Needs, characteristics and experiences from minority ethnic adults with learning disabilities and minority ethnic older people living in care homes across England- an exploratory mixed methods study

A thesis submitted for the award of Doctor of Philosophy (PhD) in Community Care

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Acknowledgements

I would like to dedicate this doctoral thesis to my father who has supported me throughout this PhD process. There is no doubt in my mind that without his continued support, I could not have completed this process.

Special thanks are due to my supervisors Dr. Julie Beadle-Brown, Professor Ann Netten and Professor Jim Mansell for their immense support and guidance throughout my time at the University of Kent as well as their unerring level of patience, enthusiasm, knowledge and vision which has taken me throughout this PhD.

I would like to thank friends from the university, especially, Dr. Theresia Bäumker, Lisa Callaghan and Lesley Curtis. I would also like to acknowledge my supportive friends outside of university, particularly, Marlon Brevitt, Kirstie Watkins and Emily Tuck. Thank you all for making this whole process more bearable.

I would also like to thank Samira Ashraf and Christine Powell from John Ruskin College Croydon for introducing me to social science and helping me to discover my passion for psychology and psychology related disciplines. Samira and Christine helped me acknowledge my potential and self belief which has undoubtedly taken me through my postgraduate studies, for which I'll always be eternally grateful for.

I am grateful to the study participants and care home staff for their participation. I would also like to thank fieldworkers involved during the data collection process, with particular thanks to Leah Vanono and Gary Aldridge for their input and advice. I would also like to thank the Confederation of Indian Organisation (CIO), the Care Quality Commission (CQC), Age Concern and Professor Zenobia Nairdshaw for invaluable support and advice.

I would like to thank the Economic and Social Research Council (ESRC), the Care Quality Commission (CQC) and the Personal Social Services Research Unit (PSSRU) for funding and assistance.

Last but by no means least; I would like to thank my three younger brothers- Christopher, James and Thomas for putting up with me over the last few difficult years. Christopher deserves special thanks in managing to keep me calm whilst resolving numerous crises with my laptops and printers!

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LIST OF ABBREVIATIONS

AAMR	American Association on Mental Retardation
ABC	Aberrant Behaviour Checklist
ABS	Adaptive Behaviour Scale
ADL	Activity of Daily Living
AJMR	American Journal on Mental Retardation
AQAA	Annual Quality Assurance Assessment
APA	American Psychological Association
ASCOT	Adult Social Care Outcome Toolkit
ASM	Active Support Measure
BBC	British Broadcasting Channel
BJLD	British Journal of Learning Disability
BME	Black and Minority Ethnic
BMEE	Black and Minority Ethnic Elders
BPS	British Psychological Society
CALD	Culturally And Linguistically Diverse
CCHOT	Cultural Care Home Observational Toolkit
cf	Cited from
CI	Cultural Index
CI- HS	Cultural Index- HS
CI-C	Cultural Index-Communication
CI-L	Cultural Index- First Language
CI-RD	Cultural Index- Religiously Diverse
CIO	Confederation for Indian Organisation
CG	Comparison Group
CLAS	Culturally and Linguistically Appropriate Services
CSCI	Commission of Social Care Inspection
CQC	Care Quality Commission
CfB	Capacity for Benefit
CMH	Campaigning for the Mentally Handicapped
CMS	Choice Making Scale
CS	Cross Sectional design
DH	Department of Health
DHSS	Department of Health and Security
DSM- IV-TR	Diagnostic Statistical Manual, Version Four, Text Revision
EMACR	Engagement in Meaningful Activity and Relationships
ESRC	Economic and Social Research Council
HBS	Handicaps, Behaviour and Skills
IADL	Instrumental Activities of Daily Living
ICAP	Inventory for client and aging planning
ICD-10	International Classification of Disease- Version 10
ICF	International Classification of Functioning, Disability and Health
ICIDH	International Classification of Impairments, Disabilities and Handicaps
ICIDH-2	International Classification of Impairments, Disabilities and Handicaps- beta draft 2
IPDL	Index of Participation in Domestic Living
ICI	Index of Community Involvement

IQ	Intelligence Quotient
JIDD	Journal of Intellectual and Developmental Disability
JIDR	Journal of Intellectual Disability Research
LD	Learning Disability
M	Mild Learning Disability
MC	Mainstream Care
MCNQ	Minority Cultural Need Questionnaire
MD	Minimum Data Set
MDS-CPS	Minimum Data Set Cognitive Performance Scale
ME	Minority Ethnic
MOPSU	Measuring Outcomes for Public Service Users
MR	Mental Retardation
N	Number
NR	Not Reported
NDG	National Development Group
NHQ/S	Nursing Home Quality/ Scale
NHS	National Health Service
NMDS-SC	National Minimum Data Set- Social Care
NSF	National Service Framework
NSFOP	National Service Framework for Older People
NVQ	National Vocational Qualification
QMF	Quality Measurement Framework
QoL	Quality of Life
Obs	Observations
ONS	Office of National Statistics
OP	Older People
PhD	Doctor of Philosophy
PMLD	Profound Multiple Learning Disability
PSSRU	Personal Social Services Research Unit
RRSSQ	Revised Residential Services Setting Questionnaire
RQ1	Research Question one
RQ2	Research Question two
RQ3	Research Question three
RQ4	Research Question four
SABS	Short Adaptive Behaviour Scale
SABs	Safeguarding Adults Board
SC	Specialist Care
SIB-R	Scales of Independent Behaviour
SPO	Structure-Process-Outcome
SPSS	Statistical Package for Social Scientists
SupRQ	Supplementary Research Question
WAIS-R	Weschler Adult Intelligence Scale- Revised
WAIS-III	Weschler Adult Intelligence Scale- 3rd Edition
WHO	World Health Organisation
UK	United Kingdom
USA	United States of America

Abstract

As the United Kingdom (UK) becomes increasingly ethnically and culturally diverse, acknowledgement of needs, characteristics and experiences of minority ethnic community care services will become an increasing priority. This exploratory mixed method study investigates needs, characteristics and experiences of minority ethnic adults with learning disabilities and minority ethnic older people living within care homes across England. This thesis explores empirical findings obtained from two sources. First, quantitative findings ascertained from 173 care homes in England recruited from the Measuring Outcomes Public Service Users (MOPSU) study conducted in 2006-2010. Questionnaires enabled opportunities to explore characteristics of care homes, care home staff and care home service users. Questionnaires and quantitative observations from the MOPSU study enabled exploration of sensitivity to cultural needs for culturally diverse groups. Second, focus groups supplemented MOPSU findings by qualitatively exploring cultural needs and experiences of care homes for South Asian and African-Caribbean older people and their relatives.

This thesis draws from Carnaby (2007) layers of influence model which stipulates various factors impacting service users lived experiences. This thesis adds to the layers of influence model by splitting factors into three levels, namely, micro or individual factors, meso or service level factors and micro or societal level factors. Findings on needs, characteristics and experiences of care homes with specific reference to minority ethnic populations were mapped onto micro, meso and macro factors. This thesis also draws upon universalism, which involves acknowledging the significance of cultural factors within phenomena including social care outcomes. Furthermore, multiculturalism was inherent throughout this thesis, namely, recognizing diversity and heterogeneity amongst groups and striving for equitable harmonious living, regardless of background.

Questionnaire findings from the MOPSU study revealed differences between adults with learning disabilities and older people with care home services, care home staff and care home service users. Additional findings reported some differences between minority ethnic care home service users and white ethnic service users in terms of characteristics of care homes, care home staff along with service user differences with physical, social and cognitive characteristics. Higher levels of depression were also found between south Asian adults with learning disabilities in comparison with other minority ethnic adults with learning disabilities.

Definitions and experiences of sensitivity to cultural needs reported from focus groups illuminated the importance of cultural factors in conceptualizing social care outcomes and experiences of care homes. Focus groups revealed considerable unmet cultural needs for minority ethnic populations within mainstream care homes as opposed to specialist care homes supporting minority ethnic service users. Observational findings on sensitivity to cultural needs reported from the MOPSU study revealed evidence of sensitivity to cultural needs and evidence of unmet cultural needs particularly, within mainstream care homes.

Whilst this research is exploratory in nature and has only begun to address the many issues that are important in supporting minority ethnic adults with learning disabilities and minority ethnic older people living in care homes. But, the questions addressed and findings on needs, characteristics and experiences of care homes for minority ethnic adults with learning disabilities and minority ethnic older people are important for striving towards equitable service delivery as well as long term outcomes of good quality of life and wellbeing for all service users regardless of background.

1. Chapter One- Introduction and Definitions

Minority ethnic and culturally diverse populations are increasingly becoming more prevalent within the United Kingdom (UK). Projected estimates suggest rapid increases in minority ethnic groups living within the UK. For example, minority ethnic populations are projected to increase from 8% to 20% for 2051 with rapid projections for individuals of South Asian descent, namely from India, Pakistan and Bangladesh (Rees, Wohland, Norman & Boden 2012). Care home service users from minority ethnic groups are also projected to increase. For example, Emerson & Hatton (1999:31) estimated 'by 2021, one in ten people with learning disabilities will belong to non-white minority ethnic groups. Similarly, minority ethnic older people are projected to increase to 1.8 million by 2016 (Manthorpe, Harris & Lakey, 2008). Reasons for increases in minority ethnic populations include closer economic unions with Europe (Redelinghuys & Shah, 1997) increased life expectancy (Lockery, 1991:58), out-group marriages, social mobility, and shifting immigration trends.

Over recent decades, policy and legislation reforms continuously emphasis equality, diversity awareness and eradicating oppression by implementing culturally appropriate environments within community care. However, despite such initiatives, non-white minority ethnic populations continually face barriers whilst accessing formal community care services. Furthermore, researchers continually comment on care home services predominately catering for white ethnic groups, consequently resulting in high unmet need for culturally and ethnically diverse service users.

Despite increasing prevalent minority ethnic communities within the UK and reforms promoting equality, only a small evidence base surrounds research on minority ethnic adults with learning disabilities and minority ethnic older people living in care homes across England. From this small evidence base, most researchers focus on singular minority ethnic groups, conduct research within singular geographical regions, rely on small samples and typically focus on staff members or family members rather than obtaining views from service users. This thesis attempted to address a research gap by conducting a mixed methods explorative study into needs, characteristics and experiences of minority ethnic adults with learning disabilities and minority ethnic older people living within care homes for adults with learning disabilities and care homes for older people across England.

This thesis reports on findings from two sources. First, needs, characteristics and experiences collected from the Measuring Outcomes Public Service Users (MOPSU) study in 2006-2010. The MOPSU study was commissioned by the UK Treasury to develop effective useable methodologies for measuring and assessing outputs of services via an Adult Social Care Outcome Toolkit (ASCOT). The MOPSU care home project monitored care home outputs that uses information routinely collected by the social care regulatory organization the Care Quality Commission (CQC) and included questionnaires, structured interviews and quantitative observations for adults with learning disabilities and older people living within 173 UK care homes. For this PhD research, measures depicting cultural needs and whether staff implemented culturally appropriate services were developed and infiltrated into MOPSU study. Second, focus groups with service users and relatives were conducted separately from MOPSU study to further explore definitions of cultural needs and experiences of care homes for minority ethnic populations.

Collectively this thesis addresses relatively unexplored research gaps by investigating needs and experiences services for ethnically and culturally diverse adults with learning disability

and older people populations living in care homes. Specifically, this thesis depicts explorative investigations into cultural needs and whether care home staff implemented culturally sensitive services for adults with learning disabilities and older people from minority ethnic backgrounds. Characteristics of care homes, care home staff and service users were also explored. Given lack of research into minority ethnic groups utilizing care homes for adults with learning disabilities and care homes for older people, it is hoped findings from this thesis will contribute to community care knowledge by illuminating needs and experiences for minority ethnic communities from learning disability and older populations utilizing care homes.

This thesis also aims to contribute to the vibrancy of disability movement by recognizing the centrality of culture in shaping needs and care home experiences. By unearthing and pursuing some tensions and debates, it is hoped that community care fields and disability movement in general will become more sensitive to cultural differences within community care services. Furthermore, existing minority ethnic populations enable opportunities to explore the viability and representativeness of theoretical frameworks and knowledge. This thesis also encapsulates historical perspectives to highlight how changes, perceptions and periodic trends influences current understanding of community care (Manion & Bersani, 1987:232). Historical evidence also illuminates differences and similarities over time (Bredberg, 1999:199) and provides clarity and understanding of future tasks (Yong, 2007:38). Furthermore, studying the past 'serves as a laboratory for future developments' (Classen, 2007:6).

This chapter begins with Carnaby (2007) layers of influence model which centralizes cultural and ethnic factors in supporting community care service users. Carnaby's model was partly utilized to justify thesis exploration of needs, characteristics and experiences from minority ethnic groups and other factors influencing effective community care service provision.

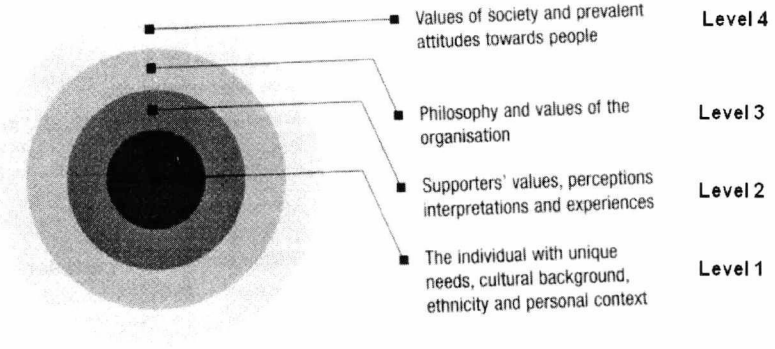
1.1. Supporting community care service users- layers of influence model

Schalock (1997:226) noted 'people live in numbers of systems that influence development of their values, beliefs, behaviours and attitudes'. Similarly, Cambridge (1999:290) outlined initial research tasks involve exploring levels surrounding inquiries and requires differentiation of immediate circumstances and individual at the micro level from wider elements of service system relevant to influencing events.

Figure 1.1 presents Carnaby (2007:9) layers of influence model, which displays four levels impacting individual experiences. For Carnaby, supporting service users within services depends on numerous factors as well as interpreting and assessing individual need. This process is likely to be influenced by the values of the organization that employs the staff member. Consequently, services are designed to reflect the wider values prevalent in society. These 'layers of influence' are dynamic in that each layer influences, and is influenced by, those around it.

Carnaby's model provides useful foundations in understanding numerous populations, challenges and factors involved in supporting service users. Identification of multilevel factors influencing service users lived experiences helps illuminate varying levels of service quality, social care outcomes as well as inferences on quality of life and wellbeing. Other models outlined elsewhere (Cambridge, 1999) similarly explore how people and different organizations within varying levels impact individual experiences.

Figure 1.1- Layers of influence (Adapted from Carnaby, 2007:10).



Level 1 outlines individual needs, cultural background, ethnicity and personal context. A core and centralized feature of Carnaby's model involves acknowledging individual characteristics in supporting service users. Carnaby's model is thus comparable with the '*person centered*' approach which similarly centralizes individuals and mobilizes individuals, family, wider social networks and utilization of resources from systems of statutory services (Mansell & Beadle-Brown, 2005).

Level 2 describes supporters values, perceptions, interpretations and experiences. Within level 2, varying levels of values, perceptions, interpretations and experiences amongst care staff or supporters elicits powerful impacts on service users' experiences. For example, if supporters possess sensitive and accommodating attitudes towards cultural diversity sensitivity, such attitudes may influence whether services prioritize service users needs, cultural background ethnicity and personal context within service provision.

Level 3 outlines organizational philosophy and values which directly influence supporters values. Commitments to ensuring care home services meet cultural needs of minority ethnic service users reflects key organizational polices. Conversely, other organizations may overtly prioritize other objectives, such as ensuring cost effectiveness which may involve reducing staff budgets, staff numbers and situating services within more deprived geographical areas. Differing service objectives across organizations indirectly impact lived experiences of service users, particularly in being able to interact with community staff and access community services. Differing prioritization of specific objectives may pose important implications for service quality as well as community care service user quality of life and wellbeing.

Level 4 describes wider societal values and prevalent attitudes towards community care service users which directly impact organizational policies, influence staff support and service level characteristics. Discriminatory, oppressive and persecutory attitudes towards service users reflect one wider societal example. Overtly discriminatory attitudes will likely influence prioritization of certain agenda over others, thus indirectly impacting staffing characteristics.

Another operational example operating within levels 2 and 3 relevant to cultural research depicts absolutist and universalistic perspectives (Berry, Poortinga & Pandey, 1997). Universalist perspectives emphasize universal basic human characteristics shaped by cultural factors. Alternatively, supporters of absolutist perspectives argue cultural factors play little or no role in either the meaning or display of human characteristics. Universalistic orientated societies may operate differently from societies with an ingrained absolutist perspective.

Specially, if staff operates absolutist perspectives which disregard significance of cultural factors and direct attention to other service agendas, then this ethos will likely have a cascading influence on service providers, service management and direct support staff and influence service users experiences.

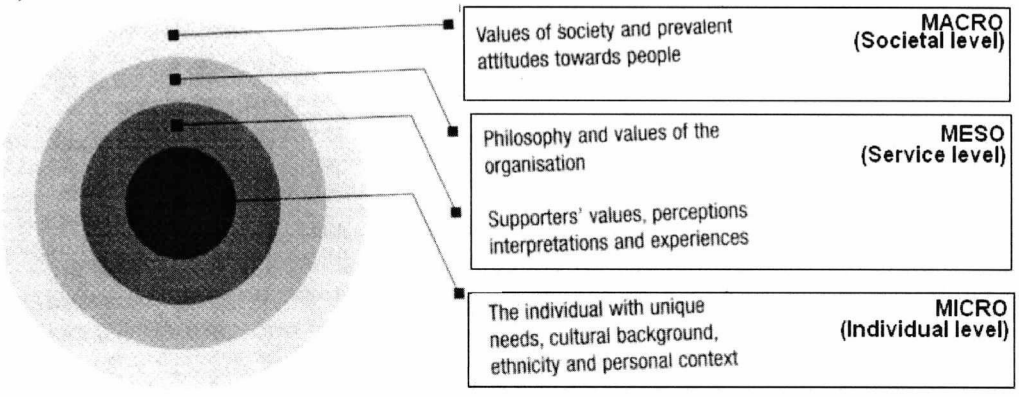
Carnaby's model visually highlights hierarchies involved in supporting service users which could be comparable to how businesses support customers. Carnaby's model further highlights potential service disconnects, gate keeping and barriers in supporting service users, namely, initial power dynamics and social hierarchies. For example, whilst community care staff directly access service users, the organizational provider level characteristically possess indirect access to service users through managers and regional directors. Within this transcendence and hierarchy of information, social psychological factors, social desirability and social influence inferences may affect information transmission across hierarchies. Specifically, risks of 'lost in translation' with information ascending across work hierarchies. Effectively supporting service users may require individuals from more senior organizational levels interacting with service users directly in addition to engaging with providers in order to appreciate challenges and experiences of service users and direct care staff. However, encouraging senior staff to consult with service users and direct support staff relies on numerous factors. First, agreement and accepting attitudes amongst senior staff. Second, resources, organizational and timing issues. Finally, accommodating attitudes towards service users with varying characteristics, including being able to communicate effectively with service users. The effectiveness of senior personnel consulting directly with service users and care staff is further influenced by budget constraints, organizational issues and behavioural change in portraying most favorable impressions via the Hawthorne effect in light of announced, expected, overt observations. Staff may also implement biases in consulting with more 'able' and communicative individuals.

Carnaby's model also usually summarizes levels which highlight service user experiences, exposes potential variables influencing service user experiences and allows initial insights into populations impacting research implementation.

Infiltration of Micro, Meso and Macro factors

Carnaby's model could be further classified into micro (individual), meso (service) and macro (societal) factors as depicted in Figure 1.2. Micro-meso-macro factors highlight three different ways in societal arrangement which helps to better understand our place in them.

Figure 1.2- Layers of influence- Micro, Meso and Macro factors (Adapted from Carnaby, 2007:10)



Other researchers identified micro-meso-macro factors in learning disability research (Verdonschot, de Witte, Reichrath, Buntinx & Curfs, 2009; Schalock & Alonso, 2002) and gerontology or research into aging (Hardy, Young & Wistow, 1999). Micro level data could be obtainable from service users themselves via questionnaires, interviews and focus groups, whereas meso level data could be ascertained from observing care home staff, examining records for care homes as well as questionnaires, interviews and focus groups with staff members. Obtaining wider prevalent societal values at the macro level reflects more challenging research but could be extracted from family members.

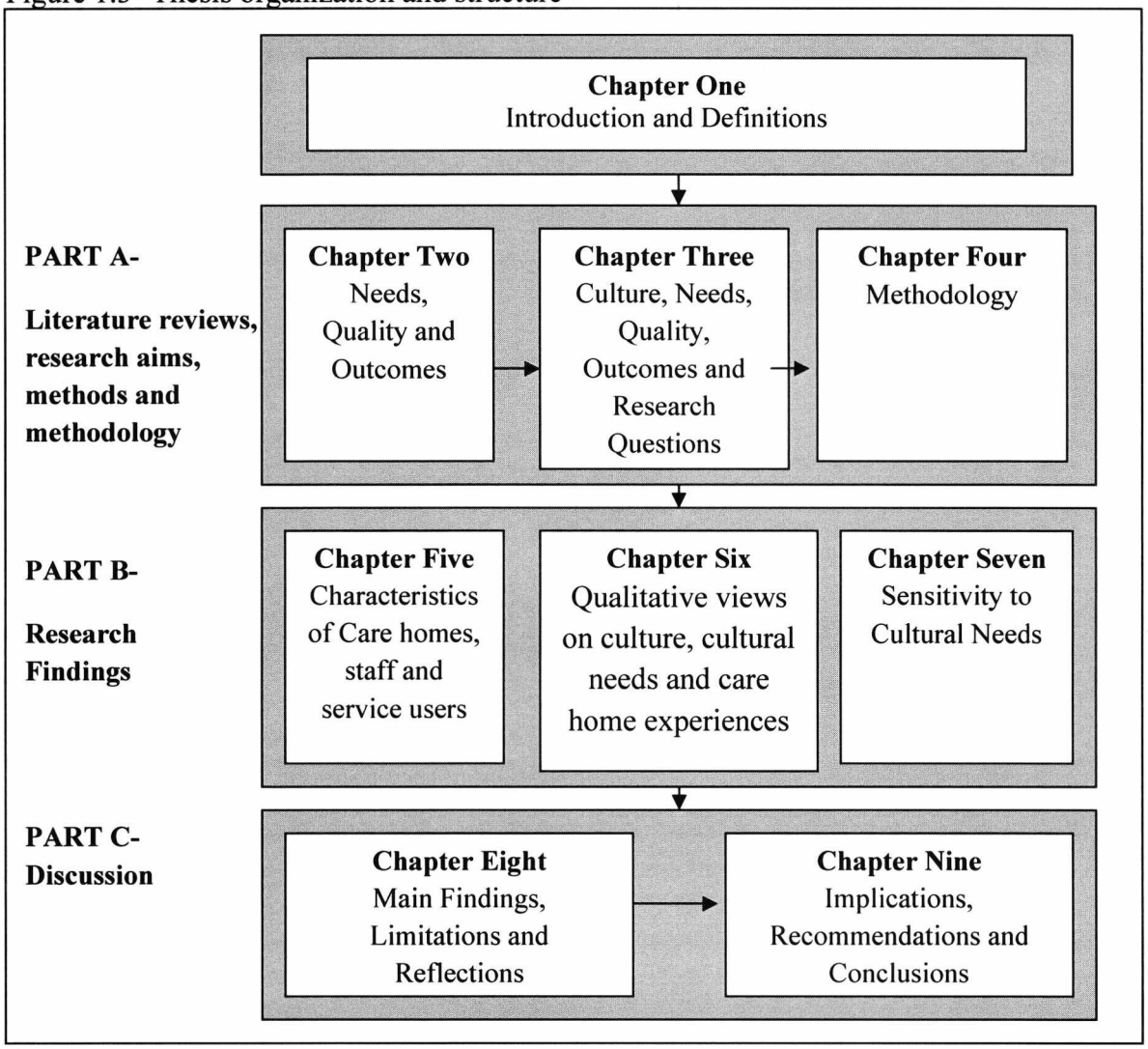
Reflective practice

Coinciding with supporting service users, reflective practice involves developing greater self-awareness regarding individual actions and interactions. Reflection is essential for good practice and highlights preliminary steps in working with people with diverse cultural backgrounds (Tummala-Narra, Sathasivam-Rueckert & Sundaram, 2012). Reflection enables improved practice (Schön 1987), recognition of differences among members of the same minority group with respect to their cultural identity (Helms, 1990) and allows for appreciation and understanding other cultures (Spruhan 1996). Reflection also illuminates damaging misconceptions resulting from stereotypic thinking which can be identified and eliminated (Harris, 1998) and reduces cultural clashes and the threat of ethnocentrism where an individual perceives their own ways as better than others (Nishimoto & Folley 2001). Given researcher reflection merits, personal reflections were continually integrated throughout this research process.

1.2. Thesis organization and structure

Figure 1.3 shows this thesis is organized and structured into three parts.

Figure 1.3- Thesis organization and structure



PART A

Part A 'sets the scene' by exploring concepts, theories, empirical research along with thesis research questions, ethics, methods, methodology and planned analyses. Chapter two presents theories, polices, legislation and empirical research on meeting needs for adults with learning disabilities and older people living in care homes. Chapter three explores cultural and ethnicity considerations surrounding chapter two content and concludes with thesis research questions. Chapter four presents thesis methods, ethics, methodology and analyses.

PART B

Part B presents qualitative and quantitative empirical research findings ascertained from this PhD research. Chapters five and seven depicts findings obtained from the MOPSU study and chapter six outlines focus group findings. Chapter five explores characteristics from care homes, care home staff and care home service users. Chapter five explores differences in the above three characteristics between learning disability and older people service users as well as differences between non-white minority ethnic service users in comparison with white ethnic service users. Chapter six presents qualitative findings from focus groups with south

Asian and African Caribbean service users and relatives on definitions of cultural needs and experiences of care homes. From observational data, chapter seven primarily investigates whether care home staff responded to the language, religious and cultural needs of ethnically and culturally diverse groups.

PART C

The final part C presents recapitulation and synthesis. Chapter eight reviews and consolidates information presented in earlier chapters by summarizing key findings, study limitations and researcher reflections. Chapter nine concludes this thesis by identifying implications and recommendations for future research, policy revisions for service development, conclusions and contributions to knowledge.

This chapter now reviews definitions, terminologies and concepts presented throughout this thesis.

1.3. Conceptualizing definitions , concepts, terminology, characteristics and measurement

1.3.1. Definitions

'Definitions depict features, characteristics and concepts necessary for group or category allocation (Thompson & Mann 1995). Bergner (1997:237) succinctly notes 'definitions state what some "X" is'. Successful definitions focus on the *definiendum* (that which is being defined) and *definiens* (that which is doing the defining) and reflects one of identity (Bergner, 1997:237). Definitions encourage theory generation (Hammil, 1990), affect funding decisions for individuals (Department of Health- DH, 2001a), advance numerous academic fields (Siegal, 1999), influences service organization (Davey, 2008) and drive standards, measurement and service process (Gaster, 1995).

Nevertheless, definitions pose numerous limitations. First, researchers occasionally utilize varying definitions on similar concepts (Hammil, 1990). Second, definitions reflect ideologies within specific scientific paradigms (Kuhn, 1962). Third, definitions potentially oppress populations and favor norms within established paradigms (Manion & Bersani, 1987:231). Similarly, definitions may reflect 'top down' power dynamics, whereby powerful organizations formulate definitions (Sabatier, 1986) which have little resemblance to service user definitions (Simmel, 1972). Fourth, following social psychological factors, definition selection may reflect *conformity* or yielding to group pressures (Asch, 1951; Crutchfield, 1955) and *social desirability bias* or need for social approval and acceptance....attained by means of culturally acceptable and appropriate behaviours (Marlowe & Crowne 1961:109). Furthermore, definition selection may suggest *group think*, whereby 'people engage when they are deeply involved within cohesive in-group, when their members' strivings for unanimity override their motivation to realistically appraise alternative courses of action' (Janis 1972:8-9). Finally, definitions may reveal social constructions within some social groups, yet remain undefined by others.

