visited the family during her parents' absence. Rehana explained what transpired:

Rehana: And, you know, he can discriminate against people, which I feel, is really wrong. Whereas me…, I don't say it to the face. I keep it inside, but you know, I feel really bad.

Interviewer: How do you know when you're being discriminated against?

Rehana : Because he…(pause)

Interviewer: Can you give us an example?

Rehana : An example of someone, I won't mention their name.

Interviewer: No, no, don't mention the name, just an example.

Rehana : it's like, do you know, once [social worker] came in, right, and my dad was away. My uncle passed away and my dad was in Pakistan,

and this person goes, 'Well, I'm sure he's enjoying himself over there and he's left you over here'.

Rehana was upset at the fact that even though the social worker had known them for two years he had made no attempt at understanding the family circumstances; the significance of death and how kinship responsibilities operate in transcontinental families during such life crisis events. Rehana felt the social worker's attitude towards her parents was discriminatory (due to their ethnic background)and narrated another incident when he visited the family along with a (White) trainee and showed no respect for her parents who, although they did not speak English, understood more than he acknowledged. She said:

> (He)… came in, right, and brought a visitor along, and he goes, 'He (father) sleeps all day, he sleeps all day long and she (mother) eats all day and she sits around'. That's all he said to the new visitor and she looked quite, you know, shocked. And I felt really bad because, you know, this person has known us for a good couple of years, and he turns round and said *that*. It really hurts inside. When my dad … he can understand but he can't, you know, express himself (in English). So I find it hard, really.

Rehana's experience raises important issues about the challenges posed by alternate notions of parenting and different ways of growing up arising within any culture (cf. Punch, 2003). We are not able to comment on how the social

worker in question interpreted Rehana's situation, since it was not possible to interview him (given the clause of confidentiality). We know, however, from this and other pieces of research that many people of Pakistani origin who do not speak English, feel discriminated against by professionals, lending support to Rehana's observations (Chattoo *et al*, 2002; Atkin, 2004). Rehana's experience is reflected more generally in the sample, as young people commented on experiences of racism and specifically, professional assumptions and stereotypes of Asian- Muslim families. This was succinctly summarised by 15 year old Yasmin, when she spoke about how others perceived her:

> You say you're British, you *are* British… but then again, you know, in some people's eyes you're Asian British, not *British* British (her emphasis).

These tensions play an important part in reinforcing feelings of difference and partial citizenship for people of Pakistani origin, underpinning their relationship with health and social care professionals. This further confounds ideas about legitimate State intervention and notions of culturally competent care.

DISCUSSION

The idea of social exclusion and partial citizenships rights of people of minority ethnic populations are, of course, not new (see Marshall, 1964), but continues to have a uneasy resonance within debates on a multi-cultural Britain and recent policy discussions on the dangers of segregation,

estrangement, polarisation (Cantle, 2001; Ouseley, 2001). Such debates raise fundamental issues for the governance and performance of public organisations as they strive to offer equitable care on the basis of social justice (Parekh, 2006).

We provided examples from the family life of people of Pakistani origin within which welfare provision, rather than a therapeutic arena, might become a potential site of conflict, where competing social values and interests seek to establish legitimacy. This process makes it difficult for practitioners to effectively communicate with and respond to the individual needs of families and illustrates more broadly, the dilemmas faced by the Welfare State in responding to cultural, ethnic and religious diversity, and enacting (implicit) legal provisions defining the rights of (particular) citizens in relation to those of the State.

It seems to us that an initial response to the existing gap between policy and practice lies in encouraging the role of the ‘reflexive practitioner’, who is able to respond to complex situations, without relying on 'fact-files' or bureaucratised responses. This seems rather uncontroversial and the idea is increasingly popular among health and social care professionals (see Evans and Harris, 2004). Promoting understanding and challenging stereotypes about family life of people from minority ethnic backgrounds is an important step towards introducing reflexivity (see, for example, National Family and Parenting Institute, 2005). Nor is there any doubt, that such reflexivity could empower professionals to raise meaningful questions regarding the social

context within which supportive relationships are legitimised and negotiated. This begins to provide them with the cultural repertoire to engage with diversity and difference.