1.3.2. Concepts

Concepts were mentioned above in conceptualizing definitions. Some researchers depict concepts as abstraction either of concrete events (Norris, 1982) and based on observations of

certain behaviours or characteristics (Polit & Hungler, 1987). Identifying concepts potentially improves clarity which strengthens evaluation and instrument development (Endacott, 1997), strengthens research findings (Eriksen, 1995; Haas, 1999), generates theory and critical thinking (Duchscher, 1999; Kramer, 1993). Furthermore, concepts assist with investigations and depict expressions of interest (Wittgenstein, 1952).

1.3.3. Terminology

Terminology depicts vocabulary of technical terms used in particular fields, subjects, science, and art (Lovis, 1998:143). Nevertheless, utilizing varying terminology, particularly within different historical and socio-cultural contexts, inhibits clarity. This thesis mostly presents terminology from UK sources given university base and data collection location.

1.3.4. Characteristics

Characteristics derive from Latin meaning '*inscription*' which differentiates something from others (Reber, 1995:120). For some psychologists, characteristics explore integration of all such markings ('traits') to yield a unified whole which reveals the nature (the 'character') of a situation, of an event or person (Reber, 1995).

Automatic categorization and impression formulation from individual characteristics are well learned, fundamental for social perception (Neuberg & Fiske, 1987) and evolutionary survival purposes (Schaller, Faulkner, Park, Neuberg & Kenrick, 2005). Impression formulation of others begins with automatic categorization from predominately overt characteristics including gender, ethnicity and age (Fiske, 2004). Nevertheless, others (Fiske & Neuberg, 1990; Fiske, Lin & Neuberg, 1999; Fiske, 2004) argue impression formulation processes are sometimes influenced and moderated by information and motivation rather than automatic processes. Furthermore, some sociologists argue society formulates impressions of others based on social classes (Bullock, Fraser Wyche & Williams, 2001) ethnicities (Welch, 2007), religions (Saeed, 2007), women (Yunjuan & Xiaoming, 2007), older people (Vasil, 1993), young people (Estrada, 2001; Schissel, 1997) and overt disability (Safran, 1998; Schwartz & Lutifyya, 2009). Some Marxist supporters argue impression formulation protects ruling class and economic interests (Engels, 1884). Some feminists outline impression formulation oppresses women to preserve patriarchy or male dominated society (Walby, 1989). Insight into varying theoretical orientations enables preliminary insights into attitude formulation of social groups.

Characteristic types

In order to investigate service users characteristics, community care researchers typically explore four characteristics groups including functional, physical, social, cognitive and psychopathology.

Activities of Daily Living (ADL) measures generally describe individual functional and physical characteristics (Fitz & Teri, 1994; Wade & Hewer, 1987). ADLs outline performance with basic daily life tasks including eating, bathing, dressing, toileting, and transferring (Wiener, Hanley, Clark & Van Nostrand, 1990:s229).

Social functioning characteristics generally explore functioning with two or more conspecifics or members of the species (Reber, 1995). Adaptive behaviour, challenging

behaviour and social impairment reflect three examples of social functioning characteristics. First, adaptive behaviour depicts abilities to withstand natural and social environmental situational demands (Herber, 1961), meeting the standards of personal independence and social responsibility expected of his age or cultural group (Grossman 1977). Others associate adaptive behaviour with models of personal competence (McGrew & Bruininks, 1990). Second, challenging behaviour defined as 'culturally unusual or unacceptable behaviors, including self injury or aggression, that place the health or safety of the person or others in jeopardy or are likely to lead to the person being excluded or denied access to ordinary community settings' (Emerson & Hatton, 1994:17). Third, dichotomous classifications distinguish individuals with social impairments from individuals without social impairments (Wing & Gould 1978; Murphy, Beadle-Brown, Wing, Gould, Shah, & Holmes, 2005). Social impairments, include characteristics of 'aloof', 'passive' or 'active but odd', regardless of Intelligence Quotient (IQ) level. 'Socially able' describes individuals without any social impairment including shy individuals (Murphy et al, 2005). Others place social functioning along severity continuums conversely to dichotomous classifications (Yoder, Stone, Walden & Malesa, 2009).

'Cognition' depicts 'mental action of acquiring knowledge and understanding through thought, experience and the senses'. Cognition includes attention, perception, memory, language operating across distributed interactive and overlapping networks within the brain (Reber, 1995).

Ossorio (1985) defined psychopathology as significant restrictions in individuals engaging in deliberate action and participating in social practices. For Bergner (1997), Ossorio's psychopathology definition benefits from considering relativity to time, culture, and situation in defining psychopathology. The adjective 'mental' is frequently discussed within psychopathology and paired with 'disorder', 'disease' or 'illness' (Wakefield, 1992a:374) as well as 'health', 'abnormality' and 'problems'. Two major issues exist with psychopathology definitions (Wakefield, 1992a; 1992b). First, some question the viability of 'mental illness' by viewing mental illness as a 'myth' used to 'disguise moral conflicts in human relations' (Szasz, 1960:118). Second, some societies may consider symptoms indicative of mental illness, yet other societies value and embrace similar symptoms.

Inferences and diagnosis of 'mental' capabilities can be traced back to antiquity from the Ancient Greek philosophers Aristotle and Plato along with references within Shakespearian texts (Szasz, 2011). Modern mental health diagnostic manuals include the American Psychiatric Association- APA (2000) *Diagnostic and Statistical Manual*, Version Four, Text Revision DSM-IV-TR (APA, 2000) and the World Health Organisation (WHO) *International Classification of Diseases, Version 10*- ICD-10 (WHO, 2001). Diagnostic manuals 'seek to impose consistency, stability and control on the centripetal forces of clinical diagnosis' (McPherson & Armstrong, 2006:57-58) and also potentially provide clarity on disorders.

Diagnoses and classifications offer numerous advantages. First, diagnosis facilitates treatment (Ashford, Borson, O'Hara, Dash, Frank, Robert et al, 2006) and encourages interventions which delay or prevent admission into psychiatric hospitals (Banerjee & Wittenberg, 2009:749). Second, diagnoses may prolong mental function and quality of life for patients and caregivers (Leifer, 2003). Third, diagnosis may reduce psychological distress due to referral to appropriate agencies (Iffie, Manthorpe & Eden, 2003) and allocating

diagnostic names to symptoms (Proudfoot, Parker, Benoit, Manicavasager, Smith & Gayed, 2009).
However, diagnoses receive numerous objections. Criticisms during the diagnostic phase include inadequate training in formulating diagnoses (Iliffe, et al, 2003), practitioner confusion given disorder overlap (Cole, McGuffin & Farmer, 2008) and clinician subjectivity and heavy reliance on observable behavioural symptoms in formalising a diagnosis (Hughes, Daniel, Ben-Shlomo & Lees, 2002; Treloar & Lewis, 2009). Other criticisms include difficulties with co-morbidity and duel diagnoses (Stewart & El-Mallakh 2007), stigmas following diagnosis from general practitioners (Cahill, Clarke, O'Connell, Lawlor, Coen & Walsh, 2008), associations between literacy difficulties and diagnosis (Carroll, Maughan, Goodman & Meltzer, 2005) and individual factors including ethnicity influencing diagnosis formulation (Paradis, Horn, Yang & O'Rourke, 1999). Misdiagnosis and undiagnoses (Boise, Camicioli, Morgan, Rose & Congleton 1999) may skew populations with higher percentages of individuals with severe symptoms accessing services which maybe unrepresentative of individuals with milder symptoms.

Depression and anxiety reflect prevalent mental health problems within the UK in comparison with other European countries (King, Nazareth, Levy, Walker, Morris, Weich et al, 2008). Depression typically describes mood states categorized by sense of inadequacy, activity disengagement or reactivity, pessimism, sadness and related symptoms (Reber, 1995). Anxiety generally depicts vague, unpleasant and emotional states with qualities of apprehension, dread, distress and uneasiness (Reber, 1995).

1.3.5. **Measurement**

Stevens (1951:1) defined measurement as 'assignment of numbers to objects or events according to rules'. For Fraser (1980:23) up until the early twentieth century, measurement was based on Platonic idealism which involved investigating measured object amounts, magnitude and numerical value or quantity assignment to objects.

Researchers typically measure phenomena via quantitative and qualitative approaches. Quantitative derives from the Latin word *'quantitat'* meaning quantity which implies close associations with measurement, numbers and frequencies defined as 'the number of occasions of the several values of the same variable' (Reber, 1995). Generally, quantitative researchers view the world as 'made up of observable, measurable facts" (Glesne & Peshkin, 1992:6). Bryant (2000:498), defined facts 'as things done, deeds, and accomplishments'. As Golafshani (2003:597-598) usefully summarizes, quantitative research generally emphasizes four qualities. First, emphasizing facts and behavioural antecedents (Bogdan & Biklen, 1998). Second, quantifying and summarizing numerical findings. Third, utilizing mathematical processes to analyze numeric data. Fourth, utilizing statistics to present findings.

Stevens (1946, 1958) identified four levels of measurement with each level corresponding to unique characteristics. First, with nominal data, numbers may serve as labels to identify items or classes. For example, assigning model numbers to classes. Second, with ordinal or ordered data, numbers reflect rank order items. For example, grades of wool. Third, with interval data, numbers depict differences among items. For example, intelligence tests standard scores. Finally, with ratio data, numbers reflect ratios among items with an absolute zero point. For example, temperature as measured via Kelvin scales. Yet, Velleman & Wilkinson (1993) illuminate the misleading nature of measurement typologies.

Conversely to quantitative measurement, qualitative derives from the Latin word '*qualitat*' meaning quality and typically explores qualities of phenomena, rather than quantities. Generally, qualitative researchers investigate understanding and illumination of particular situations (Hoepfl, 1997). Willig (2001:9) usefully summarises examples of qualitative research including exploration of texture of experience, lived experience and participant defined meanings. Qualitative researchers also explore how people make sense of the world and manage certain situations. Some researchers implementing qualitative approaches utilize frequencies to display qualitative themes defined as specific patterns of interest (Joffe & Yardley, 2004). Some researchers place frequently mentioned themes at a higher position in a theoretical model in contrast with less-frequently mentioned themes (Joffe & Bettega, 2003; Joffe & Louis Lee, 2004). However, given qualitative emphasis on meaning and typical 'what is it like' questions, qualitative researchers primarily explore meaning surrounding events and experiences, rather than investigating statistical relationships with quantitative research (Willig, 2001).

Rather than using mono-methods, namely, utilizing either quantitative or qualitative research approaches, some researchers implement both quantitative and qualitative approaches. Combining quantitative and qualitative approaches typically describes mixed methods, methodological pluralism (Howard, 1983) or triangulation which Denzin (1978:29) defines as 'the combination of methodologies in the study of the same phenomenon' (cited from- cf, Jick, 1979:602). Johnson, Onwuegbuzie & Turner (2007), positions mixed methods between Ancient Greek philosophers of extremes Plato (quantitative research) and the Sophists (qualitative research). For Johnson et al (2007), mixed research attempts to respect fully the wisdom of both viewpoints while also seeking a workable middle solution for researchers.

Measures typically involve retrospective techniques, which involves recalling previous events. Some researchers utilize cross sectional designs which measure phenomena from a singular point in time. Prospective or longitudinal designs involve data collection from the same participant across multiple time points.

Methods

Methods depict 'a way of doing things, of working with facts and concepts in a systematic fashion' (Reber, 1995). Whilst 'a way of doing things' encapsulates generic everyday application, ascertaining facts is debatable, given subjectivity, measurement approach and research objectives. Researchers, inspectors and professionals utilize various methods for testing purposes and to investigate individuals, groups and phenomena. Some use content analyses to explore recorded human communications from books, websites, paintings and laws (Babbie, 2012). Barker, Pistrang & Elliot (2002) note two method forms; self report and observation.

Self report and observation

Self report measures collect participant subjective viewpoints ascertained primarily from questionnaires defined as forms containing sets of questions to gather information (Zamorano, Grindlay, Molero & Rodriguez, 2011:1949). Self reports include either closed questions, open ended questions or both open and closed questions. For Dohrenwend (1965:175) 'closed questions are those which can be answered with a short response selected from a limited number of possible responses'. Dohrenwend (1965:175) outlines three forms

of closed questions. First, yes-no question whereby 'yes' or 'no' provides an adequate response. Second, identification questions characterized by participants selecting responses from finite sets of possibilities. Third, selection questions, whereby researchers present participants with two or more alternative responses and require participants to select one option. Vintin (1995:27) further outlines 'closed questions depict a 'check answer' approach whereby respondents select from pre-assigned categories and participant answers best fits their own views'. Conversely, open ended questions or 'free response' requires participants to divulge answers freely in prose form.

Interviews reflect self report examples (Barker et al. 2002). Bogdan et al. (1982) defines interviews as purposeful conversation between two people directed to obtain information. Yet, as Mills (2001) identifies, most interview definitions fail to define 'purposeful conversation'. Interviews ascertain research relevant information (Cohen & Manion, 1994) and assist with diagnostic purposes (Wing, Leekam, Libby, Gould & Larcombe, 2002). For Freeman (2006) focus groups reflect group interviews intending to exploit group dynamics. With focus groups, small group of participants discuss issues with an ideally impartial moderator or focus group facilitator. The duration of focus groups typically ranges from sixty to ninety minutes. Furthermore, investigators typically audio records focus group discussions.

Observational methods differ from questionnaires and interviews in directly examining behaviour instead of relying on participant individual responses to behavioural appraisals (Wang, Wiley & Zhou, 2007:778). Observation methods can be positioned along a quantitative - qualitative spectrum (Clark, 2007:2). Quantitative observations typically involve standardized and controlled observations, whereas qualitative observation draws observers into the live worlds of those being observed, namely, with participant observation. Observational methods are further categorized into covert observation where the real identity of the observer as a social researcher remains secret and entirely unknown to participants (Bulmer 1982:252). Conversely, with overt observation, participants are fully aware of observational measures and observers.

Coinciding with measurement, researchers are ethically responsible for obtaining participatory consent either from participant themselves, or in cases of children and individuals with limited mental capacities, consent via a surrogate or proxy from other individuals who know participants in detail (Magaziner, Zimmerman, Gruber-Baldini, Hebel & Fox 1997). Researchers utilize varied proxy informants (Stancliffe, 1997b) including family members or relatives (McVilly, Burton-Smith & Davidson 2000), care staff (Stancliffe, 2000) and from clinicians, relatives and care staff (Espie, Watkins, Duncan, Sterrick, McDonach, Espie & McGarvey 2003).

Methodology

Methodology refers to detailed research methods used to collect data and reflect philosophies underpinning data collection and analysis (Haralambos & Holborn, 2004). This methodology definition benefits from illuminating philosophical approaches surrounding measurement. Briefly, two broad philosophical approaches underpin quantitative and qualitative research. First, within positivism, quantitative research is supported by scientific paradigms, with 'facts' ascertained from objective scientific methods (Comte, 1865). Second, interpretivist and phenomenology supporters explore subjectivity and values affecting objectivity (Leitch, Hill & Harrison, 2010; Smith, 1992) and deem value free science an impossibility (Angden, 2000).

Inductive and deductive reasoning reflects two broad methodological approaches which frame research implementation (Susser, 1986) and illuminate research approaches (Barker et al 2002). For the philosopher Francis Bacon, induction or inductive begins 'from the senses and particulars' and ends with 'the greatest generality' (Urbach, 1982:116). Alternatively, induction begins with precise observations to broader generalizations and theories (Trochim, 2006). Conversely, as Demos (1958) notes, deduction or deductive reasoning originates from Aristotle and later debated by Popper (1968). Briefly, deductive reasoning reflects inversed induction and involves deriving theories from testable predictions known as hypotheses. Data collection involves collecting data to test the original hypothesis and theory, or in relation to Popper's terminology, formulating hypotheses capable of refutation or falsification (Barker et al, 2002; Trochim, 2006). This deductive approach reflects the scientific hypothetico - deductive method (Barker et al, 2002).

Excluding group orientated measures including focus groups, measurement is essentially individualistic. Participants, inspectors and researchers allocate individual assessments on particular measurement forms. However, measures which utilize group dynamics may reflect more appropriate methods individuals from collectivist cultures who otherwise formulate decisions, opinions and assessments as a group from than as an individual task. It follows then, that measures which embrace group dynamics may reflect more culturally appropriate measures for individuals from collectivist cultures than more individualistic measures.

Psychometric measurement

Psychometrics generally investigates quality, validity and reliability of measures (Nunnally, 1978). From reviews of reliability and validity definitions (Hammersley, 1987), reliability describes dependability, trustworthiness and consistency. A frequently cited reliability definition outlines extent to which [measurements] are repeatable and that any random influence which tends to make measurements different from occasion to occasion sources measurement error (Nunnally, 1967:206). Jadad, Moore, Carroll, Jenkinson, Reynolds, Garaghan et al. (1996:4) defined validity as 'ability of instrument to measure what it is believed it is measuring'.

Cronbach alpha (Cronbach, 1951, 2004; Cortina, 1993; Tavakol & Dennick, 2011) quantifies internal consistency or reliability of quantitative measures and depicts an important instrument tool. As Patrick & Erickson (1993) summarises, Cronbach alpha ranges from -1 to +1. Furthermore, when internal consistency is an important factor, higher values reflect the preferable option. Others however prioritize other internal consistency alternatives to Cronbach alpha (Zinbarg, Revelle, Yovell & Li, 2005).

Assessing inter-rater reliability, whereby data are independently coded and coding compared for agreements, is a recognized process in qualitative research (Armstrong, Gosling, Weinman & Marteau, 1997; Golafshani, 2003), quantitative observational research (Mansell, Beadle-Brown, Whelton, Beckett & Hutchinson, 2008) and utilized to assess agreement of subjective judgements within different settings (Tinsley & Weiss, 1975).

1.4. Key thesis definitions

This section presents key definitions utilized throughout this thesis. Given thesis emphasis on minority ethnic groups, this section firstly focuses on defining race, ethnicity and culture as

well as minority, majority and comparison groups. Other definitions presented include: impairment and disability, learning disability, older people, discrimination, needs, dependency, community care and quality.

1.4.1. Race, ethnicity, culture

Race is presented first followed by ethnicity and culture to coincide with historical origination of particular terminology. Although as Iliffe & Manthorpe (2004) identify, race, ethnicity and culture expose subjective, changing, confused, ambivalent, emotive and contested definitions and terminologies.

Race

Race was first introduced by Johann Blumenbach in the eighteenth century (Hudson, 1996; Witzig, 1996). Race was considered inconsequential amongst Ancient Egyptian, Ancient Greek and Roman societies (Snowdon, 1970; 1991). Race attracted escalating attention in later centuries, following European expansionism (Linton, 1936), radicalized history of emergent empires or imperialism (Hudson, 1972) and capitalism (Cox, 1948).

Prior to the nineteenth century, unique shared physiological features were utilized to distinguish race. Early racial classifications included body formulation, personality and mental capacities including shape of skulls or phrenology (Combe, 1830), head measurements or craniometry (Boas, 1912), facial angle (Petrus Camper [1722-1789]) (Haller, 1970), size of the brain and skull capacity (Broca, 1861), hair type (Browne, 1852) and jaw size (Beddoe, 1862). Early racial taxonomies and classification systems integrated racial hierarchies by allocating superiority to certain racial groups over others (Chambers, 1844). Assigning racial hierarchies reflects examples of scientific racism (Fairchild, 1991), biological determinism whereby biology determined social position (Bhopal, 1997) and social rather than biological conceptualizations of race (LaVeist 1994:2). Biological connotations of race were rejected from this thesis due to small biological differences (Williams, D. 1997) and links with scientific racism.

Numerous race definitions (Williams, D. 1997) highlight the changeable nature of defining race (Bashi, 1998:966). Rather than generating an 'a priori assumption that readers would simply recognize or understand what the terms meant', (Lee, 2009:1187), it was decided to follow Morris (2009) and utilize the following definition of race '[A race is a] phenotypically and/or geographically distinctive subspecified group, composed of individuals inhabiting a defined geographical and/or ecological region, and possessing characteristic phenotypic and gene frequencies that distinguish it from other such groups'. This definition benefits from showing characteristics, conversely to vague race definitions of 'group defined of common stock' (Reeves, 2009).

Ethnicity

As Straussner (2012:6) reviews, ethnicity derives from the Greek word *'ethnos'*, meaning people or nation, and refers to members of an ethnic group sharing common identity, ideals, and aspirations and a sense of continuity. For Jones (1994), ethnicity 'refers to cultural practices and attitudes that characterize a given group of people and distinguish it from other groups. The population group itself is seen to be different by virtue of language, ancestry, religion, common interests and other shared cultural practices such as dietary habits or style

of dress. Ethnic differences, in other words, are wholly learned, they are the result of socialization and acculturation, not genetic inheritance (Jones, 1994:292). Given support for this view (Baxter, 1997; Srivastava, 2007) this definition of ethnicity was utilized. Ethnicity was suggested as an alternative to race because it carries less of a strictly biologic connotation, implying that groups may differ by cultural as well as biologic heritage' (Kaufman & Cooper 2001). Nevertheless, others combine 'race/ethnicity' (Hall & Riccio, 2012) or 'ethnorace' (Shelby, 2009) which is arguably problematic as race and ethnicity reflect different definitions.

Minority ethnic individuals were defined as those with a cultural heritage distinct from a majority population (Manthorpe & Hettiaratchy, 1993). Minority ethnic populations resided in England since Roman Britain (Leach, Lewis, Chenery, Müldner & Eckardt, 2009) and early modern England (Barthelemy, 1987; Habib, 1998), yet reflect increasingly prevalent populations over the last few decades (Office of National Statistics - ONS, 2012a). Considering people from white British backgrounds reflect the modal ethnicity classification within the UK (ONS, 2012a); 'minority ethnic' refers to all other individuals from other ethnicity groups living within the UK. 'Non-white' refers to people from Asian, Black, Chinese and other ethnic backgrounds which reflect the three most prevalent non-white minority ethnic populations living within England (ONS, 2005b). 'White minority ethnic' refers to people from white Irish backgrounds and people from other white ethnic groups including other white Europeans. However, some acknowledged limitations exist with ethnicity definitions which warrant consideration. First, as Manthorpe & Bowes (2010) identifies, non-white populations sometimes reflect the majority ethnic group with people from white British backgrounds as a minority ethnic group. Second, Watson (2008) highlighted super-diversity with no majority ethnic group.

Culture

Culture derives its original meaning from Latin *cultural*, depicting cultivation of the soil (Chiu & Hong, 2006:3). 'Culture' is said to be one of the two or three most complex words in the English language' (Eagleton, 2000:1). Reviews of one hundred and sixty four definitions of culture (Kroeber & Kluckhohn 1952) illuminate multiple cultural definitions, perspectives (Keesing 1974:75) and culture complexity. Noteworthy and frequently mentioned definitions of culture include; 'Culture is the learned and transmitted knowledge about a particular culture with its values, beliefs, rules of behaviour and lifestyle practices that guides a designated group in their thinking and actions in patterned ways' (Leininger, 1978:491). Moreover, 'culture...is a set of guidelines...which an individual inherits as a member of a particular society and which tells him how to view the world and learn how to behave in it in relation to other people. It also provides him with a way of transmitting these guidelines to the next generation-by the use of symbols, language, art and ritual' (Helman, 1994:2). Both cultural definitions highlight culture is dynamic and reflects value and belief systems of communities (Kale, 2003). Srivastava (2007:58) extends these culture definitions by usefully depicting characteristics of culture according to the letters comprising c.u.l.t.u.r.e whereby culture is: *Commonly Understood*, culture is *Learned* from birth through language acquisition, 'culture also is about *Traditions* and rituals what is done, when it is done (or not done) and how it is done'; culture is not only commonly understood, it is *Unconscious* and automatic, and finally, 'cultural values determine the *Rules of Engagement* with life events..

Hatton (2004a:46) distinguishes 'emics' and 'etics' whilst discussing culture. ***Emic*** refers to research conducted within one cultural group and ***etics*** refers to comparative research across

cultural groups. Others distinguish *individualism versus collectivism* (Hui & Triandis, 1986). Parents in individualistic cultures raise their children to be independent, capable at an early age of making their own decisions, choosing their own friend. In contrast, within collectivist, interdependent, communal societies, children are taught interdependence and reliance upon family and other groups (Myers, 1992). Consequently, interdependent cultures may emphasize collective welfare, proper relations with others, and the needs of others as opposed to the importance of the distinct self, separateness, and autonomy often endangered by independent cultures. Yet, American individualism differs from Swedish individualism and Israeli kibbutz collectivism differs from Korean collectivism (Triandis 1995; Triandis & Gelfand, 1998).

1.4.2. Minority, majority and comparison group

Etymologically, 'minority' derives from Latin meaning 'minor' 'less', 'lessor' or 'smaller' and '*minuere*' indicating reduction (Coontz, 1986:155) which implies comparisons to a greater preponderant majority population. Wirth (1945) defined minority describing 'groups of people who, because of their physical or cultural characteristics, are singled out from the others in the society in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination'. However, as Singh & Orimalade (2009) notes, sociological minority is not necessarily a numerical minority as some ethnic groups may dominate numerically, but still constitute a minority with respect to education, employment, political power, and socio-economic status.

Whilst varying regional localities and existence of specific organizations may distort prevalence of minority groups, examples of minority groups include: racial and minority ethnic groups as well as people of varying ages (ONS 2012a); minority gender groups in certain professions such as males working within female dominated professions (Eriksen & Einarsen, 2010); sexual orientation minorities including prevalence of lesbian, gay, bisexual and transgendered populations (ONS, 2010); religious minorities including individuals practicing less prevalent religions (O'Beirne, 2004) and people with disabilities (Family Resource Survey, 2008).

Blakemore (1998:264) outlines three elements of the minority concept which usefully highlights initial minority group issues. First, a minority group is outlined by a larger majority, but is the various minority communities dwarfed by the majority, or if considered together, do they represent a sizeable proportion of the population? Second, minorities may live in concentrated communities and/or dispersed throughout majority populations. Finally, a minority is defined by a power relationship with the majority, whereby this relationship may be one of equality between majority and minority or of the inferiority of the minority or the dominance of the majority by the minority.

Comparison group

As Blakemore (1998) highlights, exploring whether minority communities differ from the majority depends on what kind of 'majority' one is using as a comparison group. Bhopal & Donaldson (1998) evaluated terminologies currently in use to describe participations from 'non minority' populations and recommended researchers to abandon usage of 'White', Caucasian', 'Western', 'majority' in favour of terminology such as 'reference, control or comparison' and 'general population'. For Bhopal et al (1998), usage of 'reference, control or comparison group' was the preferred term because the construct reflects the following: 1)

neutral terms, that is departure from criticized concepts such as 'White', 'Caucasian'; 2) recognizes the purpose of the non minority group in the research and finally forces the write to describe a population and clarify terminology of study or review. Furthermore, 'general population' was considered an 'excellent term for representative population samples' however is 'inaccurate unless it is a truly representative population' (Bhopal et al, 1998:1305). As discussed above, studies comparing minority ethnic groups with individuals from white ethnic groups have tended to refer to participants from white ethnic groups as the 'majority' (Hatton, Emerson, Kirby, Kotwal, Baines, Hutchinson et al, 2010).

Hatton (2002:209) notes majority populations of the United States, UK, Canada and Australia typically include people from white ethnicities, European descent, English speaking and practicing Christians. Hatton, et al. (2010) recently distinguished majority versus minority populations with a particular focus on ethnicity as an independent variable by exploring differences between majority and minority ethnic family carers and their perceptions of challenging behaviour and family impact. Hatton et al. (2010) used a comparison group including individuals of white of European descent, English speaking and practicing Christians. Hatton et al. (2010) compared findings from this comparison group with individuals from a minority population which included people from culturally diverse backgrounds and individuals belonging to non-white, non English speaking and individuals practicing religions other than Christianity.

Following reservations of neglecting experiences of white minority ethnic groups (Aspinall 2002), it was decided to conduct comparisons between white British, white Irish and individuals from other white ethnic groups before combining individuals from white ethnic groups into a majority comparison group. Initially separating white ethnic groups may highlight racism and oppression against white minority ethnic groups (Fox, 2012). Nevertheless, given potential 'meaningless data' from low samples, analyses may involve integrating all white ethnic people into a singular comparison group and compared with non white minorities.

Letter capitalisation and power dynamics

Occasionally, researchers capitalize the letter 'W' whilst describing people from 'White' ethnic groups. This capitalization of 'White' arguably depicts power dynamics, especially if compared with 'minority ethnic' depicted in lower case lettering within the same sentence. Similarly, researchers sometimes capitalize letters 'C' and 'P' whilst describing Clinical Psychologists. Presenting the term service user in lower case along with Clinical Psychologist in both lower and upper case lettering arguably reveals implicit power dynamics with mental health professionals in more dominant roles and placing service users in inferior and submissive roles. Depending on specific sentences, tables and grammatical issues, to avoid inducing any inferences on dominant power dynamics, it was decided to present all ethnicity, service user and religion labels as well as professional occupational titles within lower case.

1.4.3. Impairment and disability

The International Classification of Functioning- ICF (WHO, 2001) defined impairment as 'a deviation from certain generally accepted population standards' (WHO, 2001:12). The ICF defines disability as any impairments, activity limitations, or participation restrictions or to 'the outcome or result of a complex relationship between an individual health condition and

personal factors and external factors that represent the circumstances in which the individual lives (WHO, 2001:17).
As Appendix 1 shows, WHO (2001a) impairment and disability definitions reflect revisions to earlier WHO disability and impairment classifications. One notable change from the earlier International Classification of Impairments, Disabilities and Handicaps (ICDH) to ICF concerns 'handicap' defined as 'a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfillment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual' (WHO,1980:x). 'Handicap' is excluded from this thesis due to 'medicalisation of disability' as well as 'handicapist and repugnant' language (D. Pfeiffer, 1998). This thesis utilizes ICF definitions of impairment and disability for several reasons. First, ICF definitions 'are widely used throughout health related professions as a way of categorizing an individuals experiences of various diseases or disorders' (Yaruss & Quesal 2004:35). Second, the ICF definitions depict useful frameworks for describing disorders (Yaruss et al, 2004), enables detailed description experience of disability (Schneider, Hurst, Miller & Üstün, 2003), outlines detailed functional assessments (Peterson, 2005) and 'provides professionals with relevant information and guide the selection of interventions' (Dahl, 2002:202). Third, ICF disability definitions provide complete and consistent disability definitions' (Leonardi, Bickenbach, Ustun, Kostanjsek & Chatterju, and 2006:1219).

Selway & Ashman (1998:430) argue historically, 'disability' and 'illnesses' were often viewed as synonymous which provides insights into the social construction of disability through language. Similarly, others call for consideration of social factors by highlighting the importance of social and environmental factors in defining impairment (Woodhams & Corby, 2003) and increased appreciation of ecological (person-environment) and social aspects of disablement (Schalock, 2004a:211). For D. Pfeiffer (1998:519), 'disability is a natural part of life. Everyone will be disabled. Perhaps a person will be disabled for only moments before death from a heart attack or automobile accident, but most people will spend a significant amount of time in their life as a person with a disability'. If all individuals experiences disability at some point, this perhaps challenges presumed social group categorizations or attributions of 'them' (the person with a disability) and 'us' (the person without a disability). Potential disability inevitability also challenges group dissimilarity, whereby people without disabilities may experience similar experiences to individuals with disabilities at a later date.

Others criticize imposing labels beyond individual choice (Barnes, 1999) and challenge the usefulness of defining disability (Noon & Ogbonna, 2001). Others argue disability labels exposes little relationship between the term 'disabled', the disabled person and types of support (Cunningham & James, 2001). Further limitations of disability labels include exclusion of individuals with 'hidden' or invisible disabilities (Woodhams et al, 2003) and others refute impairment as a contributory factor in causing disability (Oliver, 1990, 1995; D. Pfeiffer, 2000). Furthermore, in some societies, disability is not a recognised as a category (Ingstad & Whyte, 1995). For example, south Asian communities in Birmingham and Tower Hamlets in London found no direct translation of disability (Maudlsey, Rafique & Uddin, 2003). Label allocation may depict no real meaning for some groups and may prefer more inclusive societies (Shaw & Hughes, 2006).

As Imrie (2004:1) notes, disability theory revolves around medical and social disability models which illuminates preliminary insights into how community care services operate and support service users. Briefly, the medical model or individual model of disability assumes a lack of ability in any functional area, which has arisen as a result of impairment and stems

from the limitations of the individual to 'adapt', 'cope', or 'cure' their condition. Supporters of medical models of disability locate disability within individuals and argue that it is the impairment of the individual which disables, thus placing considerable emphasis on how impairments results in clear disadvantages to the individual. The medical model largely sees disability as a form of personal tragedy which the individual must learn to accept and to cope with life despite impairments (cf Oliver, 1986, 1990). Others challenge medical models for neglecting impairments including nutrition (McKeown, 1979), stress and strain (Blaxter, 1983), social class (Calnan, 1987) as well as criticisms in reducing disabled populations into passive, de-ordinate, dependent and inferior statues in contrast to members of the medical profession (Abelson, Rupel & Pincus, 2008:s.25). Others argue disability is result of oppressive social environments, in effect the social model of disability (Marks, 1997:8) rather than impaired or malfunctioning body. Social model of disability advocates (Oliver, 1990; Hughes & Paterson, 1997) consider disability a socially constructed concept whereby disability is a result of hampering effects of a society geared to 'ablebodiedness' as the norm rather than disability.

1.4.4. Participant populations

Most researchers conduct research on singular populations, namely, adults with learning disabilities or older people which perhaps reflect research expertise, preferences as well as pragmatic, ethical and practical considerations. However, focusing on specific population groups potentially homogenizes, excludes and singularizes populations. Extrapolating similarities and differences from similar measures collected on multiple populations may elicit interesting questions, conclusions and debates on particular concepts and experiences. This thesis therefore explores findings from varied populations, namely, adults with learning disabilities, older people and relatives or family members. This thesis occasionally utilizes global descriptors of 'adults with learning disabilities' and 'older people' which arguably homogenizes populations. However, the intention was to explore adults with learning disabilities and older people separately, with a view to compare and contrast experiences with different populations in later chapters.

1.4.5. Learning disability

Terminology

Varying learning disability terminology elicits important influences on public perceptions and attitudes towards people with learning disabilities (Eayrs, Ellis & Jones 1993). Appendix 2 outlines historical terminology used to refer to people with learning disabilities. Nevertheless, outdated terminology is still utilised within some public domains (Siperstein, Pociask & Collins, 2010). This thesis utilizes 'learning disability' terminology to coincide with UK policy documents, legislation, CQC terminology and preferred terminology in Britain (McCarthy 1996). Learning disability terminology therefore differs from recommendations to utilize 'intellectual disability' from internationally based researchers (Schalock, Luckasson & Shogren, 2007).

The term 'learning difficulties' was considered, but later rejected due to potential confusions with educational difficulties, dyslexia and mathematics difficulties (Siegel, 1999). Following Brown & Turk (1992), this thesis integrates functional definitions of learning disability, namely, service users living within care homes for adults with learning disabilities. This functional definition of learning disability overcomes clinician skills ascertaining learning disability diagnosis with Weschler measures (Wechsler, 1981, 1997, 1999). 'Adults with

learning disabilities' were utilized throughout as all research participants were aged over the UK legal adult age of eighteen. Moreover, presenting 'adults' before 'learning disability' is consistent with 'People First' debates (People First, 1994). The phrase 'people with learning disabilities' describes adults, children and adolescents with learning disabilities.

Nevertheless, several acknowledged limitations exist with 'learning disability'. First, service users deny and refute learning disability diagnosis (Finlay & Lyons, 1998) and express uncertainty over the meaning of learning disability (Finlay & Lyons, 2005). Second, learning disability diagnosis offers blanket explanations for many behaviour, attributes and situations that are actually multiply determined and preferably explained either as responses to oppressive social environments or in more mundane ways' (Finlay et al, 2005:130). Third, grouping, categorizing and referring to 'adults' and 'people' potentially reinforce homogeneity by neglecting varying ranges of characteristics and experiences. Although this thesis explores experiences from varied backgrounds, findings may unintentionally reinforce perceptions of homogenous groups. Fourth, authors frequently use interchangeable terminology with learning disabilities descriptors which represents continual challenges in comparing research findings. Varying terminology produces confusion and ambiguity amongst both professionals and lay persons (Kavale & Forness, 2000; McLoughlin and Netick 1983; Scheepers, Keer, O'Hara, Bainbridge, Cooper, Davis et al, 2005; Stanovich, 1999). Fifth, researching adults with learning disabilities identified via convenience sampling and administratively defined populations marginalizes 'hidden' learning disability groups unknown to services (Emerson, 2011). Finally, learning disability may reflect Westernised social constructions, as some people from the Caribbean and Pakistan only received a learning disability diagnosis following relocation into the UK (Baxter, Poonia, Ward & Nadirshaw, 1990).

Appendix 3 presents learning disability diagnoses from diagnostic manuals (APA, 1994, WHO 2001) and White Paper *Valuing People* (DH, 2001a). Generally, learning disability describes significant impairment of intellectual functioning and social functioning manifesting before the UK legal adult age of 18. Learning disability is also grouped into four different subgroups including mild, moderate, severe and profound. An individual with severe or profound multiple learning disabilities is characterized by the following. First, an IQ score below 50. Second, clear signs of significant difficulties in the acquisition of adaptive behaviours from early in life. Finally, evidence of damage to their central nervous system along with physical disabilities. However, clinical definitions of learning disability are often criticized for overemphasizing psychopathology, underemphasizing social, practical and conceptual intelligence (Greenspan & Granfield, 1992; Greenspan, 1999) along with reliance on problematic IQ testing. Although clinical definitions of learning disabilities help in designing services and offering guidance for service users, some researchers critic *Valuing People* (DH, 2001a) for failing to address issues for people with profound multiple learning disabilities (PMLD Network, 2002).

Prevalence

WHO (2001b) estimated people with learning disabilities comprise 1-3% of the global population along with 0.3% for people with profound learning disabilities. Similarly, Gilberg & Soderstrom (2003) found learning disability affects between 1-2.5% of the general population in the Western world. However, establishing concrete numbers of persons with learning disabilities poses difficulties given variations in prevalence of learning disability across different countries by exploring studies published in 1960 and the early 1990s

(Roeleveld & Zielhuis 1997) and studies published in the late 1990s and early 2000s (Leonard & Wen, 2002). Numerous researchers highlight increasingly prevalent minority ethnic adults with learning disabilities (Azmi, Hatton & Emerson, 1996; Corry, 2001; Emerson, Azmi, Hatton, Caine, Parrott & Wostenholme, 1997; O'Hara, 2003). Moreover, estimates between 2009 and 2026 stipulate '29% of new adults with profound multiple learning disabilities will belong minority ethnic communities' (Emerson, 2009:55).

Aetiology, epidemiology, and characteristics

It is beyond the scope of this chapter to review all aetiology or causal factors of learning disability, but informative reviews explore learning disability aetiology (Bhate & Wilkinson, 2006). Torgesen (1986) explored learning disability aetiology factors though *neuropsychological paradigms* describing learning disabilities following brain damage and *information processing* paradigms depicting cognitive processing abilities for people with learning disabilities. Nevertheless, researchers typically explore three learning disability aetiology clusters (Sperlinger, 1997). First, pre-natal causes including genetic disorders, infections, and maternal contributors. Second, peri-natal causes depicting complications during birth such as brain injuries and infections. Third, post-natal causes including physical injuries and deprivation. Generally, varied approaches in learning disability aetiology highlight heterogeneity of learning disability populations and varied attitudes regarding aetiology.

1.4.6. Old people and aging

Terminology

Various reviews outline historical terminology describing older people (Covey, 1988; Nuessel, 1982). Older people terminology include 'eld' (elderly, elders); 'age' (aged, ageing, or aging); 'senior citizen' along with 'later life' , 'pensioner', 'retiree' and 'mature' (Nuessel, 1982; Johnson, 1998). Interchangeable terminology associated with 'old' poses problems given different terms depict different concepts of income source, employment status, and citizenship and relate to different historical narratives (Johnson, 1998). Similarly to the DH and CQC, this thesis utilizes 'older people'.

Definition

Age is typically described via chronological age, depicting age in years from date of birth on the Gregorian calendar. Most developed worlds accept the chronological age of sixty five years as a definition of 'elderly' or older person (WHO, 2013). Yet, variable economic climates, varying retirement ages, general improvements in health and subsequent predicted increased life expectancy may influence aging definitions. Nevertheless, prevalent health compromising behaviours, increased health inequalities and increased chronic health conditions may limit life expectancies and accelerate the aging process (Olshansky, Passaro, Hershow, Layden, Carnes & Brody 2005).

Researchers utilize chronological age in numerous historical accounts of old age (King & Stearns, 1981; Minois, 1989; Parkin, 2003; Roebuck, 1979; Thane, 2002) along with life expectancy trends (ONS, 2012b), comparisons since the 1950s in Europe (Leon, 2011), years spent in good health (Jagger, Gillies, Moscone, Cambois, Van Oyen, Nusselder et al, 2009) and 'disability free' life expectancy (Jagger, Matthews, Matthews, Robinson, Robine &

Brayne, 2007). Chronological age is used within UK governmental policy to divide mature adulthood and old age for pension allocation and retirement. Nevertheless, chronological age may reflect current paradigms as chronological age was largely absent from Roman Britain (Gowland, 2007) or amongst women and slaves in Ancient Greece and Rome (Finley, 1981). Furthermore, researchers occasionally use differing chronological age cut off points across countries which limits comparability (Dixon, Manthorpe, Biggs, Mowlam, Tennant, Tinker & Mccreadie, 2010:405)

This thesis utilizes chronological age to describe participant age in order to enable easier comparisons across participants and avoid subjective self perceptions and feelings associated with age (Kleinspehn-Ammerlahn, Kotter-Grühn & Smith, 2008). Chronological aging also avoids complex biological indicators of aging including skeletal muscle investigation (Suetta, Hvid, Justesen, Christensen, Neergaard, Simonsen et al 2009), functional nerve modifications and metabolism (Toescu & Verkhratsky, 2007) changes in morphological or physiological structural characteristics (Pannese, 2011), development of secondary sexual characteristics obtained after puberty (Euling, Selevan, Pescovitz & Skakkebaek, 2008) and tooth formation (Lewis & Senn 2010). Nevertheless, definitions of aging may vary according to self perceptions of aging (Kotter-Grühn, Kleinspehn-Ammerlahn, Gerstorf & Smith, 2009), media depictions within magazines (McConnatha, Schnell & McKenna, 1999), television commercials (Roy & Harwood, 1997) along with gender and deprivation levels (Raleigh & Kiri, 1997). Furthermore, emphasising youth despite advanced chronological age may also elicit self protective strategies (Weiss & Lang, 2011).

Prevalence

Since the early 1930s, the number of older people aged sixty five and over has more than doubled (DH, 2001b). The 1901 UK Census depicted 5.7 million people aged fifty and over, representing 14.7 per cent of the total population. By the 2001 Census, older people had more than tripled to 19.6 million, comprising 33.3 per cent of the whole population (Soule, Babb, Evandrou, Balchin, & Zealey, 2005). Between 1995 and 2025, the number of people aged over eighty is set to increase by almost half and the numbers of people over ninety will double (DH 2001b). The older population is currently growing twice as fast as the whole population. The growth rate for the total population was 0.4 per cent between 2002 and 2003, while the rate for people aged fifty and over was 0.8 per cent and the rate for people aged sixty five and over was 0.7 per cent (Soule, et al, 2005). After 2011, frequencies of older people are expected to rise again as 'baby-boom' cohorts (born in the late 1950s to late 1960s) reach old age (Soule, et al 2005). The UK older population, however, is not increasing as fast as other industrialized countries. In Japan, the overall population growth rate was 0.1 per cent compared with a 2.9 per cent increase of the population aged sixty five and over between 2002 and 2003 (Soule, et al, 2005). In terms of the population aged ninety or over, lower fertility rates and falls in death rates have contributed to a considerable increase in the number of people living to age ninety and over (Beaumont, 2011). Numerous researchers increasingly comment on a forecasted increase in minority ethnic older people primarily due to advancing ages for immigrant populations (Ebrahim, 1996; Samadian, 1998). The predicted increase in minority ethnic older people indicates further acknowledgement of acknowledging the needs, characteristics and experiences minority ethnic populations (Blackmore, 2000).

Aetiology, epidemiology, and characteristics

Schneider (1992) summarizes two overall biomedical models of aging; genetic theories and stochastic theories. *Genetic theories* focus on pre-determined genetic factors that contribute and accelerate aging. Genetic theories include the auto-immune theory, cross linking theory, free radical theory and 'wear and tear' theory. *Stochastic theories* focus on random assaults from the external environmental and internal environment theories. Stochatic theories include the Somatic Mutation Theory, Error-Catastrophe Theory and the Metabolic Theory of Aging/Caloric Restriction. Multiple and complex theories of aging reveal the multifaceted nature of aging which further illuminates individual variability within the aging process.

1.4.7. Discrimination and anti oppressive practice

Minority groups including minority ethnic groups, adults with learning disabilities and older people historically experienced varying levels of persecution, oppression and discrimination.

Discrimination derives from Latin *'discriminare'* meaning division or separation and implies unfair treatment of some individuals or groups' (Cassady, 1946:7). Conversely, positive discrimination or reverse discrimination highlights 'unequal treatment to achieve increasingly similar outcomes' (Garcia-Huidobro, 1994:213) or 'individuals are accorded special treatment.....because of their membership in a disadvantaged groups or groups' (Wang, 1983:191). Positive discrimination occasionally occurs within educational settings (Garcia-Huidobros, 1994; Wang, 1983) and social work (Cheetham, 1982). 'Prejudice derives from Latin *'prejudicium'* describing pre-judging somebody or something without any factual evidence (Sandu & Brown, 1996:203). Prejudicial attitudes typically reveal positive or negative conations. Allport (1979) defined *negative prejudice* as an antipathy based upon faulty and inflexible generalization. Conversely, *positive prejudice* such as in-group favoritism reflects descriptive concepts depicting tendencies favouring in-groups over out-groups in behaviour, attitudes, preferences and perceptions (Turner, Brown, & Tajfel, 1979). Lippman (1921) defined *'stereotype'* as over-simplified generalizations of people.

Researchers typically investigate discrimination based on gender- 'sexism', race and ethnicity- 'racism', age- 'ageism' and disability- 'disablism'. However, researchers devote comparatively little attention to discrimination based on ageism and disablism conversely to frequently researched gender and racism (Nelson, 2005). Given close associations with discrimination and abuse, this thesis defines abuse as lack of privacy, de-individuation, infantilisation and disrespectful behaviours, which impair quality of life (Lowenstein, 1999).

This section briefly explores attitudes towards minority ethnic, adults with learning disabilities and older people populations. Whilst attitudes do not always correlate and predict behaviours (Ajzen, 1988; 1991), underlying attitudes likely impact lived experiences which justify exploration. This section incorporates Dijker, van Alphen, Bos, van den Borne & Curfs (2011) recommendations of including both favourable attitudes and discriminatory and prejudicial attitudes, rather than exclusively focusing on discriminatory attitudes. Nevertheless, emphasis on specific attitudes may reflect author bias, political pressure, theoretical orientation and time-based norms.

Race, culture and minority ethnic groups

Racial classifications sadly correlates with ignoble history utilized to justify slavery primarily in the United States of America (USA). Until the nineteenth century (Davis, 2000), racial discrimination continued within Tudor England (Sherwood, 2003), Tudor and Stuart England

(Habib, 2008) and in most parts of England until the eighteenth century (Cotter, 1994; Lorimer, 1984). Race was utilized for 'racial hygiene' or eugenics promoting mass extermination of 'unwanted races' within Nazi Germany during the Second World War (Proctor, 1988). More recently from UK evidence, conversely to people from white ethnic backgrounds, minority ethnic populations typically experience more health inequalities (Randhawa, 2007) and lower educational attainment (Department of Education and Skills, 2006) and earning deficits (Clark & Drinkwater, 2007). Furthermore, unlike white ethnic groups, minority ethnic groups experience more poverty (Platt, 2007), overcrowded housing, express dissatisfaction with their home (Harrison & Phillips, 2003) and experience considerable housing disadvantages amongst Pakistani and Bangladeshi parents (Fazi, Bywaters, Ali, Wallace & Sing 2003).

Nevertheless, varying definitions of minority ethnic groups, unreliable statistical evidence and potentially victimizing minority ethnic populations challenges the viability of widespread discrimination against minority ethnicity groups. Moreover, despite apparent discrimination, some minority ethnic people obtained arguably powerful positions across British history. Examples include: John Blanke, the black trumpeter at the court of Kings Henry VII and VIII (Habib, 2008); influential contributions from the eighteenth century black writer Ignatius Sancho (Sancho & Carretta 1998); Queen Consort of George III, Charlotte of Mecklenburg-Strelitz, with reported mixed ethnicity background (Sweet, 2000) and Queen Victoria's admiration towards Abdul Karim, an Muslim servant from India (Anand, 1996).

Furthermore, rather than passively accepting discrimination barriers, some minority ethnic people actively campaign against discriminatory barriers. For example, Mary Seacole of Jamaican descent offered direct nursing efforts within the Crimean war front line, despite experiencing overt racism (Stanley, 2007). Moreover, Doreen Lawrence actively campaigned for justice following the racially motivated murder of her son Stephen Lawrence in 1993. In 2012, Queen Elizabeth II awarded Doreen Lawrence an Order of the British Empire (OBE) for services to community relations. Yet, arguably piecemeal coverage of inspirational minority ethnic figures within primary education may reveal oppression of minority ethnic groups or highlights rarity of minority ethnic people within prestigious positions.

Learning disability

Appendix 5 shows how people with disabilities and learning disabilities were subjected to abuse, eradication and death from Ancient Greek philosophers including Aristotle and Plato (Berkson, 2006; Stainton, 2001). Evidence from Sparta in Ancient Rome (Braddock & Parish, 2001) and Roman customs outlined in the Twelve Table further promoted infanticide of disabled children (Gracer & Alexandria, 2003). More recently, associations between death and disability were highlighted during eugenic movements promoting mass sterilization (Selden, 1999, 2000) and murders and sterilization of people with disabilities and people with learning disabilities in Nazi Germany (Sobsey, 1994). Evidence of links between death and disability continue today considering high percentages of selective abortions for fetuses with reported learning disability including Down syndrome (Bauer, 2008; Dixon, 2008; Wertz, Rosenfield, Janes & Erbe, 1991; Wertz, 1994, 2000) and chromosomal abnormalities (Drugan, Greb, Johnson, Krivchenia, Uhlmann, Moghissi et al. 2005; Holmes- Siedle & Ryynanen, 1987; Vincent, Edwards, Young & Nachigal, 1991).

Furthermore, The Bible and other Christian historical narratives imply negative attitudes associated with disability (Covey, 2005; Kokaka, Woodward & Tyler, 1984; Leshota, 2011).

Moreover, people with disabilities and learning disabilities were viewed as objects of ridicule and exhibition as 'household fools', court 'jesters', clowns (Bertoti, 1999) and general public entertainment during the Middle Ages (Fiedler, 1978) along with amusement and profit (Bogdan, 1986). People with learning disabilities were also associated with demonic possessions by Martin Luther (1483-1546), John Calvin (1509-1564) and linked with witchcraft (Denno, 1997). Evidence from historical material culture further illuminates attitudes towards learning disability (Starbuck, 2011).

However, some historical evidence depicts compassion towards with people with disabilities in prehistoric Neanderthal communities (Trinkaus & Zimmerman, 1982) and within Christianity texts (Covey, 2005). Historical evidence also associates learning disability with purity (Digby, 1669), innocence (Cusack, 1997), divine inspiration (Barr, 1904) and recipients of God's grace (Cusack, 1997:414). Furthermore, others illustrate deities with impairments within Medieval Celtic and Old Norse literature literacy texts (Bragg, 1997).

Attitudes to people with learning disabilities may also differ between diverse populations. For example, Fatimilehin & Nadirshaw (1994) noted variations in attitudes between Asian and white British families, with Asian families focusing on the spiritual explanations surrounding learning disabilities. Other studies highlight amongst some Asian families, learning disability originates from past transgressions (Kapitanoff, Lutzker & Bigelow, 2000) and a 'curse' (Confederation of Indian Organisation- CIO, 1986).

Aging and older people

Appendix six depicts further historical evidence on attitudes towards older people. Briefly, amongst Ancient Greek philosophers, old age was associated with 'cowardice' and 'wretchedness' within Aristotle's accounts, (Aristotle, Ross & Roberts, 2010; Parkin, 2011), gradual deterioration according to Hippocrates (Cokayne, 2003:35) and 'diseased state by Seneca' in the first century. Older people also received limited sympathetic representations from Roman poets (De Luce, 1989, 1993). Deteriorations in physical health associated with age were also noted within the Old Testament (Gold & Kaufman, 1970). Other literary texts associate advancing age with declining mental health in ancient-medieval literacy texts including Aesop Fables (Wortley, 1997:183), 'senile old age' and similes of aging associated with the dying fire in Chaucer's medieval literacy texts (Coffman, 1934) and continued themes of diminished mental capacity and physical mobility within Shakespeare's plays (Covey, 2000). Similarly, more recently, older people also experience oppression within society as in relation to employment (Wood, Wilkinson & Harcourt, 2008) and health care (Oliver, 2009). Others report exclusion of older people research within ethics committees (Bayer, 2000), clinical research (Bugeja, Kumar & Banerjee, 1997) and clinical trials (Crome, Lally, Cherubini, Oristerll, Beswick, Clarfield et al. 2011).

Nevertheless, some evidence portrays favorable attitudes towards older people. Some anthropologists argue older people were placed in high regard in prehistoric Neanderthal societies (Nelson, 2005). Others argue older people received care from existence of lesions from bone or osteological evidence in burial caves (Bahn, 1998). Conversely, others argue due to dearth of osteological evidence from older Neanderthals and the absence of incapacitating lower limb injuries from bone evidence, early hominids did not sacrifice the survival of the social group as a whole when threatened by an immobile individual (Berger & Trinkaus, 1995:849). However, others speculate older people were valued members of society due to contributions to the intellectual manner and group wellbeing (Trinkaus, 1983),

which were useful in surviving traumatic times (Appleby, 2011). Warren (1998:23-24) comments among Ancient Greeks, 'Erinna paints a charming picture of old ladies with silver hair gifted with golden thoughts'. Furthermore, evidence from the New Testament shows patterns of reverence for older people (Nelson, 2005:28).

Attitudes to older people may differ between diverse populations. Differing cultures attribute varying attitudes towards older people, with some cultures allocating great respect, admiration and regarding for older people (Helman, 1999; Yoon, Hasher, Feinberg, Rahhal & Winocur, 2000). Yet, other cultures within non-industrial societies may occasionally abandon and abuse older people (Helman, 1999).

Multiple discrimination

Over the last few decades, researchers increasingly explore simultaneous and multiple forms of discrimination. People with learning disabilities from minority ethnic groups sometimes experience 'double discrimination' and encounter both disablism and racism (Lewis, 1996; Azmi, Hatton, Emerson, & Caine, 1997:250). Double discrimination or 'duel dimension' of race and disability (Ali, Fazil, Bywaters, Wallace & Singh, 2001:952) illuminates potential differences in experiences between minority ethnic groups and individuals from an indigenous white British population. As Hill (1994:4) notes, the overall situation for black disabled people centres on the specificity of their oppression results in unique experiences which differ from white ethnic disabled people. Nairdshaw (1999:3) notes 'black and minority ethnic learning disabled people remain an oppressed and vulnerable group in society, suffering discrimination and disadvantage in the course of their everyday lives through socially constructed concepts of 'difference' and 'differentness'. Others stipulate triple discrimination or simultaneous oppression, namely, individuals experiencing ageism, disablism and sexism. Similarly, other researchers illuminate 'triple whammy' of age, ethnicity and mental health problems (Rait, Burns & Chew, 1996).

Others argue minority ethnic older people experience simultaneous discrimination and 'jeopardy' (Norman, 1985). Older people from minority ethnic groups are frequently considered to experience 'triple jeopardy' (Norman, 1985) of age discrimination, racism and poverty or inaccessible services. Bowes & Wilkinson, (2003) argue older people may experience 'quadruple jeopardy' with cognitive disability added to Norman (1985) three factors. Ebrahim (1996:611) notes triple jeopardy for minority ethnic older people relating to age, cultural and racial discrimination and lack of access to health, housing and social services. Similarly, women with learning disabilities face 'triple jeopardy' from race, disability/impairment and gender (Mir, Nocon, Ahmad, Jones, 2001). As O'Hara (2003) comments, women with disabilities experience simultaneous discrimination and disadvantage and have additional support needs in terms of their sexuality and motherhood (O'Hara, 2003:168). Shah (2001:160) cites the model of 'multiple jeopardy' for minority ethnic older people populations and argues that six factors contribute to the multiple jeopardy hypothesis including ageism, racism, gender disparities, restricted access to health and welfare services internal ethnic divisions and class struggle. However, as Iliffe & Manthorpe (2004:288) notes, 'We should be cautious about triple jeopardy. Triple jeopardy conceives of disadvantages as possibly multiple and dynamic, but as yet lacks empirical evidence'.