Anti-racist social work, for example, illustrates how specific strategies can be introduced to build such a repertoire, aimed at improving the relationship between social worker and client (Dominelli, 1988). Anti-oppressive practice demands an awareness of a clients' cultural and religious beliefs and ability to respond to them in an appropriate way, while valuing clients as both an individual and a member of particular community (see also Dominelli, 2004). This finds resonance in current debates about culturally competent practice in health care, which emphasises the importance of getting practitioners to challenge their own values, develop understanding and sensitivity and apply their awareness and knowledge to appropriate practice (Papadopoulas *et al*, 2004).

The starting point for successful policy and practice guidance should, therefore, be an analysis of the present difficulties, an explanation of how these difficulties are currently made sense of, and presentation of alternative ways of making sense of the situation. Achieving this, however, is far from straightforward and requires a more fundamental change in professional culture and policy formulation: with more of a shift in focus from 'understanding minority ethnic cultures' to 'how services respond to need'. Reflexivity is not simply about individual reflection on practice, but an engagement with how institutional practices make it difficult to support the role

of the ‘reflexive’ practitioner (see Alvesson, 2002).

In facilitating more appropriate polices and procedures, we need to explore the process whereby organisations make sense of the complex, multi-facetted and fluid nature of ethnic diversity and the ways this understanding then becomes embodied in professional practice. An emphasis on ‘culture’, with no reconciliation with the broader structural processes underpinning discrimination and disadvantage can, as we have seen, reconstitute the minority ethnic users as the distant, exotic ‘other’. To this extent, *communicative competence* or the process whereby practitioners - and the public agencies within which they work - frame, engage and legitimate the experiences of minority ethnic populations becomes fundamental to our sense of the reflexive practitioner (see Habermas, 1987). In effect, we need to understand the social, cultural and organisational context in which practitioners work.

The reflexive practitioner can not, of course, transcend the consequences of context, in which different stakeholders attempt to define situations, speak with legitimacy and have their views recognised as legitimate by others (see Bourdieu, 1977). He or she does, however, mediate its outcome and recognising their role in this is an important part of reflexive engagement. Welfare provision is by its nature complex, full of ambiguities, contradictions, inconsistencies and compromises, which reflect a mix of individual and collective solutions (see Habermas, 1987). To this extent, welfare provision rarely responds to the needs of populations - allocated according to some

universally agreed principles of individual need - but represents the context in which needs of particular people are interpreted and acted upon (see Anionwu and Atkin, 2001). Practitioners do not simply interpret guidance; rather it assumes meaning, expressed through practitioners' dispositions to act in ways they have been habituated (see Bourdieu, 1977). In responding to clients or patients' needs, practitioners, for example, use a sense of their *professional role and ideology*, which defines legitimate intervention on the basis of an agreed body of knowledge; *assumptive worlds*, where professionals can apply their own values and 'common sense' when making decisions; *office culture*, where experience and knowledge are reconstituted from one generation of service practitioners to the next, through the processes of myth, history, narrative, ritual and ceremonies, which come to form a shared 'organisational' reality; and the *external political, social and economic environment* in which practitioners' actions become simultaneously supported and confronted by political intent (see Lipsky, 1980 for a broader discussion).

To conclude, focusing on the dynamics of service delivery is as important as exploring the experiences of those who receive health and social care. In doing so, we create the opportunity to empower practitioners to incorporate good practices within the context of their existing professional worlds. More importantly, such a process also renders the basis and consequences of current discriminatory practices transparent, thereby providing the opportunity for these to be challenged. Achieving this implies a cultural shift in how practitioners define problems and impose solutions, and how public agencies

engage with minority ethnic populations. Such an alternative framework requires theoretical reconciliation and practical intent, especially since there is a longstanding and ongoing disparity between our understanding of the issues and our commitment to act. This means transcending the familiar and in particular avoiding confusion between recognition and action. In doing so, however, we can create radical opportunities which facilitate the citizenship claims of minority ethnic populations (see Rotry, 1989), in a way that supports 'the politics of difference' rather than the 'politics of representation' (Taylor, 1994).

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