Anti-oppressive practice

Anti-oppressive practice comprises beliefs, knowledge and practices designed to reduce inequalities impacting service users lives (Di Terlizzi, Cambridge & Maras 1999). For Plummer (1995), oppression indicates power which shapes the control that people have over their lives. Through power of participation and telling previously silenced stories, 'lives have become empowered' and given voice to marginalize groups (Plummer 1995:148). Similarly, McGlaughlin, Gorfin with Saul, (2004:710) notes, 'lack of power experienced by vulnerable groups is a negative force that results in a lack of control over their everyday lives'. For Williams, Keating & Nadirshaw (2007) oppression manifests itself in individual actions, organisational procedures and practices and how services are organized and delivered. Oppression therefore affects how practitioners behave towards service users; influences service uptake, service organization and service delivery. Community care services have collective and individual responsibilities to eliminate social inequalities impacting service user lives, their families and carers (Williams et al. 2007). Moreover, anti-oppressive practice involves not treating everyone the same, but treating people as unique individuals whose lives and experiences have been shaped by social inequalities' (Williams et al. 2007). Subsequently, minority groups maybe more susceptible to oppressive environments than majority populations.

1.4.8. Need and dependency

People with learning disabilities and older people reflect heterogeneous populations which likely impact attitudes and behavioural responses from others along with need and dependency evaluations. Asadi-Lari, Packham & Gray (2003) note need is inherently complex and depicts a slippery concept (Godfrey & Callaghan, 2000). Various need conceptualizations pose ambiguities and challenges in understanding needs due to limited consensus on need definition (Culyer, 1998). Nevertheless, as Asadi- Lari, Farshad, Assaei, Vaez-Mahdawi, Akbari, Ameri et al (2005) notes, met needs are required for community development. Some argue defining needs is critical, for the dividing line between the responsibilities of the state on the one hand, and those of the market, informal carers and the individual on the other (Tanner & Harris, 2007:83) and illuminates effectiveness of welfare policies (Lister, 2010:167).

Generally, 'need' describes circumstances in which something is necessary, yet individual subjectivity may influence need aspiration. Needs are also frequently associated with dependency which generally describes how someone or something is dependent by another individual or object. Giving varying characteristics of community care service users, community care services and care staff remain in powerful positions in ascertaining met or unmet needs. Before discussing links with met needs and unmet needs with quality definitions, the next section explores community care and service user definitions.

1.4.9. Community, Care and Service Users

Community

Bulmer (1987a:15-16) notes '*community*' implies physical neighbourhood, a defined group of interest with or without geographical boundaries which compliments social networks. Bulmer's interpretations usefully incorporate the entire life situation of individuals and the significance of responding to individuals needs which reflects a central part of this thesis. Furthermore, Fawcett (2000:59) describes, 'community' is 'often seen as a warm persuasive and friendly word that gives the impression of inclusivity and belonging'. Nevertheless, as

discussed later in this thesis, it remains to be seen whether these admirable attributes of 'community' reflect care practice.

Care

For Bulmer (1987a), care describes responding to individual needs in different ways, be it physically, socially and emotionally, paid and unpaid as well as in and by the community. Similarly, for F. Williams, (1997:81), 'care' reflects manifestations of control, responsibility, obligation, altruism, love and solidarity. This thesis focuses on formal methods of care via support from services rather than informal forms of care via family support.

Service users

Various individuals including commissioners, providers, researchers, clinicians, politicians and carers (Dickens & Picchioni, 2012; McLaughlin, 2009; Scourfield, 2007) utilize interchangeable terms including 'client' 'service user', 'consumer', 'customer' and 'patient' to describe people utilizing community care services (Shevell, 2009).

For some (McLaughlin, 2009; Heffernan, 2006) defining service user terminology or labels formulate differing identities, relationships and power dynamics. Some researchers argue 'service user' is oppressive than liberating (Heffernan, 2006). Similarly, Vojak (2009:940) argues, 'words commonly used to refer to people- recipient, subject, ward, client, patient, dependent and words used to describe their concerns- behaviour disordered, disruptive, distributed- stigmatize and exclude. They separate, objectify, impose hierarchy, assign blame and create shame'. Furthermore, McLaughlin (2010) argues 'service user' depicts homogenized entities, denies the multiple identifies we all have whilst privileging a perspective that places service users in less powerful position than the service providers.

Despite the above debates surrounding 'service user', this thesis utilizes 'service user' to describe participants living in care homes. Although, by using 'service user' an acknowledged limitation is that 'whilst the language of 'service user' or 'user' maybe acceptable at the political level, it is potentially detrimental to those it labels and arguably damaging to the underlying ethical practices of the profession' (Heffernan, 2006:145).

Community care directions

Numerous authors connect 'community' with 'care' and outline a number of associations and community care directions (Bayley,1973; Bulmer 1987a; Symonds & Kelly, 1998; Victor, 1997; Yip, 2000). *Care in* the community is viewed as changes in the sites of care from institutions to varying types of accommodation in the community. *Care by* the community is regarded as changes in the providers of 'care' and care for the community relates to caring arrangements for those currently viewed as being in need of care.

In England, historically, people with learning disabilities were seen as sick, defined in medical terms and in need of treatment (Sperlinger, 1997). Early forms of support for people with learning disabilities included hospitals and hospices organized by benevolent societies from the Middle Ages (Bradshaw, 1996; Ley & Corless, 1988) and oblation practices which involved parents donating or offering children with impairments and disabilities to local monasteries (Boswell, 1984; Sullivan, 2003) which led to subsequent overcrowding of monasteries for people with impairments (Bragg, 1997:176). For Andrews (1997:94), if

medieval communities operated a form of 'care in the community' it was very much a lassiz-faire, reactive system with violent and cruel treatments, although the aim was usually a therapeutic one'. Others discuss 'les enfants du Bon Dieu' whereby people with learning disabilities in the late Middle Ages roamed the streets of Europe unharmed (Manion & Bersani, 1987). Moreover, statutory pressures under the Elizabethan Poor Laws for parishes to provide relief for 'indigent poor' led to placements within parishes (D.Wright, 2000). The workhouses of the nineteenth century also included 'mentally defective and the crippled' (Thomson, 1983:46). From the late eighteenth and early nineteenth century institutional solutions for people with learning disabilities included the 'lunatic asylum' (D.Wright, 2000). Other services including 'trade in lunacy' and 'madhouse keepers' which accepted people with different levels of impairment as well as 'madhouses' or 'licensed houses'.

Historical evidence depicting attitudes towards older people living in the UK, differs in some respects from attitudes towards people with disabilities. From the sixteenth century until 1948, responsibility for older people in England and Wales lay with the Poor Law and thus with local government. Statutory requirements from the Elizabethan Poor Laws in the seventeenth century emphasized communities to support older people, in particular, families to accept responsibility for older relatives: 'the father and grandfather, and the mother and grandmother, and the children of every poor, old, blind, lame and impotent person, or other poor person not able to work... [were to] relieve and maintain" their relatives (cf Quigley, 1998:103). As Thomson (1984) reviews, 'community provision was to be minimal and of last resort'. Although Ottaway (1998) notes, house listing of older people living with their families cannot tell us about the quality of relationships that existed within households, existence of close bonds and mutual assistance between family members. However some UK findings suggests three-generation households were rare, whereby large number of older people lived alone in towns and villages alike. Others showed from personal histories accounts that, older people in the eighteenth century preferred to live alone (Ottaway, 1998). In the middle of the nineteenth century, older people also formed a minor portion of any workhouse population (Thomson, 1983). The use of asylums to house older people was essentially a late nineteenth century development (Thomson, 1983). As Townsend (1981) reviews, following Local Government Act of 1929, many former workhouses and workhouse infirmaries were converted into local authority hospitals. In 1948, remaining former workhouses used as public institutions during 1930s and 1994s either became NHS hospitals for the chronic sick or assigned to the local authorities as residential accommodation under Part III of the National Assistance Act.

Some authors (Nair & Mayberry 1995; Hobson, 1998) illuminate 'compulsory removal' or 'orders for removal' contained within numerous Acts and policies in the early half of the twentieth century including the Bradford Corporation Act 1925, Section 28 of the London County Council Act of 1928, the Rucker Report and the 1948 National Assistance Act. The above Acts introduced compulsory admission, care and attention for persons who were suffering from 'grave chronic illness' or 'being aged, infirm or physically incapacitated' are living in insanitary conditions and are 'unable to devote themselves', and are not receiving from other persons, proper care and attention' to be relocated to a 'place of safety' such as within institutions or smaller settings. Nevertheless, as Nair & Mayberry (1995) comments, the above reports fail to define grave chronic disease, infirmity, physical incapacity or insanitary conditions and exact figures of people deemed within the remit of compulsory admission were dependent on response rates from officers involved in the transition. Whilst Hobson (1997, 1998) highlights interferences with the civil liberty and human rights of those affected of Section 47 of the 1948 National Assistance Act.

Most industrial countries after the Second World War were characterized by numerous changes and reforms including shifts from traditional hospital or large scale institutional care to community based care. Generally, deinstitutionalization describes relocation from large scale hospitals into smaller community care settings. Motivators for change and deinstitutionalization were largely founded from humanitarian accounts highlighting deplorable institutional conditions, medication developments and shifts towards ordinary living (Thomas & Woods, 2003). Nevertheless, institutional service models are still apparent in other developed and developing countries outside of England (Vann & Šiška, 2006).

In Scandinavia, Nirje (1969) argued that people with learning disabilities should conditions of everyday living which are as close as possible to the regular circumstances and ways of society, through normalisation. Similarly, in the USA, Wolfensberger & Nirje (1972) aimed to increase acceptance of wider society by services through normalization defined as 'utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviours and characteristic which are culturally normative as possible'. Yet, given varied interpretations with normalization, some researchers refute normalization existence (Emerson, 1992:1).

Modern forms of community care

Introduction of a code of practice for residential care, *Home Life* (Centre for Policy on Ageing, 1984) following the Registered Homes Act, 1984, formally introduced more process-based measures providing standards for physical and social care with a focus on the dignity of service users. This was further developed in an independent review of care homes (Wagner, 1988). These two regulation papers influenced the inspection model *Homes Are For Living In* (Department of Health and Social Services Inspectorate, 1989) which was extended with *Fit for the Future* (Department of Health and Social Services- DHSS 1998) (DH, 1998b). However, there existed a lack of consistency in the standards applied by different local and health authorities' (Beadle-Brown, Hutchinson, & Mansell, 2005, 2008).

Subsequently, the Care Standards Act (2000) and the National Care Standards Commission (NCSC) implemented regulation policies to regulate social and health care services, previously regulated by local councils and health authorities (DH, 2003a, 2003b). The Commission of Social Care Inspection (CSCI) was launched in April 2004 as the single independent inspectorate for all social care services in England. CSCI incorporated work previously done by the Social Services Inspectorate (SSI), SSI/Audi Commission Joint Review Team and the National Care Standards Commission (NCSC). Performance of homes was assessed by inspectors of NCSC now CSCI (Beadle-Brown & Hutchinson et al. 2008:210). From 1st April 2009, the Care Quality Commission- CQC took over CSCI functions including the registration and inspection of nursing homes. A fundamental aim of these reforms involved implementing safe and quality services.

The National Minimum Standards (NMS) explore to what extent staff within care homes successfully meet needs, and secure the welfare and social inclusion, of the people who live within community care services (DH, 2003a, 2003b). The NMS are central for CQC inspectors and service provision. NMS depicts standards which apply to all care homes providing accommodation and nursing or personal care for service users (DH, 2003a, 2003b). The NMS standards for older people consist of 38 standards arranged under seven key topics: Choice of Home; Health and Personal Care; Daily life and Social Activities; Complaints and

Protection; Environment; Staffing; and Management and Administration (DH, 2003b). Each topic highlight aspects of individuals lives identified during the stakeholder consultation as most important to service users. The strategy of the NMS shifts towards standards that 'focus on the key areas that most affect quality of life experienced by service users.

The NMS for Care Homes for Adults-18-65 (DH 2003a) depict core standards applicable to all care homes providing accommodation and nursing or person care for adults age 18-65 who have, learning disabilities, sensory disabilities, autism spectrum disorders, dual and/or complex multiple disabilities. The standards focus on achievable outcomes for service users that is the impact on the individual of the facilities and services of the home. The standards are grouped under the following headings: Choice of Home, Individual needs and choices; Lifestyle, Personal and Health care support; Concerns, complaints and protection; Environment; Staffing and Conduct and management of the home. (DH, 2003a:50). Nevertheless, the inspection process has attracted numerous criticisms. First, focusing upon NMS rather than person centred as *Valuing People* would advocate (Holman, 2004:4). Second, inspections include limited time to talk to staff and service users. Third, inspectors represents an intimidating figure' (Wright, 2005:1104). Finally, researchers identify inconsistencies between inspectors judgment, which may impede detecting differences between services (Beadle-Brown et al, 2008:216).

Service models

Mansell & Beadle- Brown (2009) define two types housing; dispersed housing and clustered housing. *Dispersed housing* depicts 'apartments and houses of the same type and sizes as most of the population live in scattered throughout residential neighborhoods among the rest of the population'. *Clustered housing* describes a number of living units forming separate community from the surrounding population' (Mansell et al, 2009:314). Dispersed housing consists of small group homes defined hereafter as 'care homes' and supported living whereas clustered housing refers to village communities, residential campuses and cluster housings.

As this thesis focused on care homes, unless otherwise stated, the next sections will focus on exploring care homes only. Care homes reflect residential facilities in communities where groups of service users are cared for in a supervised environment under one roof. In the UK, care homes include 'nursing' homes (where there is a 24-hour presence of qualified nurses), 'residential' homes (where there is a 24-hour presence of staff, but not necessarily qualified nurse/s) and 'dual' registered homes (where both 'residential' and 'nursing' facilities exist on the same campus). Care homes differ from 'sheltered housing' or 'warden controlled flats' where residents live in their own flats in the building and look after themselves but have access to wardens for help if needed. The warden may or may not be on site, especially at night time (Purandare, Burns, Challis & Morris, 2004:549). Nevertheless, whilst care homes research implies final step and permanent accommodation source, as Reed & Roskell Payton (1998) identify, care home service users including older people can and do move out of care homes, often following reduced dependency needs.

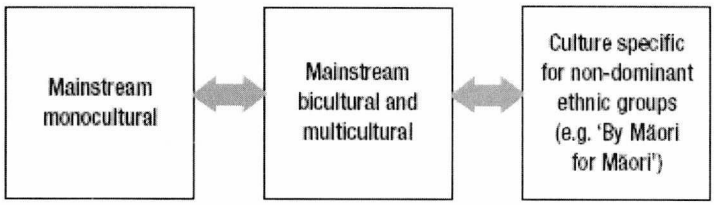
Specialist community care

Some forms of community care include 'specialist services' which requires clear definition (Bhui, Bhugra & McKenzie, 1999). For Bhui et al. (1999:5) specialist services implement separate operational procedures, differing lines of accountability' and are also 'funded by the

same source as generic services, but allowed to exist as a separate contractor to deliver services to specialist groups'. Specialist care homes include care homes catering for individuals with particular types of impairment such as autism, adults with profound multiple learning disabilities. Other specialist care homes offer expertise in supporting orthodox religious communities and minority ethnic groups. Askham, Hensha & Tarpey (1995:4) define specialist care homes as 'separate provision' whereby minority ethnic groups receive separate services for people from particular ethnic groups. Other terms of 'specialist' include separate services based on ethnicity and 'ethnically integrated services' (Hatton, Akram, Shah, Robertson & Emerson, 2004), as well as terms from USA including, 'ethnic specific' services (Zane, Hatanaka, Park & Akutsu, 1994) or 'ethnically clustered' nursing homes (Lee, 2010) or 'Culturally and Linguistically Appropriate Services- (CLAS) in America (Parker, 2011). Unless otherwise stated, as this thesis emphasizes minority ethnic and culturally diverse populations, this thesis emphasizes specialist care in relation to ethnically and religiously diverse populations.

Researchers typically compare specialist services with 'mainstream' services. Unlike specialist services, mainstream services do not claim specific expertise for supporting particular groups such as minority ethnic groups (Manthorpe, Moriaty, Stevens, Sharif & Hussein, 2010). Mainstream services is also depicted as 'integrated' (Mir, et al. 2001), 'ethnically integrated' (Hatton, et al. 2004) and 'mixed'. Figure 1.4 presents a useful continuum of mainstream and specialist services outlined by Thomas (2002). Figure 1.4 usefully summarizes distinctions between mainstream services catering containing 'monocultural' populations or singular cultures, mainstream services proving care for multicultural populations and culturally specific or specialist services catering for minority ethnic populations.

Figure 1.4: Continuum of programs and services (Thomas, 2002)



Begum (1995:38) notes, debates exist amongst statutory agencies as to whether time and effort should be investing in making existing service provision more sensitive to the needs of Black disabled people, or whether it would be quicker, easier and more cost effective to develop specific services exclusively for them (Bhui & Sashidharan, 2003). Some studies highlight low awareness of services amongst South Asian populations and even lower for specialist services (Hatton, Azmi, Caine & Emerson, 1998). Some studies focusing on interviews with carers of South Asian disabled populations highlight preferences for integrated services rather than preferences for specialist care (Hatton et al. 2004:119). Conversely, many minority ethnic older service users expressed preferences for specialist care homes, particularly within seemingly racist societies (Farrah, 1986; Klein, 1979; Murray, 1998). Askham et al (1995) notes from interviews that hardly any African-Caribbean and South Asian older people requested special preferences from health and special services providers. Patel (1990:58) argued that it is the responsibility of social services departments to provide services for all older people whereby minority ethnic older people are part of this society and hence entitled to mainstream services. Manthorpe, Iliffe, Moriarty, Cornes, Clough, Bright et al. (2009) found specialist services were required in response to mainstream services inability to cope with language needs of minority ethnic populations.

Nevertheless, low levels of service uptake amongst minority ethnic populations may produce false impressions and stereotypes that 'they look after their own'. Minority ethnic populations still utilize services and this thesis explores the experiences of minority ethnic populations utilizing care home support.

Specialist care home directory

Given research emphasis on minority ethnic groups reported in this thesis, a directory of specialist care homes was developed to explore prevalence of specialist care homes in England in 2008-09 supporting adults with learning disabilities and older people from ethnically, culturally and religiously diverse populations. Appendix 12 outlines further information on directory development. In total 316 specialist care homes were identified with 79% of specialist care homes for older people homes. Of the total 316 specialist homes, over 56% of homes had a Christianity ethos, over 16% of homes had a Jewish ethos, 7% of homes specialized in caring for South Asian populations, over 4 % of homes were homes for retired clergy members and over 2% of homes specialized in ex- service- men and women. Of the 65 learning disability specialist homes, the four most frequent groups were specialist care homes for adults with leaning disabilities from Jewish faiths, Christian faiths, South Asian ethnic groups and Orthodox Jewish homes reflecting 48%, 34%, 11% and 5% respectively. In contrast, of the 251 older people specialist homes, the four most frequent older people specialist care homes were Christian (62%), Jewish (9%), Christian homes for retired clergy members (6%), South Asian (4%) and Polish service users (4%). In summary, these findings suggest high proportion of specialist care homes for practicing Christians, which is unsurprising as Christianity is widely practiced within England.

Care home admission

The ONS (ONS, 2004, 2005a) presents findings from the 2001 UK census on communal establishments including residential accommodation which is supervised, either full- or part-time. Focusing on service users in care homes, figures for the general population show the number of supported service users rose by 8 per cent between 2002 and 2003 but when excluding the preserved rights clients the number fell by around 5 per cent. Whilst sociologists including Durkheim (1970) advocate statistics reflect reliable sources, given potential biases (Chambliss, 1973) and non-reporting within official statistics calls for consideration of survey data.

Learning disability

From *Valuing People* (DH, 2001a) approximately 60% of adults with learning disabilities live with their families. In 2005, about 39,500 people with learning disabilities live in care homes and hospitals which is about a third of all the people in touch with learning disability services and about 11,000 of these people live 'out of area', that is away from their home area (DH, 2005b). Similarly, Emerson, Davies, Spencer & Malam (2005) conducted the first national survey of adults with learning disabilities in England in 2003-04 and found from a sample of 2,898 people with learning disabilities, that one in three people (2000 people; 69%) were living in private households and one in three people (898 people; or 31%) were living in some form of supported accommodation. Of the people living in supported accommodation, nearly two out of three (62%) lived in residential care homes; one in three (34%) were supported under the Supported People programme and the rest (3%) lived in NHS hospitals. Emerson & Hatton (2008:6) collected national representative data from the

DH on accommodation arrangements for people with mild/moderate and people with severe and profound multiple learning disabilities and found people with more severe learning disabilities were more likely to be living in residential care homes and NHS accommodation. Such findings illuminate that care homes continually reflect a significant service option for adults with learning disabilities, particularly amongst people with more severe forms of learning disability suggesting that care home populations reflect considerably dependent populations.

Various researchers depict varying admission use by ethnicity group, with South Asian families traditionally under-utilizing services compared to white ethnic populations (Baxter, et al. 1990; Fatimilehin & Nadirshaw 1994; Durà-Vilà, & Hodes, 2009; Emerson et al, 2005). Other evidence highlights higher proportion of adults with learning disabilities from African Caribbean groups utilizing services in comparison with South Asian groups (Lewis, 1996).

Older people

Health Survey for England (2000) (DH, 2002b) reported 4% of total population aged 65 and above lived in care homes, rising to 30% of those aged 90 and above (Bajekal 2002). Evandrou, Falkingham, Rake & Scott (2001) investigated dynamics of living arrangement in households containing persons aged 60 and over from the British Household Panel Survey (BHPS) (1991-99). Evandrou et al (2001) reported changes in living arrangements for people aged 60 or over, bereavement and moving into institution (or supported accommodation. Moving into supported accommodation reflected 53% of older people aged over 80 (Evandrou et al, 2001:42).

Evidence highlights ethnicity differences in care home admissions for older people. For example, Bebbington, Darton & Netten (2001) noted minority cultural older service users were more likely to be younger, more likely to be men, more likely to have been living with their family prior to admission, have a higher incidence of cognitive impairment /dementia and incontinence and are more dependent on services. Furthermore, physical health problems are less likely to feature among the reasons for admission for minority cultural service users than for the white group. On the other hand, mental health problems, housing and carer difficulties are more likely to feature for the minority cultural group (Bebbington et al, 2001:58). Similarly, Salive, Collins, Foley & George (1993) found from a biracial North Carolina cohort (N=4074), physical and cognitive impairment were leading risk factors for admission of whites but not African Americans. Furthermore, among African Americans, nursing home admission was significantly associated with prior nursing home use, impairment in daily living skills and perceived social support (Salive et al, 1993:766). Other studies note black service users were less likely to be married on admission to nursing homes than whites, but were significantly more likely than white service users to have lived with someone before admission (Weintraub, Raksin, Gruber-Baldini, Zimmerman, Hebel, German & Magaziner, 2000). Studies report racial disparities in access to care homes (Belgrave, Wykle, Choi & 1993; Mercer, 1996). Possible explanations for varied care home admission include varying financial and health status and preferences for family care (Mold, Fitzpatrick & Roberts 2005).

Barriers to service uptake

Researchers typically stipulate five notable barriers to service uptake. First, limited awareness of services. Second, lower levels of psychopathology, especially disruptive behaviour

disorders amongst minority ethnic communities (Hackett, Hackett & Taylor, 1991). Third, preferences for family care (Fatimilehin & Nadirshaw, 1994; McGrother, Bhaumik, Thorp, Watson & Taub 2002), beliefs that disabled offspring will improve or be cured (Fatimilehin & Nadirshaw 1994; Katbamna, Ahmad, Bhakta, Baker & Parker 2004) and preferences for home care (Fazil, Bywaters, Ali, Wallace & Singh, 2002). Fourth, guilt and apprehension in admitting relatives into care (Robinson & Stalker, 1992). Finally, other barriers include lack of trust in services in services (Bywaters, Ali, Fazil, Wallace & Singh, 2003) and bad experiences with care (Ahmed, 1998); problematic information (Lewis, 1996). Latter barriers of service uptake illustrate quality inferences and require definition.

1.4.10. Quality, outcomes and equality

Quality

'Quality' reflects immensely popular terms whilst implementing public services. 'It is on the lips of politicians, managers, professionals and citizens themselves. In health care, education, personal social services, fire services, and police and many other sub sectors, commentators are being made to improve 'quality' and increase responsiveness to the customers (clients/patients/students/users)' (Pollitt & Bouckaert 1995:3). Furthermore, 'growing demand for health care, rising costs, constrained resources, and evidence of variations in clinical practice have increased interest in measuring and improve the quality of services in many countries of the world' (Campbell, Roland & Buetow, 2000:1611).

Donabedian (1968:182) depicts a useful general definition of quality as the evaluative dimension and judgment of what is 'good' or 'bad'. For Donabedian, quality involves exploring elements, interactions and characteristics of what constitutes 'goodness' by focusing on provider performance. This emphasis of individuals evaluative dimension implies some degree of subjectivity in assessing whether something is 'good' or 'bad'. Quality thus implies favorable connotations, conforming to the common meaning of the team and evoking a set of virtuous or worthy attributes' (Haddad, Foutnier, Machouf, & Yatara, 1998:382). A 'mismatch' between need and response is indicative of poor quality (Kristiansen, 1996). Yet, the vast majority of health and social care staff focus on the quality they provide (Moullin, 2002:6).

Quality of life

Gihooly, Gilhooly & Bowling (2005) traces quality of life to Ancient Greek philosophies, whereby Ancient Greek philosophers predominantly focused on happiness and ascertaining good life. Aristippus, a fourth century philosopher taught the goal of life was to experience the maximum amount of pleasure and happiness. Quality is frequently associated with 'quality of life', yet quality of life is vague and difficult concept to define (Petry, Maes & Vlaskamp, 2005:36) and complicated by varied meanings within different disciplines (Lefort & Fraser, 2002). Whilst numerous reviews highlight various definitions of quality of life (Brown , Bowling & Flynn, 2004; Farquhar, 1995a), Schalock & Alonso (2002:1) depicts concise definition of quality of life whereby ***quality*** is associated with excellence or 'exquisite standard' coupled with human characteristics and positive values such as happiness, success, wealth, health and satisfaction whereas ***of life*** indicates the very essence or essential aspects of human existence'.. Nevertheless, when we talk about quality of life we are not simply talking about the good things in their lives, but also the bad things too; descriptions centre on the nature of peoples lives and the ability to maintain or even improve

the quality of their lives' (Farquhar, 1995b:1439). Quality of life has been argued to reflect one of the most important outcomes of community care (Maes, Geeraert & Van den Bruel, 2000:544).

Outcome

For Donabedian (1980), outcomes depicts 'change in a patients current and future health status that can be attributed to antecedent health care (this includes) social and psychological function in addition to the more usual emphasis on the physical and physiological performances' (Donabedian, 1980:83). Outcomes also includes 'patient attitudes (including satisfaction), health related knowledge acquired by the patient and health related behavioural change. All of these can be seen either as components of current health or as contributions to future health (Donabedian, 1980:83).

Quality, outcomes and equality

Mansell (1993) argued guiding principle of effective quality of life is that all humans are entitled to enjoy quality lives, regardless of characteristics and level of disability. Yet as highlighted in later chapters, findings depicting quality of life highlight considerable variability in quality of life and need for improvement. Similarly, N. Thompson (2002) argued implementing effective community care services, requires awareness of how discrimination, be it disablism, ageism or a combination of discriminatory attitudes impacts lived experiences. A fundamental principle of anti-discriminatory practice thus recognizes need for sensitivity to discrimination and oppression to avoid the pitfall of becoming oblivious to their existence (N. Thompson, 2002:89). As N. Thompson: (2002:93) comment 'to work with an older person without taking on board issues of the marginalization and stereotyping of older people as an oppressed groups increases the likelihood of poor practice, practice inconsistent with their rights and dignity'.

1.5. Conclusion

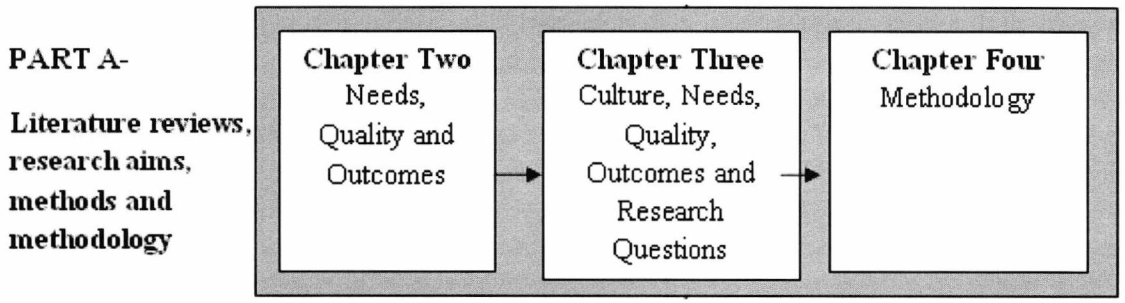
This chapter introduced Carnaby's model which centralizes service user ethnicity and cultural background whilst supporting community care service users. This chapter shows both adults with learning disabilities and older people reflect two heterogeneous service populations subject to varying levels of discrimination and oppression over time. Minority ethnic groups reflect increasingly prevalent populations within the UK and historically experienced continued oppression, discrimination and persecution. Over the last few decades, numerous community care polices increasingly recognize that some minority ethnic people in community care settings experience addition oppression, discrimination and persecution than their white ethnic peers. Effectively implementing successful, equitable and good quality community care requires sensitivity to meeting the needs of all community care service users, regardless of service users background. Yet, there exists continued dearth of community care research into lived experiences of community care settings for minority ethnic groups which this thesis aims to resolve.

PART A

LITERATURE REVIEWS, RESEARCH AIMS, METHODS AND METHODOLOGY

Part A presents literature reviews on service user needs, cultural needs, care home service provision, along with research aims, methods and methodology underlying this thesis.

Chapter two contains literature reviews on needs, quality and social care outcomes for care home service users. Chapter three explores cultural considerations surrounding needs and social care outcomes for people with learning disabilities and older people and concludes with research questions and research models. Chapter four outlines methodology forming the basis for thesis findings presented in Part B.



2. Chapter Two- Needs, Quality and Outcomes

2.1. Introduction

This chapter reviews theoretical, policy and empirical research evidence surrounding needs, quality and outcomes for adults with learning disabilities and older people living within community care services. Next, includes discussions surrounding measurement and links with the MOPSU study. This chapter concludes with further highlighting the significance of minority ethnic and culturally diverse perspectives within community care research.

2.2. Chapter two literature review search strategy

The University of Kent electronic resource database and British Library's integrated catalogue provided relevant community care literature. Six methods framed the literature review search strategy. First, identification of key terms including: 'learning disability/disabilities', 'intellectual disability/disabilities', 'mental retardation/mental retard', 'disability', 'physical disability' 'elderly', 'older people', 'senior citizen', 'care' 'institution', 'quality', 'quality of life', 'service quality', 'outcomes', 'policy', 'prejudice', 'discrimination', 'persecution', and 'oppression'. Second, key terms were entered onto academic databases or search engines including Cochrane Library and community care and psychologically oriented articles from EBSCOHost, Google Scholar, Medline, PsychARTICLES, PsychINFO, PubMed, Academic Search Complete and Social Care Online. Third, further articles were collected from manually navigating through the following journals; *Mental Retardation, American Journal on Mental Retardation, Journal of Applied Research in Intellectual Disabilities, Journal of Intellectual Disability Research, British Journal of Learning Disabilities, Age and Ageism*. Fourth, in order to narrow search results, two or three key terms were simultaneously entered into online academic search engines. For example, placing both 'learning disability' AND 'policy' within search engines. Fifth, filters condensed search results. Filters included articles published on specific dates ('after 2000', 'after 2005', '1940-2000', '1900-2011'), locations ('UK', 'Europe', 'England'), language (English Language) and full text articles only. Finally, inspecting article bibliographies from selected publications produced more articles.

This thesis deliberately prioritizes peer reviewed evidence given links with quality control (Hemlin, 2009:5) and prestige (Marsh Jayasinghe, & Bond, 2008). However, given suspected biases within peer review processes (Bornmann & Hans-Dieter, 2009; Newcombe & Bouton, 2009), evidence from non-peer reviewed evidence, books, doctoral dissertations, policy reports and presentations were also integrated.

2.3. Needs

This section summarises needs approaches relevant to community care services. Asadi-Lari, Packman & Gray (2003) provides more comprehensive reviews of needs approaches. Acheson (1978) outlined two approaches to defining needs in health care which has relevance to community care. First the 'humanitarian' view (Donabedian 1974) portrays need as requiring support from medical care services and identifies suffering populations. However, given criticisms of the humanitarian approach, namely, failing to consider consequences of limited resources and emphasis on medical care, Acheson (1978) depicts a second more 'realistic approach'. The realistic approach explores procedures available to meet need including providing staff with tangible targets in meeting needs. Asadi-Lari et al (2003)

usefully summaries other main need models. First, consideration of social needs (Bradshaw, 1972). Second, pragmatic attainment required for health and comfort. Third, economists approach depicting individual ability to benefit from services, whereby need only exists if there is a 'capacity to benefit' from particular care services. Finally, the health service approach stipulates needs exists when individual functioning falls below or threatens to fall below some minimum specified level.

2.3.1. Classifying need

Maslow (1943) human motivation work presents useful starting points with need classification. Maslow (1943) divided human needs into a hierarchy of ascending order of probability of appearance. Maslow (1943) five human needs included: i) physiological, ii) safety and security, iii) belonging and love, iv) esteem and v) self actualization. For Maslow (1943:113), need emergence is characterized by 'gradual emergence whereby when a need is fairly well satisfied, the next higher need emerges in turn to dominate the conscious life'. Some researchers (Porat, 1977) partially supported Maslow's need hierarchy. Nevertheless, others cite limited support for multilevel need hierarchy from causal correlation tests (Lawler & Suttle, 1972) and limited support for Maslow's developmental sequence of emergent needs (Goebel & Brown, 1981). Maslow could also be criticized for deriving a theory from very limited samples and reflections from influential people in Maslow's life.

Bradshaw (1972) devises taxonomies of social need across four categories. First, *normative* (as defined by the expert or professional). Second, *felt* (what people want). Third, *expressed* (felt need turned to action). Fourth *comparative* (arising where similar populations receive different service levels). In the context of normative needs, for Bradshaw, service providers or organizational bodies sets standards. If service users fall behind set standards, individuals are classified as being in 'need' of the service. Bradshaw's work normative approach benefits from introducing social approaches to understanding needs, illuminates individual subjectivity in defining needs as well as implicit power dynamics and biases of professionals defining needs. Social constructivism and universalism highlights difficulties in objectively defining needs if professionals utilize a singular unique definition which may differ from service users understanding of needs.

2.3.2. Prioritizing need

Drawing from Maslow's work, certain needs including physiological and security needs portray more fundamental and functional purposes for human survival. Other needs encapsulating esteem, belonging and self actualization depict higher needs and are only accomplished after fulfilling initial lower level physiological and security base needs. Failing to meet basic needs or providing evidence of 'unmet need' in certain domains typically results in immediate service reviews as well as illuminating social problems, demonstrations and catalysts for public inquiries. This reveals an initial binary dichotomy of 'needs met' versus 'unmet needs'. For example, focusing on unmet needs associated with physiological needs such as diet are typically associated with sickness and morbidity. Similarly, unmet needs associated with safety are typically linked with falls and abuse. Furthermore, unmet needs associated with belonging and love is typically associated with isolation and trigger factors for numerous psychopathological problems including depression. Yet, arguably more attention is placed on meeting basic physiological needs in comparison with the attainment of higher level needs. This need conceptualization reveals important consequences and implications for quality outcomes.

2.4. Needs, quality and community care service provision

Meeting the needs of service users is integral to many quality consumer based definitions of quality (Smith, 1993; Oakland, 2000) and models of perceived service quality (Parasuraman, Zeithaml & Berry, 1985). Over recent decades, researchers increasingly emphasize output and outcome measures of quality (Shaughnessy, Kramer, Hittle & Steiner, 1995). Quality frameworks outlined by Donabedian (1980) which is widely accepted and easily understood (Haddad et al, 1998:384), places outcomes as the final part of quality assessment. For Donabedian (1980), quality framework begins with structural features 'relatively stable characteristics of providers of care, of tools and resources they have at their disposal and the physical and organizational settings in which they work' (Donabedian, 1980:81). Structural qualities are followed by processes of care which outline management by the physician, or any other primary practitioner, of a clearly definable episode of illness in a given patient' (Donabedian, 1980:4). A key research endeavor involves ascertaining whether community care staff adequately responds to individual needs expectations and requirements (Parasuraman, Zeithaml & Berry 1988). Schalock (1990) outlined quality of life is experienced when individuals basic needs are met and individuals have equal opportunities to pursue and achieve goals in the major life settings of home, community and work. An initial step involves ascertaining domains comprising met need and subsequent social care outcomes, namely quality of life.

Following from normalization (Nirje 1969; Wolfensberger & Nirje 1972), O'Brien & Tyne (1981) outlined five service accomplishments that define individuals lifestyle in maintaining normal lifestyles and necessary for quality of life. First, *Community Presence* includes service users presence within same neighbourhoods, schools, workplaces, shops, recreation facilities and churches as ordinary citizens. Second, *Choice* involves supporting service users in making choices about their lives by encouraging people to understand their situation, the options they face and to act in their own interest both in small everyday matters. Third, *Competence* involves developing functional and meaningful skills for natural community environments. Fourth, enhancing *Respect* for service users by developing and maintaining positive reputations for service users. Along with ensuring that the choice of activities, locations, and forms of dress and use of language promote perception of people with difficulties as developing citizens. Fifth, *Community Participation* ensures service users participate within communities by supporting peoples natural relationships with their families, neighbours and co-workers and personal relationships. As Table 2.1 outlines, similarly to O'Brien & Tyne (1981) other writers stipulate quality of life domains.

Table 2.1 Researchers quality of life domains (cf Schalock & Alonso, 2002:16).

Investigator	Core domains
Flanagan (1982)	Physical and material well-being, Relations with other people, Social, community and civic activities, Personal development and fulfillment Recreation, Emotional well-being
Felce (1997)	Physical well-being, Material well-being, Social well-being Emotional well-being, Rights or civic well-being
Schalock (2000, 2004b)	**1. Emotional well-being**. Indicators: a) Contentment (satisfaction, moods, enjoyment); b) Self concept (identity, self-worth, self esteem. c Lack of stress (predictability, control)
	2. Interpersonal relations. Indicators: a) Interactions (social networks, social contacts); b) Relationships (family, friends, peers); c) Supports
	3. Material well-being. Indicators: a) Financial status (income, benefits); b) Employment (work status, work environment); c) Housing (type of residence, ownership)
	4. Personal development. Indicators: a) Education (achievements, status); b) Personal competence (cognitive, social, practical); c) Performance (Success, achievement, productivity)
	5. Physical well-being. Indicators: a) Health (functioning, symptoms, fitness, nutrition); b) Activities of daily living (Self-care skills, mobility); c) Leisure (recreation, hobbies)
	6. Self determination. Indicators: a) Autonomy/personal control (independence) ; b) Goals and personal values (desires, expectations); c) Choices (opportunities, options, preferences)
	7. **Social inclusion**. Indicators: a) Community integration and participation; b) Community roles (contributor, volunteer) c) Social supports (support network, services
	8. Rights. Indicators: a) Human (respect, dignity, equality); b) Legal (citizenship, access, due process

Verdugo, Schalock, Keith & Stancliffe (2005:709) note two aspects of quality of life domains. First, domain number is less important than recognition that any proposed quality of life model implements a multi-element framework. Second, people know what is important to them and domains must represent an aggregate the complete quality of life construct.

Building on previous work (Netten, Ryan, Smith, Skatun, Healey, Knapp & Wykes, 2002) and a series of consultations (Netten, McDaid, Fernandez, Forder, Knapp, Matosevic & Shapiro, 2005), Netten and colleagues (Netten, Beadle-Brown, Trukeschtiz, Towers, Welch, Forder, Smith & Alden, 2010; Netten, Beadle-Brown, Caiels, Forder, Malley, Smith et al, 2010; Netten, Trukeschitz, Beadle-Brown, Forder, Towers & Welch, 2012) outline numerous social care outcomes. Although domain frequency differs across reports, the latest domains (Netten et al. 2012) include: 1) accommodation cleanliness; 2) control over daily life; 3) meals and nutrition; 4) occupation and employment; 5) personal care; 6) safety; 7) social participation and involvement. For Netten and colleagues, these domains intend to address all interventions, all service user groups and carers. Moreover, quality reflects what services are delivering in practice, ideally both the degree to which needs are met and the service process fundamental for individual welfare (Netten et al, 2012).

Mapping domains

Table 2.2 maps social care outcomes (Netten et al, 2012) with comparable outcomes outlined by researchers (O'Brien & Tyne 1981; Schalock, 2000, 2004b) and within policy reports (DH, 2001a; DH 2005b). Table 2.2 generally shows social care outcomes identified by Netten

and colleagues are representative, comparable and relatively consistent to social care outcomes identified previously. This thesis therefore utilizes social care outcomes outlined by Netten and colleagues. Table 2.2 also shows social care outcome domains particularly choice, engagement in activities and social inclusion are considerably emphasized across reports.

Table 2.2- Mapping social care outcomes with other quality of life related domains

Domains of social care outcome (Netten et al, 2012)	**O'Brien & Tyne (1981) Five key service accomplishments**	**Schalock (2000, 2004) Quality of life domains**	***Valuing People* (DH, 2001a)**	***Independence well being and choice* (DH, 2005b)**
Accommodation cleanliness, comfort and accessibility: *Environment is clean, comfortable and easy to get around*		Physical wellbeing	(Rights)	
Control over daily life: *Individual can choose what to do and when to it, having control over their daily life and activities*	Choice: right to make choices	Self determination	Choice and control	Exercise of choice and control
Employment and occupation: *Individual is sufficiently occupied in meaningful activities whether formal employment, unpaid work or leisure activities*	Right to learn new skill and participate in meaningful activities with whatever assistance is required	Social inclusion	Inclusion	(Making a positive contribution)
Meals and nutrition *Individual has nutritious, varied and culturally appropriate diet with meals at regular timely intervals*		Physical wellbeing	(Rights)	
Personal cleanliness and comfort *Individual is personally clean and comfortable, presentable in appearance and is in bed at appropriate times of the day.*		Physical wellbeing	(Rights)	(Personal dignity)
Safety *The individual feels safe and secure*		Physical wellbeing) Emotional wellbeing	(Rights)	Freedom from discrimination or harassment
Social participation and involvement *Individual is content with their level of emotional support, general social contact and level of community participation*	Experience valued relationships with non disabled people	Social inclusion	Inclusion	

2.5. Policy

In post Second World War Britain, community care policies increasingly emphasized improving service users lived experiences. Contributions included institution critics (Titmuss, 1959; Powell, 1961), public inquiries into abuse within learning disability hospitals (Howe

Report 1969), numerous academic views within the 1960s and 1970s (Foucault, 2008; Goffman, 1961; Townsend, 1962, 1981; Tizard 1964) and depictions of staff infantilizing adult community care service users (Jones, 1975; Hockey & James, 1993). Such reports generally illuminated humanitarian concerns of undesirable conditions adversely impacting quality of life and wellbeing.

Increased drives towards normalization (Nirje, 1969; Wolfensberger & Nirje 1972), living within ordinary living environments, deinstitutionalization and promoting ways to improve quality of life characterize many social policy reports within the 1960s, 1970s and 1980s. Noteworthy contributions include: *Better Services for the Mentally Handicapped* (DH, 1971); Campaign for the Mentally Handicapped (1972); Barbara Castle's third policy initiative in 1975 (Cunningham, 1975), *Caring for People* (DH, 1989), 1990 NHS Community Care Act; enquiries into learning disability nursing from the Jay Committee (Jay, 1979) and the Griffiths Report (Griffiths 1988).

Polices increasingly emphasized long term objective of improving measurement and understanding of personal social services (PSS) output and productivity in social care. For example, Professor Sir Tony Atkinson led a review for ONS on future development of government outputs, productivity and associated price indices' (ONS, 2005b). Further service improvement initiatives include National Accounts (ONS, 2005b) which state 'output of government sector should in principle be measured in a way that is adjusted for quality, taking account of the attributable incremental contribution of the service to the outcome' (ONS, 2007:4). Moreover, as Netten, Forder & Shapiro (2006) outline, 'The Atkinson Review followed Eurostat guidance that countries should be developing direct measures of government services that are individually consumed'. Other legislation emphasizing service improvement includes NHS plan (NHS, 2000) and Clinical Governance illuminating accountability, maintenance and improvements towards quality care (DH, 1997, 1998a, 2005c; DH, Social Services and Public Safety, 2001; Donaldson, 1998, Donaldson & Gray, 1998). Other reforms emphasise improving quality and cost include *Best Value* (Department of the Environment, Transport and the Regions, 1998a, 1998b, 1999) and *Modernizing social services: A quality strategy for social care*, (DH, 1998b).

Other policies emphasize continual improvements with indicators of quality of life for community care service users. First, policies emphasized rights for service users to **enjoy life** (Jay 1979). Second, enabling service users to experience more **choice** (Griffiths 1988); *Caring for People* (DH, 1989); 1990 NHS and Community Care Act; *Health of the Nation* (DH, 1992); *Valuing People* (DH, 2001a); *Improving the Life Chances of Disabled People* (DH, 2005a); *Independence, well-being and choice* (DH, 2005b) and the *Our Health, Our Care, Our Say* (DH, 2006) White Paper. Third, encouraging **independence and independent living** (*Valuing People*- DH, 2001a); *Improving the Life Chances of Disabled People'* (DH, 2005a); *Independence, well-being and choice* (DH, 2005b). Fourth, treating service users as **individuals** (Jay 1979; *Valuing People*- DH, 2001a). Fifth, encouraging **social inclusion** (*Valuing People*- DH, 2001a). Finally, increased **participation in employment and engagement in activities** (*Improving the Life Chances of Disabled People'* -DH, 2005a; *Valuing People Now* DH, 2009). Numerous policies also highlighted fair high quality services for adults with learning disabilities, irrespective of disability (Mansell, 1993) and old age from the National Service Framework for Older People- NSFOP (DH, 2001b).

2.6. Needs, quality and outcomes

This section 'sets the scene' by exploring research findings on community care lived experiences for adults with learning disabilities and older people. Lived experiences discussed in this chapter fits in line with social care outcomes (Netten et al, 2012). Chapter three explores cultural and minority ethnic considerations surrounding social care outcomes. As this section summarizes experiences within community care services, the following articles provide comprehensive reviews on needs, quality of life outcomes and experiences of community care services for adults with learning disabilities (Allen, 1989; Chowdhury & Benson, 2011; Emerson & Hatton, 1994, 1996a, 1996b; Kozma, Mansell & Beadle-Brown, 2009; Molony & Taplin, 1988; Walsh , Emerson, Lobb, Hatton, Bradley, Schalock & Moseley 2010) and older people (Kane, 2001; Lee, Woo & Mackenzie, 2002).

For research focusing on adults with learning disabilities, this section primarily focuses on post deinstitutionalization studies to reflect modal UK service model and post-deinstitutionalization ethos of this thesis. Institutionalization and deinstitutionalization evidence are briefly presented to illustrate potential community care progression. However, historically, deinstitutionalization generally depicts experiences for people with learning disabilities and mental health problems relocating from hospitals to smaller community care settings. Where possible, lived experiences relating to social care outcomes of both adults with learning disabilities and older people in community care settings were summarized in order to highlight met needs, service quality and quality of life for service users.

Nevertheless, numerous limitations exist with reviewing and comparing community care research which warrants consideration. First, limited evidence exists from early institutional services (Wood, 1994). Second, variability in institutional practices (Spencer-Wood & Baugher, 2001; Wood, 1989). Third, as Emerson et al. (1996) notes, some researchers neglect outcome definitions. Fourth, variations in quality with different types of service models and environmental characteristics. Fifth, variations in service user characteristics, staff characteristics as well as organizational funding and policies. Sixth, researchers utilize flawed methods, methodology and sometimes neglect service users perspectives (Fido & Potts, 1982:31; Manthorpe, 1999:111). Seventh, adverse situations within community care settings portray misleading conclusions that service users depict passive victims of institutionalization. However, some service users actively shape their lives and develop positive coping ways within care homes including developing relationships (Reed & Roskell Payton, 1996). Finally, care home research implies care home as a final step, yet service users occasionally leave community care services (Reed, Roskell Payton & Bond, 1998).

2.6.1. Accommodation cleanliness, order and accessibility

Attractive, clean and well maintained community care settings are typically associated with wellbeing and dignity for adults with learning disabilities moving from large institutional nursing homes to smaller residences (Heller, Miller & Hsieh 2002) and older people living in care homes (Reed & Roskell Payton, 1997). Researchers typically ascertain accommodation cleanliness via observations (Cattermole, Jahoda & Markova, 1998), family interviews (Booth, Booth & Simons, 1990) and service user interviews (Cullen, Whoriskey, Mackenzie, Mitchell, Ralston & Shreeve et al. 1995).

Asylums, workhouses and hospitals

'Filth' and 'squalor' descriptors were frequently associated with asylums in nineteenth century Britain (Maclay 1958). For example, Brown (2006) cites eye witness accounts of 'miserable bedding, lying on straw' saturated in human waste 'walls also besmeared with excrement and 'perfectly dark when the door was closed'. Conversely, Lyon & Colquhoun (1999) cites Llewellyn-Smith (1932:207) findings on early twentieth century workhouses, which aimed to provide 'warm clean and sanitary conditions for those unable to achieve any of this in their own homes' (Llewellyn-Smith, 1932:205)'. Although, impressions of sanitary workhouses diverge from Dickens's literary contributions depicting widespread unsanitary conditions throughout nineteenth century England (MacKenzie, 2008).

Goffman (1962:4) noted physical attributes of total institutions reflects 'barriers to social intercourse with the outside' and included locked doors, high walls, barbed wire'. Furthermore, spatial attributes including surveillance, physical isolation, control of access characterized institutions (Goffman, 1962:4) and reformers attempts to control inmates and inmates abilities to resist social control' (Spencer-Wood & Baugher, 2001:14). Cattermole, et al (1988) found people with learning disabilities living within learning disability hospitals slept in sparsely furnished dormitories with six to eight people, but most shared with twenty others and encountered little privacy. Similarly, Hatton & Emerson (1996) note little variations in hospitalization appearance, with little privacy for service users and typically portrayed impoverished material environments. Institutionalization critics arguably emphasize negative and deliberating institutionalization characteristics without attending to therapeutic aspects of institutions (Weinstein, 1982:274). Generally, institutionalization evidence depicted unclean, and uncomfortable environments infiltrated with oppressive practices from community care staff against vulnerable populations.

Deinstitutionalization

Generally, physical environmental characteristics improved following deinstitutionalization according to adults with learning disabilities (Cullen, et al 1995; Shah & Holmes, 1987) and relatives (Booth et al. 1990). For example, conversely to institutions, small staffed houses for adolescents with learning disabilities included: conventional upstairs downstairs room arrangement of ordinary houses, bedrooms rather than dormitories; access to door handles, light switches and TV controls; comfortable lounge including wall to wall carpet, soft lighting, modern future and individual decorations (Hughes, May & Harding, 1987). Similarly, following relocating from learning disability hospitals to small staffed houses, Mansell & Beasley (1993) notes institutional wards provided more space, were shared with large numbers of people, contained locked rooms including kitchens, bathrooms, bedrooms, staff rooms, laundries; cooking were organized centrally and cleaning was undertaken by domestics. Conversely, small housed homes had less space with no locked rooms. Material environment of institutions were often barren, contained dilapidate living units and service users were restricted to sitting, watching television or walking around institutional dorms. However, following relocating from institutions to houses resulted in richer decorated environment and a wider range of furnishings representative of average households (Mansell et al, 1993). Similarly, others cite less shared bedrooms in community services than hospitals (Davies, 1988). Although, Wing (1989) found no difference in appearance between hospitals and hostels (cf Hatton et al, 1996).

Post deinstitutionalization and care homes

As Hatton et al (1996) review, environmental characteristics of smaller community care settings for adults with learning disabilities vary, with some studies depicting well maintained, attractive settings (Cambridge, Hayes, Knapp, Gould & Fenyo, 1994; Perry & Felce, 1994). Whereas others report poorer physical environmental qualities with overcrowding and noisy nursing home environments (Kayser-Jones, Schell, Lyons, Kris, Chan & Beard, 2003). However, variations within smaller community care models included: more normalized settings within community staffed houses in comparison with hostels (Conneally, Boyle & Smyth, 1992), more homely and less institutional settings with dispersed housing schemes than residential campuses (Emerson, Robertson, Gregory, Hatton, Kessissoglou, Hallam et al. 2000).

Environmental characteristics of building designs also vary across care homes for older people. For example, Parker, Barnes, McKee, Morgan, Torrington & Tregenza (2004:944) described environmental characteristics of three levels of care homes and nursing homes for older people. First, small homes (less than 31 older people) generally portrayed conversions of Victorian or Edwardian houses with large reception rooms, high quality fittings and fixtures and mature gardens. Second, medium homes (31-41 older people) were purposely built by the local authority, with generous public spaces, generally small bedrooms, clusters of service users private rooms each with their own communal lounges, dining rooms and bathrooms, with the service users also able to use spaces and facilities throughout the building. Finally, purpose built large homes (41 or more older people) were private nursing or residential care and nursing homes (customarily known as dual-registered homes). Room areas, facilities and safety standards were comparatively high. Most comprised several independent living units: groups of service users rooms occupied discrete wings, and service users had little or no access to other units. Generally, homeliness and accommodation comfort within care homes is generally associated with smaller care home settings, for both adults with learning disabilities (Emerson et al. 2000; Perry & Felce, 1995) and older people (Parker, et al. 2004). Similarly, others depict complaints from relatives regarding space, privacy and cleanliness in nursing homes for older people (Friedemann, Montomery, Maiberger & Smith, 1997). Other findings include crowding, limited privacy and noisy environments from nursing home occupants (Kayser-Jones, et al. 2003).

However, drawing comparisons across studies is problematic considering variations in independent versus statutory sectors (Raynes, Wright, Shiell & Pettipher, 1994), services with greater skills and abilities (Perry & Felce, 1994) and gradual deterioration in physical environment quality over time (Cambridge et al. 1994). Variations in accommodation cleanliness and comfort could result from preoccupation and persistence with the medical model and 'clashes with efforts to satisfy the non-medical models of frail older people (Barnes & the Design in Caring Environments Study Group, 2002). Furthermore, service ownership with nonprofit facilities for older people may influence more comfortable physical environments (Lemke & Moos, 1989). Variations with sampling sizes, participation populations, length of follow up sessions for longitudinal studies and flaws with methods and methodology may also influence findings.

2.6.2. Control over daily life

Wullink, Widdershoven, van Schrojenstein Lantman-de Valk, Metsemakers & Dinant (2009:816) noted 'one of the most important issues in human life is autonomy and individualization'. Control is fundamental for quality of life and reducing challenging behaviour (Cannella, O'Reilly & Lancioni, 2005). Long term psychological consequences of

limited control can increase susceptibility to learned helplessness whereby expectations that individuals can do anything to affect or change events diminishes (Roets & Van Hove, 2003). However, choices are often limited given communication impairments, regimented staff practices, funding restrictions and societal restrictions on enabling choice. Researchers typically explore control and choice via observations (Mansell & Beasley, 1993), questionnaires (Emerson, Robertson, Gregory, Kessissoglou, Hatton, Hallam et al, 2000) and family interviews (Friedemann , et al. 1997).

Asylums, workhouses and hospital

Early asylums were inherently regimented demonstrated from letter testimonies from John Home an inmate of Edinburgh Asylum during the nineteenth century (Barfoot & Beveridge 1990:275), institutionalization critics (Goffman 1962) , mechanical restraint prevalence (Smith, 1988) and empirical research noting regimented depersonalised and segregated institutional routines (Booth, 1985). Similarly, Parry-Jones (1988:409) noted 'public asylums became so organized and regimented that systems of care, designed to be protective and nurturing easily became patronizing and enfeebling. Inmates could be treated like children under a perceptual personal guardianship'. Similarly, workhouse life for some poor children and older people were 'highly regimented with regular times for rising, eating, working and retiring' (MacKay, 1995:216).

Case studies conducted by Cattermole et al. (1988:137) highlights the following findings on control within learning disability hospitals. First, regimented lives with washing, shaving, brushing teeth, taking baths, eating meals. Second, weekly allowances operated at fixed times under supervision by staff. Third, hospitals contained locked kitchens, meals were cooked in a central kitchen, staff decided bedtimes and waking times with extended waking times for weekends. Similarly, Rimmer, Braddock & Marks, (1995) notes highly restrictive environments whereby adults with learning disabilities seldom left institutional campuses with careful monitoring from staff in comparison with less restrictive environments for adults with learning disabilities living in group homes and natural settings. Generally, diversions from regimentation portrayed social order disruption (Stein, 1980). Moreover Eyers , Arber, Luff, Young & Ellmans (2012) notes pleasing the majority takes precedence over rhetoric of choice, and pursuit of personal interests and respect for individuality are confronted by the reality of resources, formal structures and procedures'.

Deinstitutionalization

Generally, relocating from learning disability hospital to smaller settings resulted in increases in control and choice making opportunities in comparison with peers who remained within institutions (Stancliffe & Abery, 1997). Studies typically depict improvements in choice following relocation from learning hospital to smaller community units (Dagnan, Trout, Jones & McEvoy, 1996). Although variations in choice may illuminate differences in learning disability severity which influenced choice amongst movers and stayers (Stancliffe & Abery, 1997). Nevertheless, despite gains following deinstitutionalization, choices still below normally acceptable levels (Fleming & Stenfert-Kroese, 1990; Stancliffe & Abery, 1997).

Post deinstitutionalization and care homes

Control in smaller care home settings for adults with learning disabilities varies, although control for adults with learning disabilities is considerably less than for individuals without disabilities (Wehmeyer & Metzler, 1995). Community care researchers typically use the Choice Making Scale (CMS) questionnaires (Conroy & Feinsten, 1986) to ascertain choice. Some studies note overall CMS averages of 64% (Raynes et al 1994), although others report higher CMS average scores of 80.5% (Mansell & Beadle-Brown, 2004), 85% (Beadle-Brown, Hutchinson & Mansell, 2005) and 70.2% (Beadle-Brown , Mansell, Whelton, Hutchinson & Skidmore, 2006a). Furthermore, other studies report more choice within group homes for adults with learning disabilities than either independent settings or family homes in Canada (Stainton, Brown, Crawford, Hole & Charles, 2011).

Nevertheless, conversational analysis following video evidence from one UK learning disability care home, showed whilst routine choices were offered by care staff who supported them, staff facilitated choice confusingly or through complicated steps (Finlay, Walton & Antaki, 2008). Furthermore, Stancliffe (1997a:8) concluded staff free homes may enhance choice for individuals who can cope reasonably safely during intervals without supervision, particularly regarding bedtimes. Similarly, for older people living in care homes, evidence depicts more decisional autonomy than older people living in nursing homes (Boyle, 2004). Although, Boyle (2004) found older people living in nursing homes reported more perceived choice than those living in private households. Others note bedtime choices for older people comply with care home shift and staffing patterns (Luff, Ellmers, Eyers, Young & Arber, 2011; Persson & Wästerfors, 2009). Furthermore, Persson et al (2009) found staff believed they 'succeeded' if service users were put into bed by set times. Moreover, regimented set bedtimes continued year-round, even during lighter summer evenings. Overall, such findings on control suggest staff primarily control lifestyles of service users which suggest continued institutional regimentation noted by Goffman.

However, numerous factors limit research into control. First, variations with service user characteristics including cognitive ability, severity of learning disability influence choice making (Nota, Ferrari, Soresi & Wehmeyer, 2007). Second, previous experience of choice and degree of dependency influence choice. Third, choice depends on management support in facilitating choice along with staff competency, and willingness from staff to teach service users how to make choices. Fourth, variations in choice could also be attributable to size of community care setting (Hanson & Zako, 2005) and community integration (Heller, Miller & Factor, 1999). Although, occasionally, studies report no relationship between choice and challenging behaviour for adults with learning disabilities living in care homes (Beadle-Brown et al, 2006a). Fifth, longitudinal findings of significant reduction in levels of choice between 41 and 53 months (Dagan, Ruddick & Jones, 1998) suggest eventual plateau or choice reduction which may limit peoples choice in the long term. Sixth, as Antaki, Finlay, Walton & Pate (2008) reviews, encouraging choice isn't always easy given varying service user communication abilities, divergent definitions on 'choice' (Bland, 1999) and failing to clearly define choice (Hatton, 2004b). Seventh, choice making is confounded by conflicts with health and safety responsibilities, organizational differences in service targets, staffing resources and practical and time constraints within shift patterns and divergent attitudes about completing tasks quickly and cost effectively. Eighth, daily activities, scheduled visits to day centres and staff anxieties about service users with challenging behaviours waking at times with limited staff may also impede control. Ninth, complying with CQC requirements from care home inspection may inhibit control, particularly if CQC inspectors insist on stringent requirements including five different chopping boards for different types of foods which requires staff supervision in selecting correct chopping boards and likely differs from

practices within our own homes (Finlay, et al. 2008). Finally, given heterogeneity amongst service users, community care staff may also impede some aspects of control in order to protect service users best interests.

2.6.3. Employment and occupation

Activity participation is frequently associated with quality of life and wellbeing, both for people with learning disabilities (Robertson, Emerson, Gregory, Hatton, Turner, Kessissoglou & Hallam, 2000) and older people (Silverstein & Parker, 2002; Brooker & Duce, 2000). Activity participation reflects important outcomes along with health benefits and associative connections with other outcomes including relationships and skill development (Mansell, Beadle-Brown, Macdonald & Ashman, 2003). Longitudinal studies highlight favourable outcomes following engagement in meaningful activities including: improved self esteem for older people following video game participation (McGuire, 1984); improved sleep, agitation and cognition following indoor gardening for service users with dementia (Lee & Kim, 2008) and improved health and longevity in late old age (Lennartsson & Silverstein, 2001). Equally, community integration was associated with improved self esteem amongst adults with learning disabilities (Abraham, Gregory, Wolf & Pemberton, 2002).

Bellamy, Newton, LeBaron & Horner (1990) amongst others (Mansell, Elliot, Beadle-Brown, Ashman & MacDonald, 2002) note implementing stimulating environments and generally improving peoples lived experiences is essential for effective community care. Staff reflects an integral part of engagement and 'reinforce either client engagement in meaningful activity or passivity and inactivity through the disposition of their social interaction' (Mansell, Elliot, et al. 2002:344). Similarly, 'engagement with life' is essential part of successful aging (Rowe & Kahn, 1998).

Exploring participation in meaningful activities typically involves exploring whether service users were occupied activities utilizing observations (Mansell, Elliot, et al. 2002; Mansell, et al. 2003) inspection of home log books (Fleming et al, 1990) and diaries (Dagnan, Howard & Drewett, 1994).

Asylums, workhouses and hospital

John Home, a former nineteenth century asylum occupant (Barfoot et al, 1990:275) noted engagement in meaningful activities was restricted to compulsory daily walks with other inmates. Furthermore, proxy records of chains, confinement to rooms and emphasis on custodians within nineteenth century asylums, suggests engagement in meaningful activities were limited (Parry-Jones, 1972). However, Oswin (1998) noted within a large scale hospital for people with disabilities, hundreds of children with disabilities conducted menial tasks including kitting dishcloths a stones near to beach or alternatively lived without occupation, consequently developing rocking and self mutilation habits. Similarly, Spencer-Wood & Baugher (2001) noted within eighteenth century institutions, 'bells were often used to control the activities permitted during each temporal segment of the day' which links to the regimented routine of institutionalization discussed previously. During the early twentieth century, schools, homes and hospitals for disabled children focused on training activities that were usually rigorous and unimaginative. Training appeared to be gender specific with boys occupied with shoe making and tailoring and girls occupied with embroidery and dress making (Oswin, 1998). Similarly within workhouse environments, individuals were probably engaged in meaningful activities in terms of workhouse productivity, although likely engaged

in repetitive, mundane and laborious activities. Nevertheless, some recommendations of activities existed within workhouses for example 'entertaining and instructive books will help to cheer and enliven many a dull and vacant house, especially in the workroom' (Workhouse Visiting Society: 1859:7).

Commenting on institutional life, Goffman (1962:50) noted 'attempts by staff to manage the daily activity of a large number of persons in a restricted space with small expenditure of resources'. Day (1983) recommend more 'ward based activities' for people unable to leave a learning disability hospital ward (Day, 1983). Some evidence suggests higher levels of engagement in exercise for adults with learning disabilities living in institutional settings rather than living in group homes (Rimmer, et al. 1995) and examples of domestic duties undertaken by some adults with learning disabilities from hospital records (Atkinson, 1988a). Nevertheless, most evidence suggest prominent disengagement within institutions.

Deinstitutionalization

Typically, activity engagement increased following deinstitutionalization (Dagnan, et al. 1996; Mansell & Beasley, 1993) with noted improvements in participations in domestic tasks (Booth et al, 1990; Evans, Todd, Blunden, Porterfield & Ager, 1987; Mansell & Beasley, 1993; O'Neill, Brown, Gordon, Schonhorn & Greer, 1981). Community participation in terms of shopping, leisure activities, visiting the park, clubs and watering plants (Booth et al, 1990; Shah & Holmes, 1987) also increased following deinstitutionalization. Although others note no statistically significant increases in domestic activity following deinstitutionalization (Rapley & Beyer, 1998), no significant differences in number of trips between hospitals to care homes (Dagnan et al, 1994) and no immediate increase in number of community leisure activities following deinstitutionalization. Eventual increase in leisure activities were also found from 30 months to 41 months (Dagnan, et al. 1998).

However, despite varying degrees of engagement, adults with learning disabilities spend large amounts of time doing nothing (Mansell,1996). Moreover, others show activity range undertaken following deinstitutionalization for adults with learning disabilities is fairly limited (Fleming & Stenfert-Kroese, 1990). Moreover, Emerson, Beasley, Offord & Mansell, (1992:301) cited one service user with approximately 50% reduction in time engaged when compared to pre-move institutional setting. Findings may differ for service users with differing impairments, given individuals with considerably more impairments and disabilities showed no increases in community involvement following relocation from hospital to smaller settings (Shah & Holmes, 1987).

Post deinstitutionalization and care homes

Generally, adults with learning disabilities living within care homes spend most of their time doing nothing or disengaged from participating in real meaningful activities (Mansell, Elliot et al. 2002; Mansell, et al. 2003). Similarly, lack of involvement in activities was found for older people with dementia in care homes (Hancock, Woods, Challis & Orrell, 2006) and qualitatively noted by people with dementia and family carers (Popham & Orrell, 2012). Researchers recently explored significance of engagement in religious activities for spiritual enlightenment. Religious identity was important amongst some adults with learning disabilities (Hatton, Turner, Shah, Rahim & Standfield, 2004; Sparrow, 2006; Swinton 2002) and older people (Krause, 2003). Numerous researchers within learning disability (Swinton 2002; Wilson 2011) and gerontology fields (McFadden, 1995) outline membership of

religious congregations may provide sense of belonging and continuity regardless of whether service user articulate religious affiliation. Denial of spirituality of faith communities poses significant moral, legal and interpersonal consequences (Swinton, 2002) along with potential source for distress, impedes opportunities for social engagement (Wilson, 2011) and potential devastation as shown from narratives from parents and children with special needs (Sparrow, 2006).

Many researchers however challenge associations between activity engagement and quality of life. For example, Forster (2010) notes forcing 'people into meaningless activities in the name of passing for normal is not dignifying for the person, and can be construed as demeaning and tokenistic'. Furthermore, ascertaining conclusions regarding occupation and participation is problematic given: reviews different definitions and theoretical contexts of engagement and participation (Verdonschot, de Witte, Reichrath, Buntinx & Curfs. 2009); varying friendship networks impacting activity participation amongst older people (McKee, Harrison & Lee, 1999); differences in how tasks are introduced to service users (McGill & Toogood, 1993); varying activity levels throughout the day for older people in nursing homes (Bond & Bond, 1990) and severity of learning disability with more severe disability associated with under occupation (Felce & Emerson, 2001; Felce & Perry, 1995a). Although Beadle-Brown, Mansell, Macdonald & Ashman (2003) noted no significant differences in engagement in care homes containing less than 75% of service users with severe challenging behaviours in comparison with care homes containing more than 75% of service users with challenging behaviours which challenges associations between individual characteristics and active engagement.

2.6.4. Meals and nutrition

Nutritious meals typically reduce morbidity and mortality for adults with learning disabilities (Jolly & Jamieson, 1999) and older people (Sacks, Dearman, Replogle, Cora, Meeks & Canada, 2000; Sullivan, Patch, Walls & Lipschitz, 1990). Most nutritional data derives from staff proxy report for adults with learning disabilities (Humphries, Traci & Seekins, 2009). Methods used to investigate meals include service user interviews (Booth et al, 1990), mixed methods of observations, interview, analyses of menus, shopping lists, grocery receipts to ascertain nutritional information (Humphries, Traci & Seekins, 2004) and meal photographs (Elinder, Bergström, Hagberg, Wilhman & Hagströmer, 2010).

Asylums, workhouses and hospitals

Case histories from nineteenth century Victorian asylums depict dietary supplements including beef-tea and tonics containing iron, arsenic, phosphorus, quinine and alcohol and accounts of force feeding if service users refused food (Renvoize & Beveridge, 1989:26). Marx (1968) commented meals within workhouses and other charitable organizations were largely insufficient with chiefly vegetables of porridge, potatoes and soup with very little meat. However, institutional dietary practices of the nineteenth century were probably more favourable then lack of any foods and quality of foods outside of the asylum (Marx 1968). Others note institutions for people with disabilities were self sufficient and tended to grow food on site (Oswin, 1998). Findings from learning disability hospitals included poor quality meals with little variety and no access to food other than mealtimes (Cattermole et al, 1988); high levels of under-nutrition and dehydration (Macdonald, McConnell, Stephen & Dunnighan, 1986); higher than average intakes of fat and lower intakes of fibre and carbohydrate (Cunningham, Gibney, Kelly, Kevany & Mulcahy, 1990) and poor nutrition

with severely learning disabled populations (Moletno, Smith, Mills & Huskisson, 2000). Under nourishment, poor dietary intake and failure to meet recommended daily allowances was similarly found with hospitalized older people (Lipski, Torrance, Kelly & James, 1993).

Deinstitutionalization

Relocation from learning disability hospital to hostel result in food improvements commented by adults with learning disabilities (Booth et al, 1990). Although other studies highlight unintentional weight loss and weight gain following deinstitutionalization for adults with learning disabilities with variations reported for service users (Bryan, Allan & Russell, 2000).

Post deinstitutionalization and care homes

Typically, adults with learning disabilities living in community care settings consume poor diets. For example, most adults with learning disabilities living in village communities, residential campuses and dispersed housing failed to meet the criteria for a balanced diet (Robertson, Emerson, Gregory, Hatton, Turner, Kessissoglou & Hallam, 2000) as well as insufficient fruit and vegetables consumption (Draheim, Stanish, Williams & McCubbin, 2007). Malnutrition has similarly been noted within in nursing homes for older people (Morley & Silver, 1995). Others note complaints regarding foods from older people living in nursing homes are often trivialized by staff, 'which be minor things from a staff perspective, but they note necessarily for the elderly themselves' (Persson et al, 2009:9).

Whilst above findings depict bleak portrayals of dietary practices for people living in community care settings, sample size variations, failing to control for gender differences, service user characteristics and changeable nutritional standards over time and country limits the viability of nutritional evidence. Furthermore, prevalent undiagnosed eating disorders and traumatic associations developed from consuming foods may explain poor dietary habits amongst some service users. Moreover, service users may continually engage in poor eating habits if poor eating habits equates to staff attention, particularly if service users feel lonely and disengaged.

2.6.5. Personal cleanliness and comfort

Feeling personally clean and comfortable, wearing comfortable, age-appropriate clothing and having the choice of bedtimes and waking times is frequently associated with quality of life, dignity and wellbeing. As Twigg (2010:226) observes, 'comfort is not just a question of looseness or lack of constraint- of sweat pants and pyjamas. How you are socially presented, with the embedded meanings implied, can be a source of ease and calm-or its reverse'. Ascertaining personal cleanliness, comfort, dress and bedtimes typically involves observations of service users and from family views (Wright, 2000).

Asylums, workhouses and hospitals

Personal cleanliness were presumably limited within early institutions as demonstrated by eye witness accounts of extensive urine and excrement and asylum occupants wearing clothes soaked in urine and excrement (Oswin 1998). 'Secure dress' were associated with therapeutic advantages for 'disturbed inmates' of Staffordshire Asylums in the nineteenth century and dress distinguished social and institutional classes (Wynter, 2011). Similarly within workhouses, occupants wore uniforms displaying the church Parish name, mothers of

illegitimate children wore blue and yellow dresses and individuals considered refractory or unruly wore special badges and dresses (MayKay,1995). Cattermole, et al. (1988) highlighted adults with learning disabilities within learning disability hospitals primarily wore clothes with stamped on names and hospital location. Good clothes were also reserved by staff for service users to wear on special occasions.

Deinstitutionalization

Relatives commented locating from learning disability hospital to hostel resulted in improvements with personal hygiene including the addition of eye spectacles and hair styling for adults with learning disabilities (Booth et al, 1990). Furthermore, adults with learning disabilities commented that whilst living in a hostel, they were allowed to take a free to bath and shower and lock doors when they wanted, which differed from hospitals, were they were more than likely to find themselves sharing bathrooms (Booth et al, 1990). Gains in ability in terms of hygiene and health were noted following deinstitutionalization for people with learning disabilities (Fleming et al, 1990). Although, Shah & Holmes (1987) commented of frustrations amongst some adults with learning disabilities of having to pay for hairdressing which was free within hospitals. Similarly, improvements in dress were noted by relatives of adults with learning disabilities following relocation from learning disability hospitals to hostels, specifically, adults with learning disabilities wore their own clothes along with clothes appropriate for their age (Booth et al, 1990).

Stancliffe & Abery (1997) found increased choice making opportunities for bedtimes for adults with learning disability relocating to smaller settings in comparison with peers who remained within institutions. Nevertheless, Raynes , Johnson, Sumpton & Thorp (1987) reported from case studies that adults with learning disabilities in both hospitals and hostels were not involved in decisions surrounding bedtimes. Others note of increased choice on what to wear each day following deinstitutionalization (Dagnan et al. 1996).

Post deinstitutionalization and care homes

Some carers presented examples of male service users appearing unkempt, unshaven, with dirty clothes within nursing homes (Cartwright, 1991). Whilst others show within assisted living and nursing homes with 20% of services containing people with dementia were considered unkempt during at least one observation (Zimmerman, Sloane, Williams, Ree, Preisser, Eckert et al 2005). Nevertheless, personal cleanliness, hygiene and appearing clean and presentable may reflect service users wishes in wearing unkempt clothing, attentiveness of staff and extent of service user characteristics, for example, presence of pica and challenging behaviours.

2.6.6. Safety

Fears of abuse reflect crucial antecedents for distress for people with learning disabilities (Weiss, Waechter & Wekerle, 2011) and distress and morality amongst older people (Lachs, Williams, O'Brien, Pillemer & Charlson, 1998). Similarly, some people with learning disabilities (Ramirez & Kratochwill, 1997) and older people (Iaboni & Flint, 2012) experience stress and fears of failing, particularly given varying physical characteristics.

Addressing fears of abuse is necessary as abuse is 'morally indefensible' against people with learning disabilities (Cambridge, 1999:285) and is 'unacceptable to government and society'

to abuse older people (Gaplin: 2010:254). However, 'abuse will undoubtedly always happen at some level' (McCarthy & Thompson 1996:216). Findings suggest older people (Cooper, Selwood & Livingston, 2008; Mansell, Beadle-Brown, Cambridge, Milne & Whelton, 2009:34) and older women (Biggs, Manthorpe, Tinker, Doyle & Erens, 2009) are particularly susceptible to abuse. Furthermore, considering falls resulting in injury are amongst the leading causes of death and disability (Finlayson, Morrison, Jackson, Mantry & Cooper 2010:966) requires fall prevention policies, especially as adults with learning disabilities and older people (Rubenstein, 2006) experience more falls than general population. Falls also occur in community care settings for adults with learning disabilities (Wagemans & Cluitmans, 2006) and older people (Cameron, Murray, Gillespie, Robertson, & Cumming et al, 2010) which warrants fall prevention policies within community care.

Given importance of safety and security for individual quality of life and wellbeing, implementing safe and secure community care by addressing abuse and implementing fall prevention initiatives is paramount within social care. Methods to ascertain service user safety include observation (Hughes, May & Harding 1987), case studies (Cambridge, 1999), eye witness testimonies (Robinson & Johnson, 1996), audits depicting abuse against service users and adult safeguarding protection referrals (Cambridge, Beadle-Brown, Milne, Mansell & Whelton, 2011; Cambridge, Mansell, Beadle-Brown, Milne & Whelton, 2011; Manthorpe & Martineau, 2009, 2010).

Asylums, workhouses and hospitals

Nineteenth century asylums generally portray saturated abusive and violent atmospheres which presumably installed fear amongst occupants. Franklin (2002:172) notes within nineteenth century asylums, 'the mad were seen as non human and beyond the pale of normal life and were treated accordingly, being shackled, whipped, kept naked, bedded down on straw and fed through bars'. Furthermore, cold shower baths were utilized as 'corrective' treatments for violent and abusive patients within Victorian asylum case histories (Renvoize & Beveridge, 1989). Similarly, Brimblecombe (2006) notes physical abuse and treatment approaches of seclusion and cold baths for challenging behaviour for inhabitants of Scottish asylums. Chronic pessimism and stigmatization of pauper patients (Lomax, 1922) cruelty, abuse and inhumane treatments were widespread in institutions of the early nineteenth century (Parry-Jones 1972; Smith, 1988). Service user testimonies from Scottish asylum commented on observations of sexual assaults on a service user carried out by asylum staff (Barfoot & Beveridge 1990). Moreover, eyewitness reports from social reformers from Norah Fry commented 'feeble-minded' children living in workhouses with pauper women were regularly mocked by other children and cite an example of a child tied to a table leg (Oswin, 1998).

Examples of abuse within learning disability hospitals include punishment villas, cold baths, carrying bags of sands and beatings existed for seemingly rebellious people with learning disabilities (Fido & Potts, 1982). Others note of sexual abuse experienced by both men and women whilst living on learning disability hospital grounds (McCarthy & Thompson, 1997). Furthermore, considering asylum physicians actively campaigned against non-restraint from the beginning of its practice in Britain in the early 1840s for the purposes of therapeutic value (O' Conner, 1998), it is likely that physical safety was maintained by considerable restraining. Indeed, bed rails were first introduced in nineteenth century institutions for agitated psychiatric service users as precautionary measures against falls (Hignett & Masud, 2006). Furthermore, longitudinal observations of service users with dementia living on long

stay hospital wards revealed passive neglect, rough handling, verbal abuse, ridiculing service users and infantizing service users (Bowie & Mountain, 1990). Humanitarian arguments depicting extent of abuse within learning disability hospitals (Goffman, 1961) similarly highlight continued abuse which became important catalysts for deinstitutionalization.

Deinstitutionalization

Observational studies depict no incidents of beatings, bullying, hosing downs, locked doors, prolonged sensory deprivation following relocation from hospitalized settings to home settings for teenagers with learning disabilities (Hughes, May & Harding, 1987). Yet, Hewitt (1987:129) noted 'people with learning disabilities transferred from hospitals into their own premises or small group homes, do not receive fullest support over the length period it takes many of them to orientate themselves' which suggests transitioning from hospital to communities was still problematic.

Post deinstitutionalization and care homes

Physical abuse was recently stipulated as most common form of alleged abuse amongst social care staff banned from working in social care (Hussein, Stevens, Manthorpe, Rapaport, Martineau & Harris, 2009). Similarly, adult protection referrals indicate 'those at greater risk of abuse appear to be older women, those living in care homes and those with long term illnesses' (Mansell, Beadle-Brown, Cambridge, Milne & Whelton 2009:34). Although Beadle-Brown, Mansell, Cambridge, Milne & Whelton (2010) found approximately one third of all adult protection referrals related to adults with learning disabilities and adults with learning disabilities were more likely to be abused in care homes. Thus supporting conclusions that abuse remains a reality for some learning disability service users (Cambridge, 1999) and older people in care homes and hospitals (Cohen, Halevy-Levin, Gagin, Priltuzky & Friedman, 2010; Hussein, Manthorpe & Penhale, 2007). Furthermore some adults with learning disability service users living in community care services experienced: punches and slaps in the face following inconvenience (Buckinghamshire County Council, 1998); deplorable verbal and physical abuse of adults with learning disabilities at the Winterbourne View care home near Bristol in 2010 (Dyer, 2011) and failures to meet safeguarding relevant care standards (Cole, 2011). Rough handling during personal care, swearing, and generally acting aggressive towards service users was noted in care homes for older people in Sweden (Saveman, Aström, Bucht & Norberg, 1999) with similar findings reported in England (Dixon, Biggs, Tinker, Stevens & Lee, 2009).

Examples of strategies utilized to protect service users include the following. First, drafting prevention and resolution strategies and barriers prevent abuse of adults with learning disabilities (DH, 2000) and older people (Payne & Fletcher, 2005). Second, implementing safeguarding policies (DH, 2000; Humphries, 2011). Third, closing homes following accounts of abuse and swiftly terminating employment contracts for violence perpetuators (McCartney & Campbell, 1998). Fourth, developing psychological treatment packages for abused individuals (Sinason, 2002) and ensuring that such practices are followed through from abuse. Encountering both threatened and actual accounts of abuse will likely compromise feelings of security, especially amongst anxious service users.

However, abuse prevalence is hampered by barriers in disclosing abuse following varying service user communicational abilities, intimidation within staff teams, recognizing abuse and organizational failures in handing abuse (Cambridge 1999). Nevertheless, as chapter one

described, sympathetic and positive attitudes towards people with disabilities and older people perhaps challenges abuse universality. Furthermore, assuming widespread abuse within community care could be detrimental to relatives and service users wellbeing, particularly amongst anxious service users. Assumptions of inherent abuse also potentially undermines excellent work carried out by direct care staff and further yields suspicious attitudes against services which impact admissions, personnel recruitment and overall attitudes towards community care.

Furthermore, given unpredictable falls (Harris, 1989), fall preventions reflect continual challenges in reassuring service users. Eliciting fall prevention environments may however conflict with normalized and homely environments thus diminishing quality of life (Parker, Barnes, McKee, Torrington & Tregenza, 2004). Variations in risk aversive environments across care homes highlight heterogeneity of community care environments as well as numerous cost and practical considerations of the layout of community care settings. Nevertheless, fall unpredictability balanced with adequate staffing issues in fall prevention reflects key challenges with community care settings. Yet, sensitivity to ensuring adequately accommodated environments for service users is necessary for ultimate empowerment, dignity and respect for community care service users.

2.6.7. Social participation and involvement

Humans are essentially social beings. Social contact, friendships and community participation influence self esteem (Hartup & Stevens, 1999) and protect or buffer individuals from significant morbidity, mortality (Cohen, 2004; Holt-Lunstad, Smith & Layton, 2010) and depression (Ibarra-Rovillard & Kuiper, 2011). Increased social participation is also associated with quality of life, wellbeing and social functioning for adults with learning disability (Forrester-Jones & Grant, 1997) and older people (Golden, Conroy & Lawlor, 2009). Striving towards enhanced social participation is generally emphasized within community care. Nevertheless, favourable outcomes following social participation may depend on quality social interactions rather than quantity (Amieva, Stoykova, Matharan, Helmer, Antonucci & Dartigues, 2010). Moreover, increased social participation increases risks for social, emotional, and behavioral problems from abusive relationships (McCarthy & Thompson, 1997), bullying (Mishna, 2003) and increased vulnerability to crime victimization following increased community participation (Sharp, 2001).

Researchers ascertain social participation data from questionnaires (Forrester-Jones, Carpenter, Coolen-Schrijner, Cambridge, Tate, Beecham, et al, 2006), interviews with service users and staff, scrutiny of house records depicting relevant social outings (Fleming et al, 1990) and case studies (Cattermole et al, 1988).

Asylums, workhouses and hospitals

Historical accounts of early asylums generally portray socially destitute environments. For example, Pinel's 'therapeutic' seclusion methods in eighteenth century asylums, (Holmes, Kennedy & Perron, 2004), highlights limited social contact. Similarly, historical case histories highlighted seclusion was 'used in a limited way and only for the management of the very restless and overactive patient (Renvoize & Beveridge, 1989:26). Oswin (1998) highlighted asylum occupants had no or very little awareness of life outside the asylums and were largely contained within institutions for life. Occupants of learning disability hospital reported extreme isolation from outside communities and expressed wishes to make friends

and participate in social activities outside hospitals (Cattermole et al, 1988). However, there are some accounts of social contact within asylums as evident from daily walks with asylum occupants of varying abilities (Barfoot et al 1990). Findings of social exclusion within asylums and hospitals are unsurprising given widespread support for segregation of people with suspected learning disabilities and mental health problems (Radford, 1991).

Deinstitutionalization

Moving from learning disability hospital to smaller settings resulted in increased family contact (de Kock, Saxby, Thomas & Felce, 1998; Spreat & Conroy, 2002) and wider social networks (Cambridge, et al. 1994). Although decreases in family contact (Grimes & Vitello, 1990) and visitor frequency (Bratt & Johnson, 1988) also occurred following relocation from learning disability hospital to smaller settings. Others report increased contact from both staff and other service users (Mansell & Beasley, 1993) and staff implementing primary sources of emotional support (Fleming et al, 1990; Forrester-Jones, Carpenter, Coolen-Schrijner, Cambridge, Tate, Beecham et al. 2006). Most reviews (Myers, Ager, Keer & Myles, 1998) and empirical studies (Young, 2006) highlight increases in community participation following relocation from learning disability hospital to smaller community care setting.

Nevertheless, additional factors influence social outcomes following deinstitutionalization. First, studies outline deteriorations in social relationships after one year post relocation (Booth et al 1990). Second, differences in methods and research approaches across studies limits generalisability (Forrester-Jones et al, 2006). Third, failing to control for time of day with social participations across studies (Fleming et al, 1990). Fourth, social participation is likely to be influenced by low staffing and lack of transport (Fleming et al, 1990). Finally, social care outcome findings may reflect extent of disability within services (Fleming et al, 1990) and staff interactions predominately focusing on more active verbally able service users (Reep, Felce & de Kock, 1987). Older people may also develop closer networks than younger people following deinstitutionalization (Forrester-Jones, Carpenter, Coolen-Schrijner, Cambridge, Tate & Hallam et al, 2012).

Post deinstitutionalization and care homes

Adults with learning disabilities (Beadle-Brown et al, 2005; Robertson, Emerson, Gregory, Hatton, Kessissoglou, Hallam & Linehan, 2001) and older people (Hubbard, Tester & Downs, 2003) living in care homes develop friendships, receive visits from family and receive social contact with others. However, service users are still typically socially isolated compared with non disabled populations (Fleming et al. 1990).

Additional variables potentially influence social participation. First, personality factors including introverted personality traits and ingrained institutional reclusive dispositions limits interactions. Second, service users may become accustomed to loneliness following considerable isolation and disillusionment from others. Third, reluctance to socially engage following from previous traumatic memories of bullying and ridicule from others. Fourth, communication impairments may compromise confidence in social participation. Fifth, service users may develop infatuations with care home staff, consequently reducing desires to meet new people. Sixth, given social psychological associations with attraction and similarity (Byrne, Griffitt & Stefaniak, 1967), given institutionalized regimented routines, service users may experience considerable dissimilarity to others leading to socialization

reluctance. Finally, accommodation layout (Salari, Brown & Eaton, 2006), occupancy rates (Curry & Ratliff, 1973) and service user characteristics may collectively influence socialization.

Numerous staffing factors undoubtedly impact socialization. First, restrictions to outside social activities given limited staffing numbers. Second, restricting social activities to people from similar community care populations. Third, staff fears of challenging behaviour within communities may limit social participation. Fourth, staff beliefs and prejudices regarding social relationships for people with learning disabilities. Fifth, staff failure to equip and teach service users how to engage with others diminishes service user confidence in interacting with others. Finally, tolerance from the wider community on service user populations may exert powerful influences on social integration (Dijker et al, 2011). For example, societal physical barriers such as lack of transport and poverty also impact friendship development for adults with learning disabilities (Nunkoosing & John, 1997).

For Goffman (1961), social isolation within institutions compromises identity constructions and further mortification of the self. Conversely, Philo (1997) advocates societal perspectives by suggesting community segregation implies implicit wishes to prevent adults with learning disabilities from reproducing, which links back to negative depictions of people with learning disabilities highlighted in chapter one. Nevertheless, Cummins & Lau (2003) notes, simply increasing social and community opportunities may not always lead to favourable outcomes, particularly if individuals vary with self perceived social connectedness which may differ according to whether individuals feel they have something in common with other people.

2.7. Normalization

Considering normalization (Nirje, 1969; Wolfensberger & Nirje, 1972), so far, this chapter revealed service users living within smaller community environments do not always live within normalized environments . Variations in service user and staffing characteristics may considerably influence social care outcomes. Inferences as to whether service users live mainly institutional lives but within different smaller settings continually attracts research attention.

2.8. Measurement

Measurement enables monitoring social care outcomes, assessing service performance and transcends powerful messages on service expectations and service delivery (DH, 1998a). Measurement and monitoring of social outcomes reflects *Best Value* policy (Department of the Environment, Transport and the Regions, 1998a, 1998b 1999), illuminates potential excellence in health and social care (Moulinn, 2002:187) and essential for improving service user care (Suresh, Ferguson, Tomlinson, Campbell, Oblinger, Prochnicki, et al. 2007). Nevertheless, quality measurement is a complex phenomenon to assess because it is elusive, multifaceted, and fraught with measurement problems' (Schalock & Alonso, 2002:189).

2.8.1. Measurement issues

Sensitivity to measurement issues is important as care home service users reflect some of the most vulnerable people in our society and are often the least able to make complaints or express dissatisfaction (Wright, 2005:1105). Effective measurement thus plays important roles on research findings (Borthwick-Duffy, 1996). Acknowledgement of measurement

issues illuminates initial preliminary problems, developing strategies to resolve issues and validates previous research.

Measuring quality related concepts and outcomes illuminate numerous advantages. First, measurement depicts valid insights as all perspectives are inherently valuable and equally useful (Ferguson, Ferguson & Taylor, 1992). Second, people with learning disabilities are increasingly depicted as reliable informants (Stalker, 1998). Third, failing to consult with service users denies an important voice (Atkinson, 1988b). Fourth, measurement offers opportunities to explore, discover and challenge phenomena (McConkey, 1996:3). Fifth, measurement arguably moves away from hidden agenda of ivory tower scientific rigor (Minkes, Townsley, Weston & Williams, 1995), consequently improving service provision (Cummins, 2001).

Conversely numerous researchers challenge measurement. First, individuals seldom conceptualize views on quality of life and satisfaction (Farquhar, 1995a, 1995b). Second, measurement enables professionals to retain professional power (Ager & Hatton, 1999; Hatton & Ager 2002). Third, measurement generates 'wholesale surveillance leading to further problems (Hatton, 2002). Third, measurement saturates services with performance measures (Moullin, 2002). Fourth, participant response is also known to be influenced by question format (Tourangeau & Smith, 1996), question order (McFarland, 1981), question structure (Bircham, 2003) and topic of question (Adams, 1956). Finally, participant responses are also influenced by interviewer gender (Thumin, 1962) and ethnicity of interviewer, particularly in relation to ethnicity issues (Cotter, Cohen & Coutler, 1982:278).

2.8.2. Techniques

Section 2.6 showed in order to ascertain findings on quality of life and social care outcomes, researchers utilize various measures including proxies, observations, questionnaires and qualitative focus groups. As evaluating measurement tools is essential for selecting the most appropriate measure for community care research, this section evaluates key measures utilized within community care research.

Proxy

Numerous researchers identify benefits of proxy measurement (Nota, Soreshi & Perry, 2006). Proxy measurement enables ascertaining viewpoints from individuals in a unique position to evaluate the situations that they and the people around them are experiencing. Proxy measurement also increases staff participation in interventions, reflects a reliable measure for older people (Bond, 1999) and reflects better alternative than no information (Lefort & Fraser, 2002). Conversely, others highlight the unreliability of proxy reports in describing the lives of people with cognitive impairment (Bond, 1999; Ostbye, Tyas, McDowell & Koval, 1997). Furthermore, Proxy findings are also influenced by proxy subjectivity (Bond, 1999) and differ from service user views (Cummins, 1996; Stancliffe, 2000).

Observations

Observation benefits from enabling insights into activities and events as they happen (Clark, 2007:6) and documents lifestyles from people with verbal and cognitive limitations (Clark, 2007; Hubbard et al, 2003). Observational also depict accurate methods of collecting information. (Bowie & Mountain (1993:57), offer invaluable insights into social interaction

unattainable via self report (Gardner, 2000:187) and depart from problematic staff reports (Schenelle, Osterweil & Simmons, 2005:576). Direct observational protocols also illuminate specificity, timeliness, and accuracy requirements necessary for effective staff management and quality improvement efforts (Schnelle et al, 2005:578). Mann, Have, Plunkett & Meisels (1991:227) outlined several advantages for time sampling including simple implementation, utilizes minimal equipment, includes simple observer training and serves as an audit tool to ensure accuracy of information recorded by nursing home staff.
Nevertheless, observations attract numerous limitations. Wang , Wiley & Zhou (2007) identified two limitations with conducting observational studies with cultural research, namely, unreliable inter-coder reliability of multi-ethnic coders and the cross-cultural validity of coding schemes. Wang et al. (2007) found with observations of parent-toddler dinner interactions between Chinese and European coders, Chinese coders interpreted Chinese immigrant parents as having significantly more positive affect, more negative affect and higher parental confidence, although there were no significant differences for coding on sensitivity, intrusiveness and detachment. Moreover, Chinese coders were more likely to code Chinese Immigrant parents as significantly more confident. Furthermore, Margolin , Oliver, Gordis, O'Hearn, Medina, Ghosh & Morland (1998:204) notes 'ethnicity may affect coding because coders from various cultures and backgrounds may learn different communication patterns, as reflected in varying tolerance levels of conflict, different expressions of respect, and different expected roles based on gender and age'. Margolin et al (1998) further comments that 'having a diverse group of coders to raise these issues and stimulate discussions may help reduce ethnically myopic judgments about international behaviour'.

Researchers identify other observational limitations. Namely, limitations associated with making generalizations from data and reliability (Clark, 2007), time and expense of observations in terms of training observers, carrying out observations, coding interactions and carrying out inter-observer reliability checks (Gardner, 2000:187). Others note problematic coding systems (Margolin et al (1998:201), disparity between the 'observed' experience and the way in which people who have dementia experience the service (Cheston, Bender & Byatt, 2000). Moreover, incidents of observer drift whereby observers gradually modify behavioural codes applied to the observed behaviours but still maintain inter-observer agreement typically occurs (Schnelle et al. 2005:579). Furthermore, researchers discuss uncomfortable feelings associated with observation from the point of view of the fieldworker (Brooker, 1995). Finally, Schnelle et al (2005:579) highlighted behaviour changes may change following observation through reactivity, namely, influence of the observation procedure on the behaviour of the subjects (Bowie & Mountain 1993:862). However, as Schnelle et al (2005:580) note, 'that many observational studies of nursing home quality have reported significant care problems. If direct observations of care delivery were reactive, one would expect between conclusions about quality in these studies'.

Despite the above observational limitations, extensive training, expertise of fieldworker may limit limitations. Individual differences and the interaction of possible gender and ethnicity confounding variables perhaps illuminate debates of subjectivity and value free science.

Focus groups

Focus groups can be viewed as a therapeutic activity (Cheston et al, 2000:476), and enable recommendations, to service managers, particularly if given a remit for discussion prior to the meetings. Furthermore, support gained from being with others enables individuals to express

views they would not otherwise communicate (Cheston et al, 2000:476). Focus groups also allows useful insights into main beliefs and cultures that influence feelings, attitudes and behaviours of individuals' (Rabiee, 2004:655). Kitzinger (1994) offers several advantages of focus groups including encouraging people to engage with others, verbally formulate their ideas and draw out cognitive structures previously unarticulated. Focus groups also enable respondents to allocate concepts in a hierarchy of importance and enables insights into respondents language, frameworks for understanding the world, knowledge and attitudes unattainable from reasoned responses to direct questions. Focus groups also allow insights into group norms and encourage open conversation about embarrassing subjects. Nyamathi & Shuler (1990) comment typically focus groups have high face validity due to the credibility of comments from participants.

Mixed methods approach

Mixed methods have also been used to explore outcomes and quality of life. Mixed methods benefit from producing a fuller picture than any one method (Barker, 1984), and illuminate comprehensive accounts of service outcomes (Hatton, Emerson, Robertson, Henderson & Cooper 1995). Mixed methods also reflects important components of measuring quality of life (Schalock & Alonso, 2002), neutralizes or cancels out some method disadvantages (Tashakkori & Teddlie, 2002) and generally results in superior research in comparison with mono-method research (Johnson , et al. 2007).

2.9. MOPSU study

Chapter one noted the MOPSU study utilized a mixed methods approach of proxy questionnaires and observations which enabled opportunities to harness relevant benefits of proxy, observations and mixed methods. The MOPSU study also collected findings on needs, characteristics and social care outcomes for both adults with learning disabilities and older people. The MOPSU study therefore enables useful insights into determining whether progress has been made in social care outcomes and quality of life for community care services following from numerous policies stipulated at the beginning of the new millennium. The MOPSU study therefore enables a unique opportunity to explore the needs, characteristics and experiences of minority ethnic people living in both learning disability and older people care homes.

2.10. Significance of culture and ethnicity in community care research

This chapter primarily reviewed needs, outcomes and quality of life indicators whilst emphasizing lived experiences for adults with learning disabilities and older people living in community care settings. This chapter also briefly evaluated varying measurement approaches.

Nevertheless, researchers often assume social care outcomes and quality of life indictors such as individuality and choice are universally and similarly defined by all cultures. Given values, preferences and experiences of people within minority groups are often different from majority populations, increasingly diverse populations allows opportunities to question universality of concepts, definitions and behaviours. Specifically, how majority populations interpret, perceive and experience such concepts of quality of life may differ and be viewed as inappropriate amongst minority ethnic populations. Community care staff may undervalue that not everyone will perceive concepts associated with quality of life such as choice and

social inclusion the same way. Furthermore, if society emphasizes how majority populations perceive and interpret concepts associated with quality of life and fail to acknowledge the significance and value of minority populations, our understanding of quality of life, may reflect views from a majority population and Eurocentric biases. Consequently, our understanding of quality of life, wellbeing and social care outcomes may miss pertinent issues for minority ethnic populations and services become culturally inappropriate as a result. Continued culturally inappropriate community care services may marginalize, alienate and oppress minority populations from many community care services which do not recognize their concerns.

Considering pertinent and increasing political, moral and policy emphasis on eradicating oppression, promoting equality and implementing person centered approaches, it is imperative that researchers and community care providers acknowledge such differences. Minority ethnic contributions also help improve service development and challenge and subsequently improving our understanding of lived experiences, quality of life and wellbeing which further highlights emphasis on minority ethnic populations. Earlier this chapter, good quality service provision involved recognizing the needs of service user populations and implementing appropriate care in light of varying service user needs. Quality service provision also needs to be designed in ways that reflect the norms and expectations of particular populations rather than just assuming that traditional Westernized understanding of quality service provision is universally apparent across all cultures. Furthermore, given theories outlined in chapter one of universalism and social constructivism, concepts of 'needs' may well be defined and conceptualized differently for different groups with differing cultural norms, values and attitudes.

Considering more general theories into needs such as Maslow, regardless of different cultural groups, all organisms need food for survival, which reflects basic level needs. However, taking into account universalism and social constructivism, how we view 'food' are arguably shaped cultural norms and values. Whilst there may well be some universal aspects towards certain physiological basic needs, how we perceive and interpret some basic physical needs may differ for people from different backgrounds with different cultural norms, values and attitudes. Collectively, differing cultural values towards particular phenomena raises questions on the universality of current understandings of needs, quality and social care outcomes.

However, numerous researchers comment on a dearth of community care research acknowledging the perspectives and views for people from minority ethnic populations. If there is a neglect of perspectives from minority groups, this calls into question whether current understandings of social care outcomes are representative and reflective for all groups. Namely, are understandings of needs and outcomes reflective of more dominant westernized cultures? Are there any missing domains particularly pertinent for people from minority cultures? Of the small but significant research on minority ethnic groups, researchers increasingly identify the importance of meeting 'cultural needs' within social care. However, existence of 'cultural needs' suggests that there maybe other outcomes and points of consideration in meeting the needs of people from diverse backgrounds which may have been missed from existing conceptualizations of needs and social care outcomes.

An additional question relates to relative importance of particular domains. Bodily and environmental cleanliness were associated with spiritual and material justifications in Ancient civilizations (Porter, 1999). Nevertheless, in England, historical evidence highlights personal

cleanliness was less of a priority in the sixteenth century (Sim, 2001), conversely to stringent standards in health and safety, infection and sanitation in social care today (CQC, 2011). Thus even within England, different norms and values associated with particular domains were prioritized over others, which highlights that current understanding of needs and domains reflects understanding within particular time paradigms and historical eras.

Taken into account cultural considerations, there is also the question that norms and values held by people within different cultures prioritize certain domains over others. For example, Netten et al. (2010) noted relative importance put on social care domains may differ for people from different populations, for example, 'historically at least we might think the French population would value meals and nutrition rather more highly than the English'. Moreover, this preference weighting for particular domains could also apply to people from different cultures living in England. For example with meals and nutrition, consuming meals that comply with religious requirements could be seen highly valued and important amongst religiously observant individuals in comparison with atheists.

A central feature of person centered care involves recognizing that people may have differing norms and attitudes which could be associated with particular domains and effective service provision involves tailoring care appropriately to meet peoples needs. If there are any normative variations surrounding 'needs' itself, then the task of appropriate service implementation involves operating in accordance with variations surrounding needs. Failing to implement person centered care or recognize individual needs could also indicate continued oppression, discrimination and persecution of community care service users highlighted in chapter one. Sensitivity to unmet needs and actively working towards combating unmet needs therefore remains a crucial imperative part of community care service provision. Yet, research into minority ethnic populations within community care research remains considerably unexplored (Shah, Doe & Ksenia, 2008). The question remains whether society explores sensitivity to needs as defined by a majority dominant culture only and primarily neglecting unmet needs for ethnically and culturally diverse groups.

Content analyses

Content analyses of peer reviewed journals illuminate unidentified knowledge gaps. Pontoretto (1988) utilized content analyses and found less than 6% of articles explored ethnicity or racially diverse individuals from ten years of publications within the *Journal of Counseling Psychology*. Similarly, between 1970 and 1989, Graham (1992) found 3.6% of total published articles explored data that analyzed race and included African Americans. These content analyses initially illuminate research gaps in acknowledging the significance of ethnicity and culture within research. Other researchers similarly conducted content analyses within multicultural counseling competency research and despite small increase in multicultural research across 20 years, only small number of scholars specifically explore multicultural research (Worthington, Soth-McNett & Moreno, 2007). Continued neglect of research into ethnically and diverse populations may generate misleading, unrepresentative and inaccurate conclusions within social science literature.

Learning disability research

Hatton (2004a) conducted content analyses of three journals [*American Journal on Mental Retardation* (AJMR), *Mental Retardation* (MR) and *Journal of Intellectual Disability Research* (JIDR)] published between 2000-2002. Hatton (2004a) focused on ethnic

composition of study samples, number of studies reporting cross-cultural comparisons or within cultural variations. Hatton (2004a) found a small portion of empirical studies disclosing ethnic composition of participant samples: 27%- AJMR; 44% -MR and 14% - JIDR. Hatton (2004a) also found if ethnicity data was reported, the samples were overwhelmingly white: 80%- AJMR; 66%-MR and 89%-JIDR.

Table 2.3 partially replicates Hatton (2004a) content analyses, but instead focuses on three UK based learning disability journals- *Journal of Intellectual and Developmental Disability* (JIDD); JIDR and the *British Journal of Learning Disability* (BJLD). The intention was to investigate whether empirical articles published between 2006 -2009 disclosed ethnicity data and attended to cultural differences within research. Unlike Hatton (2004a), this content analysis extracted the following information. First, studies that disclosed all ethnicity groups, Second, studies that reported white ethnic groups only. Third, studies that reported 'white' and other ethnic groups. Fourth, studies reporting minority ethnic groups only. Fifth, studies that disclosed data for white ethnic groups only. Sixth, studies that explored differences by comparing different countries or 'cross national' studies. Finally, studies reporting differences between and within cultural groups.

Table 2.3 highlights only small proportions of research articles from JIDD, JIDR and BJLD depicted sample cultural sample characteristics. Most researchers disclosed all ethnicity groups, or disclosed participant data for participants from white ethnicity groups only. Similarly limited studies within JIDD, JIDR and BJLD empirically explored differences between and within cultural groups. These findings support Hatton (2004a) whereby empirical articles within learning disability journals, neglect cultural considerations surrounding lived experiences which potentially illuminate gaps in community care knowledge base.

Table 2.3- Cultural emphasis within learning disability journals

	Learning disability journals		
	JIDD (2006-2009)	**JIDR (2006-2009)**	**BJLD (2006-2009)**
Total number of empirical research articles	111	328	74
Studies disclosing cultural sample characteristics (country of origin, ethnicity)	114 (13%)	65 (20%)	12 (16%)
Description of cultural sample characteristics			
All ethnic and cultural groups	8 (57%)	23 (35%)	6 (50%)
White ethnic groups only	3 (21%)	7 (11%)	1 (8%)
White and other	0 (0%)	10 (15%)	2 (17%)
Minority ethnic groups only	2 (14%)	8 (12%)	0 (0%)
Disclosed white groups only	1 (7%)	17 (26%)	3 (25%)
Studies exploring differences between and within cultural groups			
Between cultural groups	1	6	0
Within cultural groups	1	2	0

Gerontology research

Similarly, content analyses were utilized to explore whether gerontology researchers published between 2006 -2009 considered the impact of culture within gerontology journals

(*Age and Aging* and *Ageing and Society*). Table 2.4 shows a high percentage of empirical articles in *Ageing and Society* disclosed cultural sample characteristics in contrast to *Age and Aging* that reported a comparatively small proportion.

Table 2.4- Cultural characteristics within peer reviewed gerontology journals

	Gerontology journals	
	Age and Aging- (2006-2009)	**Ageing and Society- (2006-2009)**
Total number of empirical research articles	238	134
Studies disclosing cultural sample characteristics (country of origin, ethnicity)	20 (8%)	100 (75%)
Description of cultural sample characteristics		
All ethnic and cultural groups	7 (35%)	31 (31%)
White ethnic groups only	3 (15%)	39 (39%)
White and other	5 (25%)	4 (4%)
Minority ethnic groups only	0 (0%)	20 (20%)
Disclosed white groups only	5 (25%)	6 (6%)
Studies exploring differences between and within cultural groups		
between cultural groups	4	12
within cultural groups	4	5

Section 1.1 introduced Carnaby's model which centralized service users ethnicity as a core central component of supporting service users. Nevertheless, content analyses findings discussed above depicts limited research investigating needs and experiences of minority ethnic populations, particularly amongst minority ethnic older people and minority ethnic adults with learning disabilities. International researchers from other developed countries also comment limited research on older minority ethnic populations within USA (Liu, 2003) as well as limited research on minority ethnic adults with learning disabilities in the USA. Sue (1999) comments several reasons for this lack research into ethnicity including lack of interest amongst researchers, rejections of articles from peer reviewers, a tendency to draw conclusions about human beings in general rather than about the particular human being in the study as well as difficulties in recruiting 'ethnic participants'. Other researchers noted difficulties in recruiting individuals from minority ethnic groups (Yancey, Ortega & Kumanyika, 2006). Nevertheless, hiring training, bicultural and bilingual individuals, both as recruiters and staff involved in clinical assessment may increase participation from minority ethnic groups in research projects (Hinton, Carter, Reed, Beckett, Lara, DeCarli & Mungas, 2010).

Drawing from geographical dispersions of minority ethnic groups, Blakemore (1998) argues settlement of minority communities has two major implications for community care. First, it has been relatively easy for the majority white community to marginalize minorities, both psychologically and in terms of policy and service provision. Second, planning of minority settlement potentially impacts the planning and delivering of community care as groups are clustered into particular regions. Consequently, certain minority groups may be defined as 'inner city problems' and are accordingly seen as irrelevant to the majority.

2.11. Conclusion

This chapter presents theoretical, policy and research overview of needs, quality, quality of life outcomes, measurement and social care outcomes (Netten et al, 2012) including: 1) accommodation cleanliness; 2) control over daily life; 3) meals and nutrition; 4) occupation and employment; 5) personal care; 6) safety; 7) social participation and involvement. Within each social care outcome domain, research evidence focused on adults with learning disabilities and older people across three community care paradigms, namely, institutionalization, deinstitutionalization and post- deinstitutionalization. Content analyses from peer reviewed learning disability and gerontology journals showed minimal research attention to cultural considerations surrounding needs, quality, measurement and social care outcomes, which may suggest ingrained absolutist perspective amongst researchers. Failing to acknowledge cultural considerations surrounding needs, quality and lived experiences may perpetrate inequalities, marginalize populations, potentially leaves minority ethnic populations susceptible to considerable unmet needs and conflicts with equality and person centered agendas depicted by social policy and legislative context. The next chapter explores cultural considerations surrounding needs, quality, measurement and social care outcomes with specific focus on culturally and ethnically diverse adults with learning disabilities and older people.

3. Chapter 3- Culture, needs, quality and care homes

3.1. Introduction

This chapter explores diverse ethnicity and cultural factors surrounding needs, quality, measurement and social care outcomes. This chapter predominately focuses on adults with learning disabilities and older people from minority ethnic and culturally diverse groups. This chapter emphasizes three most prevalent non-white minority ethnic populations living within England (ONS, 2005c), namely Black, Black British individuals from African-Caribbean descent along with south Asian and Chinese populations. Given close associations with minority ethnic populations and religion, this chapter explores religious doctrines within four most UK prevalent minority religions (ONS, 2005c), specifically, Jews, Hindus, Muslims and Sikhs. This chapter concludes with thesis links with the MOPSU study, research questions and models.

3.2. Literature review search methods

Replication of search criteria outlined in section 2.2 framed the chapter three literature reviews. Terminology presented in section 2.2, were paired with additional terms, namely, 'ethnicity', 'ethnic', 'minority', 'culture', 'cultural', 'race', 'identity' 'diverse' and 'difference'. Findings on specific minority ethnic and cultural groups were ascertained from the following search terms; 'south Asian', 'Asian', 'Chinese' , 'Indian', 'Black', 'European', 'Middle Eastern', 'Islam', 'Hindu', 'Sikh', 'Jewish'. Terms including 'Tribal', 'Tribe', 'Clan' 'society' 'community', 'Africa'. Anthropological journals including '*Annual Reviews of Anthropology'* along with anthropology books produced further articles.

3.3. Needs and quality- cultural inferences

Chapter two reviewed empirical research on needs and community care experiences in accordance with social outcome domains (Netten et al. 2012). Nevertheless, consideration of social care outcomes and quality of life conceptualization, generally neglects contributions and significance of culturally diverse considerations. Honigmann (1967) outlined culture influences values associated with behavioral relations with nature, time orientation, interpersonal relations, self, use of wealth, and interpersonal expression. Similarly, Wolfensberger (1994:287) argued, 'one of big problems with constructions of quality of life is that they are bound to be relative to the experiences, expectations and aspirations of the surrounding culture and its historical realities. Thus such concepts will differ widely among cultures and over time even within the same culture'. As Schalock (1997) reviews, understanding cultural basis surrounding words draws from cross cultural psychology which explores implicit meanings which shape psychological processes, examines the distribution of these meanings across cultural groups. Consequently, differences in group views of the person and sense of self may produce discrepant notions of happiness, satisfaction, or well-being across cultures, and hence different conceptions of what one means by quality of life and application (Schalock, 1997:229). Collectively, people from diverse cultural backgrounds may conceptualize and experience social care domains differently, yet the impact of culture on community care experiences is relatively unknown. Content analyses from section 2.10 identified limited research attention into culturally diverse and minority ethnic groups.

3.4. Policy

Policy interest in culturally diverse groups partly illuminates societal attitudes on ethnicity and culture. Increasing policy interest in ethnicity generally coincides with wider societal changes including changes with immigration and migration, colonialism changes, increased travel opportunities, changing societal attitudes towards minorities, technological advancement and media portrayals of international communities. Advancing technological and media outlets enable interactive greater access to humanitarian accounts following from civil wars, genocide elicited between different cultural groups and more recently, minority ethnic people obtaining leading privileged powerful positions. Other reasons include equality reforms and academic developments illuminating individual heterogeneity and concept universality debates.

The Race Relations Act (1976) reflects important catalysts in illuminating minority ethnic concerns and striving towards equality. Subsequent community care reforms in the 1980s and 1990s [Griffiths, 1988, *Caring for People* White Paper (DH, 1989), 1989 Children's Act; *Patient Charter*- (DH 1991)] referred to minority ethnic needs and culturally sensitive provision. Nevertheless, four criticisms exist with early policies. First, inclusion of only one main paragraph on minority issues in *Caring for People* (DH, 1989) reflects tokenism rather than a commitment to minority needs (Blakemore, 1998:262). Second, Blakemore, (1998) argues content underlying Griffith's Report (Griffiths, 1988) and *Caring for People* (DH, 1989) were 'bland and featureless construction' which failed to recognize the UK for what it is- a complex and rapidly changing mosaic of many different kinds of community... devoid of cultural diversity and the rich ethnic mix that actually exists'. Third, neglecting minority ethnic needs generates regional differences in interpretation and reflects further missed opportunities to illuminate minority ethnic experiences (Brammer, 1999). Fourth, Brammer, (1999) notes of piecemeal and slow developments with UK anti-discrimination law.

Post millennium, sensitivity to minority ethnic needs was noted within NMS (DH, 2003a, 2003b) and within regulatory organizations (CSCI, 2008). Needs of minority ethnic adults with learning disabilities were mentioned in *Valuing People* (DH, 2001a) and DH commissioned reports (Mir et al, 2001). Moreover, as Manthorpe, Iliffe, et al (2009) reviews, the NSFOP explicitly outlined numerous standards in addressing minority ethnic needs. Williams , Keating & Nadirshaw (2007) note building a picture of the possible effects of racial and other inequalities on the life of a person is an essential first step in empowerment practice'.

3.5. Needs, quality and cultural considerations

Chapter two outlined empirical research on needs and social care outcomes from learning disability and older people living in community care settings. This section adds to community care knowledge by illuminating significance of minority ethnic and culturally diverse perspectives on social care outcomes (Netten et al. 2012). Evidence surrounding reviews on religious sensitivity and particular religions were obtained from numerous sources (Baxter, 1998b; Henley & Scott, 2004).

3.5.1. Accommodation and cleanliness, order and accessibility

Ascertaining cleanliness and comfort varies between cultures, given divergent cultural attitudes associated with purity, hygiene and dirt dangers (Curtis, 2007).

Accommodation cleanliness

Douglas (1966) considered dirt as a matter out of place from ordered world and attitudes. Miller (1997) notes ascertaining 'disgusting' and 'dirty' accommodation may not be universally apparent across cultures. For example, wearing outdoor shoes in a Japanese home maybe viewed as dirty, yet, removing shoes could be viewed as dirty in an American home. Furthermore, emphasizing cleanliness may reflect westernized cultural norms in reducing pathogens and disease antecedents. In some cultures, dirt preserves nature by reducing polluting hazards of civility from cleaning products (Gerr, 2004:4).Living within dirty environments may elicit distress amongst religiously observant individuals given emphasis on purity and cleanliness. For example, within Judaism, extensive home cleaning rituals during Passover eliminates impurities (Sered, 1988). Similarly, within Islam, 'cleanliness is considered half of the faith' (Rassool, 2000:1480). Moreover, within Hinduism, cleaning and decorating of thresholds reflect central features of rending a house auspicious or favourable as they mark the luminal moment of crossing social and symbolic spaces' (Säävälä 2003:240). Cleanliness is also important amongst Sikhs (Sambhi, 1990).

Waterless alcohol based hand cleaners are increasingly recommended (WHO, 2009) and utilized within UK health and care services to increase hygiene. However, alcohol based cleaners initially conflicts with forbidden alcohol doctrines within Islam (Allegranzi, Memish, Donaldson & Pittet 2009). Although as Allegranzi, et al. (2009) describes, the Qur'an permits any substance manufactured to reduce illness or contribute to better health including alcohol as a medicinal agent. Consequently, usage of alcohol-containing hand rub solutions are acceptable to many Muslim health care workers. Nevertheless, staff and service users may fear to use alcohol based cleaners if strictly abiding by non-alcohol doctrines (Allegranzi, et al. 2009).

Comfortable accommodation

How we define 'comfortable' may differ between cultures. For example, cultural differences exist with household heating procedures. For example, Norwegian households created thermally consistent environments, conversely to Japanese households which included smaller heaters placed under tables to heat individual bodies rather than surrounding areas (Wilhite, Nakagami, Masuda, Yamaga & Hanea, 1996). Moreover, living in uncomfortable environments may yield cultural advantages in terms of status, prestige, along with therapeutic and redemptive qualities. Furthermore, *Feng Shui* integral to some Chinese societies (Choy, Mak & Ho, 2007) emphasizes harmony between natural and built environments in relation to water and air movement (So & Lenug, 2004) Ignoring *Feng Shui* practices may distort 'comfortable accommodation' inferences amongst diverse cultures.

Alternatively, 'comfortable' living may reflect westernized cultural norms. Researchers typically measure comfortable accommodation by observing available soft furnishings, appropriate air conditioning and presence of technological items. However, striving towards comfortable living may differ between cultural groups residing in capitalist and non capitalist countries. For example, following Marxist philosophies, striving towards comfortable items may divert societal attention from social unrest and injustice, consequently preserving capitalism within westernized societies. Furthermore, recommending expensive comfortable accommodation items enhances company profits consequently preserving capitalism.

Furthermore, some devout religious individuals deliberately live within 'simple' means without environmental attributes designed to implement individual 'comfort' in order to achieve spiritual purity. 'Comfortable' secularized environment may therefore conflict with preferences from religiously devout individuals seeking to live in seemingly meager accommodation. Moreover, some cultures incorporate caste systems which incorporate differing views and attitudes on ascertaining accommodation comfort. To live within environments where 'comfort' is representative of lower castes or social classes may induce distress, or considered as 'unclean' and 'untouchables' by some cultures. Furthermore, within religions such as Islam, implementing personal care with continually running water reflects the preferred personal care response. Availability of facilities to allow for continually running water for personal cleanliness such as including showers and bidets close to toilets may constitute as accommodation comforts.

Mir et al. (2001) notes, institutions for adults with learning disabilities may restrict evidence of cultural diversity to private spaces within bedrooms. Consequently, service users may define their private bedrooms as comfortable conversely to all other seemingly uncomfortable rooms within community care services. Comfort may also relate to feelings of living within close proximity to families as shown by interviews from Finnish immigrants moving into a Swedish older people community care service (Heikkilä & Eskma, 2003). Furthermore, development of same gender facilities, especially female facilities may reassure female minority ethnic adults with learning disabilities (Singh, & Orimalade 2009). Nevertheless, some of the above findings comment on accommodation cleanliness from interviewing staff, providers or service users themselves without observing accommodation settings themselves. Qualitative measurement may allow for exploration of cultural considerations surrounding accommodation cleanliness and comfort.

3.5.2. Control over daily life

Individual control typically characterizes individualistic cultures. Conversely, collectivist cultures emphasize formulating group rather than individual decisions (Mir et al 2001). People from collectivist cultures may feel alienated within predominately individualistic societies, consequently distorting trust and partnership within services (Baxter, 1998a, 1998b). Collectivism and interdependence was prioritized within Asian cultures conversely to striving towards independence (Vernon, 2002). Ahmad & Atkin (1996) found members of south Asian communities often perceive kinship-based groups as an important source of identity and support. Furthermore, Mir et al (2001) found African Caribbean adults with learning disabilities were also positive about families and felt that independence could be achieved within a family setting.

Culturally diverse issues also illuminate potential contradictions with control. Time management and regimented waking times for work, business, leisure pursuits and societal orientated appointment times typically categorize westernized lifestyles. If working populations and non disabled populations typically live within strictly regimented timetables, how much control do non disabled working populations have in reality? Is it somehow less normal to have non regimented and more individually controlled lifestyles whilst living within time regimented and focused societies?

Regimented timetables in accordance with specific times depicted on clocks and watches may reflect social construction biases of how westernized cultures control everyday living. Yet, other cultures may consider control as group commodities rather than governed by individual

control. Furthermore, some cultures may define choice in supernatural and spiritual terms, whereby fate and divine deities control life as opposed to individual control. Differing cultures may also conceptualize control as governed by celestial or planetary cycles, meteorological or weather changes along with interpretations from particular portents or 'signs'.

Researchers typically measure choice via waking times and bedtimes. However amongst religiously observant individuals, decisions surrounding waking times and bedtimes reflect important events, especially surrounding religious occasions. For example, during Ramadan, devoted healthy Muslims fast between sunrise and sunset (Qureshi, 2002). Whilst the sick may decline from fasting, individuals may prefer to change bedtime routines in order to wake before sunrise during religious events. If bedtimes and wakeup times are strictly regimented by community care staff, this may prevent individuals from participating in worship within certain times of the year, which could induce distress amongst observant individuals.

Whilst attention is placed on levels of choice making, a further question depicts the nature of choice, namely, whether choice operates in accordance with service users cultural and religious beliefs. Offering choices on whether to eat sausages or beef would be culturally inappropriate for vegetarian practicing Hindus. Similarly, offering choices to either watch television or listen to music via audio players could be problematic for people from developing cultures unfamiliar with technological and electronic devices. Drawing from the person centered approach, ascertaining control and choice may require sensitivity to the individuals skills capabilities and backgrounds.

3.5.3. Employment and occupation

Perceptions of employment, occupation and meaningful activity potentially differs between cultures. Specifically, conceptualizing 'meaningful' activities may require participation in culturally appropriate activities or activities reflective of cultural groups. For example, amongst Chinese populations, activities including Tai Chi, Chinese fan dancing, Chinese games and television programmes as well as examples of watching a game of 'Mah-jong' were noted as examples of activities described by practitioner and managers accounts of promoting the wellbeing of older people from black and minority ethnic groups (Manthorpe, Moriary et al 2010). Participating in Majohng and visiting tea-house were similarly noted by Chinese older people recently admitted into care homes in China (Lee, 1999).

Implementing cultural inappropriate activities was mentioned as a barrier for community care support from interviews with south Asian carers with adult with learning disabilities (Hatton , Azmi, Caine & Emerson, 1998). Furthermore, numerous studies highlight implementing culturally appropriate activities including Korean dance and traditional games for older Koreans may increase service uptake (Moon , Lubben & Villa, 1998). Suggestions for improving community care services include providing 'culture-specific activities' following from findings from carers for people with learning disabilities (O'Hara, 2003) and literature reviews of minority ethnic older people living in UK care homes (Mold et al. 2005). Suggestions for supporting carers for black and minority ethnic groups (Robinson & Stalker, 1992), similarly recommended different media including temples, community meeting places, Asian TV or radio programmes, along with videos and tape recordings. Similarly, utilizing satellite television shows presented in languages familiar to service users reflected examples of support outlined by managers supporting older black and minority ethnic person (Manthorpe & Moriarty et al. 2010).

Conversely, engaging in religiously inappropriate activities and leisure pursuits may conflict with how religiously observant individuals define meaningful activities. Staff may need to consider whether activities are culturally appropriate for diverse populations. Kelleher & Hillier (1996) reported parents restricted activities for their daughters to safeguard them from situations which elicit vulnerability to abuse and unacceptable behaviours. Similarly, Mir et al (2001) commented activities will not necessarily be equally acceptable to all communities, whereby many Muslim families for example, may frown on the provision of dance, whereas Hindu and Sikh families were more likely to participate in dancing based activities. Furthermore, some religions set restrictions in participating in religious activities for menstruating women within Islam (Bharadwaj & Patkar, 2004) and Hinduism (Ahmed & Yesmin, 2008). Consequently, religiously observant individuals may refrain from activity engagement during seemingly 'unclean' physiological changes.

Furthermore, activities may reflect advancements of philosophical thought, technology, capitalism, industrialization within the developed world. People living within developed worlds typically utilize electricity, technology and obtain information from books and writing. Yet, people from developing countries may have limited understanding and operational knowledge in how to utilize technological devices and use writing materials. For example, Shah (1999) notes limited literacy and writing skills amongst older south Asians.

Older people living within developing countries may define activities as 'meaningful' if activities accentuate community survival, solidify relations with other cultures and reflect cultural traditions of singing and socialization for entertainment and social purposes. Conversely, other cultures may conceptualize meaningful activities in terms of active engagement. Some researchers focusing on supporting Asian family carers of people with dementia (Ismail & Mackenzie, 2003) recommended consideration of cultural and religious needs in providing refreshments and transports, for example ensuring that transport is carried out by female drivers if the service user and family stipulated no male drivers. Activities including cooking are essential for survival, yet serve to promote gender roles within some cultures, but may also illuminate social status with people from higher social groups less likely to participate in actual cooking tasks (Mintz & Du Bois, 2002). Equally, playing games, talking and singing carries numerous social, psychological and physical benefits may differ between cultures.

A further issue concerns conveyance of activities for culturally diverse groups. Activities including reading books, watching films, participating in recreational games and activities need to reflect service users language capabilities. Sensitivity to industrialization and appreciation of technological advancements may also reflect important considerations in performing meaningful activities for minority ethnic populations.

Some older minority ethnic populations express preferences for activity disengagement. For example, disengagement from activities was found amongst Chinese older people wishing to lead more secluded lifestyles (Hsu, 1967). Moreover, few Chinese older people participate in activities following transition into care homes in Hong Kong (Lee, 1999). Furthermore, Lee (1999) found from interviews with ten Chinese care home service users, that half of the female service users expressed relief from participating in 'tedious housework' which enabled escape from traditional hard and secluded life in patriarchal Chinese families. This finding suggests living within care homes and disengaging in activities illustrate functional advantages in escaping from traditional cultural gender roles and encouraging participation in

care home activities may not be appropriate for older Chinese care home service users (Lee, 1999). Moreover, inclusion of 'culturally appropriate' activities may not necessarily increase participation. For example, semi structured interviews with older Chinese populations revealed participants were uncomfortable participating in activities in 'senior centres' with people from different economic or occupational backgrounds (Liu, 2003).

Participating in culturally appropriate activities is typically associated with important psychological advantages for culturally diverse populations. For example, Bunning & Steel (2006) found participating in Jewish culturally relevant activities amongst people with learning disabilities from Jewish communities enabled sense of belonging and positive self concepts. In the absence of culturally appropriate activities therefore, individuals may lack a sense of belonging and positive self identity. Others highlight that engagement in spiritual activities formed part of service users way of life. For example, Bunning & Steel (2006) found that Jewish spiritual activities formed part of lifestyles of people with learning disabilities and prayer was expressed as a connection between individual and God. Failing to participate in spiritual activities could compromise individuals accustomed way of life and also severe connections with divine deities which could be particularly important for some people.

Furthermore, given occasional religious stoicism, active activity engagement potentially compromises psychological wellbeing and quality of life. For example, Buddhism and Hinduism include meditation defined as 'one in which attention to spontaneously generated mental events occurs in a state of deep physical relaxation, thereby constituting a form of global self-desensitization (Goleman, 1990:25). During meditation, observers may assume individuals are 'doing nothing'. Yet, in the context of mediation, the individual may well be fully engaged in participating in meaningful activity. To conduct or be made to participate in active forms of engagement whilst otherwise engaged in meditation or private prayer could distort psychological wellbeing and daily routines.

Religious observant individuals occasionally restrict certain activities during religious occasions. Staff may need to acknowledge that engagement in activities during religious events maybe culturally and religiously inappropriate during religious events. For example, during Ramadan, adult and healthy Muslims typically refrain from taking any food, beverages, or oral drugs as well as from sexual intercourse between dawn and sunset (Gomceli, Kutlu, Cavdar & Inan, 2008). Within Judaism, every Saturday is Shabbat or Sabbath reflects the Jewish day of rest (Cato, 2003). Others note on the Sabbath, the seventh day of the week, no work or kindling fire or turning on electricity is permitted (Berkowitz, 2008). Consequently, during religious events and specific days of the week , active activity engagement may indicate religious insensitivity.

Ascertaining activity levels maybe further complicated by other factors. Machizawa & Lau (2010) showed from interviews with older 'Nikkei' people of Japanese origin, varied life experience, acculturation level, English proficiency and generation influenced activity participation, whereby, older people from Kibei war brides and Shin Issei showed stronger preferences for cultural resources such as television programmes, newspapers and a return to their homeland Japan. Moreover, Machizawa & Lau (2010) found escalating age led to accelerating wishes in engaging in cultural activities of their past in order to feel connected with their culture of origin. Participants also expressed a wish to participate in activities including included ikebana (flower arrangement), buyou (Japanese dance), origami, taiko

(drum), and sadou (tea ceremony). Returning to place of origin was also speculated to be important for minority ethnic groups including African Caribbean groups (Ebrahim, 1996).

Commenting on adults with learning disability services, Mir et al (2001) noted care homes maybe isolated from areas of cultural diversity. Participation in activities reflective of cultural background therefore maybe considerably limited for minority ethnic groups. Similarly, engagement in activities may also depend on fostering links with minority ethnic organizations to encourage greater community engagement (Manthorpe & Moriaty et al, 2010).

3.5.4. Meals and nutrition

Providing 'culturally appropriate' meals is typically noted whilst discussing minority ethnic and culturally diverse needs (Daker-White, Beattie, Gilliard & Means, 2002). Providing culturally appropriate foods are important for older minority ethnic populations quality judgments (Azam, 2007) and important for preferences (Machizawa & Lau, 2010). Yet, 'culturally appropriate diet' depicts vague and generalized statements. This section unpacks 'culturally appropriate diets' by exploring cultural and religious considerations surrounding meals.

Meaning

Some cultures and religions associate foods with particular meanings and significance. For example, some minority ethnic older people associate foods with healing (Evans & Cunningham, 1996). Similarly, from interviews with older Jewish women in Jerusalem, within Judaism foods strengthen relationships with God, enrich ancestral history, and define the Jewish calendar and life cycle (Sered, 1988).

Types of food

Mintz & Du Bois (2002:99) noted food is 'utterly essential to human existence'. Yet, dietary habits vary within and between ethnic groups (Gilbert & Khokhar, 2008:203). International foods are sometimes classified as 'ethnic foods' (Khokhar, Marletta, Shahar, Farre, Ireland, Jansen-van der Vilet et al, 2010). Food sometimes depict country of origin, including 'Caribbean foods', 'Asian foods' and 'Chinese foods'. Whilst food categorization adds to national or ethnic identity of particular countries (Mintz et al, 2002) and assists consumers in identifying foods, 'ethnic foods' implies people from certain ethnicities consume particular types of foods only without considering consumption of a multitude of different foods, regardless of ethnic and cultural background. Furthermore, some chefs combine different food from international communities rather than exclusively focusing on one food categorization. Nevertheless, Korean older people living in long term care services distinguished 'Korean food' from 'American food' (Moon et al, 1998), older Japanese participants similarly discussed 'American food' (Machizawa & Lau, 2010). Traditional vegetables consumption has been associated with cultural heritage of some south Asian communities in Bradford (Pieroni, Houlihan, Ansari, Hussain & Aslam, 2007). Table 3.1 summarizes traditional foods consumed by African Caribbeans, south Asians and Chinese people as reviewed elsewhere (Gilbert & Khokhar, 2008). Table 3.1 shows non-white minority ethnic groups traditionally consume varied diets, although individuals may consume foods from multiple cuisines and origins.

Table 3.1- Traditional food consumed by African Caribbean, south Asians and Chinese

Group	African Caribbean	Asian or Asian British	Chinese
Meat	Meat curries or roasted meat including lamb, beef, goat, mutton. Meats are seasoned and sometimes coated in flour and fried	Variation	Variation
Poultry/game	Meat curries or roasted chicken	Chicken	Variation
Fish-non scaled and non scaled	Wide variety including salt fish	Variation	Variation
Diary products	Variety	Variation	Variation
Fruits	Tropical fruits eaten throughout the day	Variation	Variation
Cereals	Rice, corn and wheat	Chapatti, Paratha, Roti and/or rice	Rice common in southern china, wheet products such as noodles, are typical of northern regions
Vegetables	Starchy vegetables such as yam, potato, cassava and plantain. Usually boiled, added to soups an eaten with meat and fish	Variation	Variation
Drinks	Wide variation including ginger beer	Variation	Variation
Herbs	Heavily seasoned with herbs	Variation	Chinese tea
Snacks	Patties, salt fish fritters and fried dumplings	Sweet dishes- keheer, sevia and mithai. Khahi- a yoghurt an chickpea soup	Variation

Social and anthropological contributions illuminate cultural differences with food preferences. Consuming insects in the Amazon (Dufour, 1987) beetles in African regions (Takeda, 1990; Illgner & Nell, 2000) and sago larvae grubs in Irian Jaya populations (Ponzetta & Paeoletti, 2010) reflect cultural delicacies for some cultures. Yet, other cultures may perceive such foods as abhorrent.

Individual motivations to consume particular foods may solidify cultural identity and social status. For example, Hayden (2003) notes consuming rice implies an indication of high status within some developing countries. Other factors may influence food selection including, war onset, advances in capitalism and productions, limitations with agricultural production and natural disasters impacting types of foods. Furthermore, consuming particular types of foods may trigger memories of ancestors and cultures, supernatural beings, but also interacts with varying gender role identity. Practicality in finding ingredients, cross cultural exposures, changing family roles, career changes and health education have also been found as motivators for changes in consuming types of foods amongst some African Americans (Airhihenbuwa, Kumanyika, Agus, Lowe, Saunders & Morssink 1996). Service users may thus select foods which reflect their cultural identity, history and socialization experiences and denial of such foods may comprise wellbeing.

Religious beliefs surrounding foods can also powerfully influence food choice and reinforce religious and ethnic boundaries (Mintz & Du Bois, 2002). Some religiously observant people respect their religion by eating culturally appropriate foods, namely, foods prepared and cooked in accordance with religious restrictions. Any divergence or violation to complying with these dietary needs could elicit distress for some individuals and in extreme form, violation of human rights, wellbeing, preferences and wishes. For example, Hinduism is based around Karma and pollution, therefore some Hindus may fear future repercussions by consuming 'polluting' foods. Observation of others consuming forbidden foods may be considered as 'polluting' and 'untouchable' and influence social interactions. Furthermore, within Hinduism, caste systems influences consumption of particular foods, whereby foods may only be consumed if prepared by people from particular castes (Stevenson, 1954). Most Muslims only consume meat provided the meat was killed by a Muslim with religious prayer, depicted as halal foods. Any ambiguity on halal food availability, Muslims may resort to vegetarian food (Hutchinson & Baqi-Aziz, 1994). Equally, Muslims, Sikhs, Jews and Hindus may refuse foods on grounds of contaminated with forbidden foods.

Table 3.2 summarizes food needs and restrictions for Jews, Muslims, Hindus and Sikhs respectively. Table 3.2 explores main food groups of meat, poultry, fish, diary, food and vegetables as well as alcohol, blood consumption collated from health and social care literature surrounding religion. The following publications depict guidance on meals consumed within Judaism (Sered, 1988), Islam (Hammoud, White & Fetters, 2005), Hinduism and Sikhism. Table 3.2 shows practicing Jews, Muslims and Sikhs typically consume meat and poultry if slaughtered appropriately to religious doctrines. Both Sikhs and Hindus do not consume beef. Furthermore, alcohol and consumption of pork is not consumed by both Jews and Muslims. To consume foods which conflict with religious laws could suggest religious insensitivity and induce distress amongst religiously observant individuals.

Table 3.2 – Food restrictions and religion

Group	**Judaism**	**Hinduism (non vegetarians)**	**Islam**	**Sikhism (non vegetarian)**
Alcohol	No alcohol	Alcohol	No alcohol	Alcohol
Blood*	No blood	Blood	No blood	Blood
Meat*- beef, lamb, goat, rabbit	Kosher meats	No beef, Lamb, goat, rabbit	Halal meats	Jhatka meat only
Poultry/ game*		Chicken, duck, turkey		
Fish- scale * (tuna, cod)	Kosher fish	Scaled fish	Scaled fish consumed without contamination with non halal meats.	Fish
Fish-non scaled* eels, catfish, shark shellfish	No non scaled fish	Non scaled fish	Non scaled fish	Non fished scaled fish
Fruit and vegetables	Dirt free	Dirt free fruits and vegetables. Some refuse to eat onions and garlic	Dirt free	Dirt free
Diary products *	Diary products, no blood	Diary products	Diary products	Diary products

*not suitable for vegans who refrain from meat or animal products of any kind

Food preparation and culinary practices

Culinary and cooking practices represent universal parts of human societies (Murcott, & Marshall, 1995), yet are culturally distinguishable. As Brownlie, Hewer & Horne (2005:8) notes, ' if cooking is understood to mark the "transition between nature and culture" (Levi-Strauss 1970:164), then it clearly suggests potentially rich vein of social inquiry about how people construct their world in texts and talk, and what is done with those constructions'. Social and anthropological evidence depicts differing food preparation and culinary practices. Within some collectivist cultures, meals are cooked for large social cultural networks and eaten together as a group which could be contrasted with more individualistic meal preparations whereby meals are prepared for singular family units. For example, the entire collectivist Israeli Kibbutz community consume meals in common dining rooms (Talmon, 1972; Sharabany, 1993). Similarly, anthropological reviews highlight sharing of communal meals are integral to some cultures (Kaplan & Hill, 1985).

Some religions stipulate clear food product separation including diary and meat separation, consuming foods with appropriate preparations and separation of meat from vegetarian foods for vegetations. In terms of meal preparations, clear separate food areas were noted within Jewish homes in order to separate meat and diary products (Sered, 1988). Numerous authors stipulate diligence with utensils in potentially contaminating foods for observant Jews (Sered, 1988), Hindus (Stevenson, 1954:54) and Muslims (Iftikhar & Parvez, 2009). Consequently, separating utensils to prevent food contamination maybe particularly pertinent amongst some cultures.

Equipment and cultural food etiquette

Cutlery and crockery

Various cultures use different modes of equipment to assist with eating, which may reflect different cultural norms along with differences in industrialization, capitalism and colonization. Within most westernized developed countries, food is consumed primarily with cutlery of forks, knifes and spoons. Nevertheless, others consume food by hand and chopsticks rather than westernized cutlery of knifes and forks. Cwiertka (2004:121) comments handling cutlery was already a torture for novice Japanese dinners' who otherwise consume foods with chopsticks. Equally, cross cultural differences may exist with handling of cutlery and eating behaviours which has been shown to irritate people utilizing bed-and-breakfast establishments (Stringer, 1981). Further food consumption issues concerns the usage of eating serving dishes or crockery. Others depict differences between Westernized bowls in comparison with Japanese bowls (Goldstein-Gidoni, 2001:74). O'Hara (2003) comments behavioural and skills training for minority ethnic adults with learning disabilities operate according to 'white culture' which emphasizes teaching on eating with knifes, forks and spoons. Community care staff may unintentionally transcend cultural norms promoting usage of cutlery and crockery without considering that not all cultures consume foods the same way or use equipment to assist with food consumption.

Food consumption location and etiquette

In some cultures, food is typically consumed on floors, (Cwiertka, 2004), rather than consuming foods at tables. Furthermore, foods may not always be consumed within designated dining rooms. Moreover, certain religions including Islam (Iftikhar & Parvez,

2009) stipulate foods should be consumed by the right hand, whereas the left hand should be used for personal care. Insisting service users consume foods at tables, within a designated dining room and consuming foods with the left hand may elicit eurocentric biases and consequently implement cultural insensitivity with food related etiquette. Moreover, Fuller (1979:469) illuminates food exchange within Hinduism, whereby consuming leftover and thus 'polluted' food demonstrates lower status. Consuming left-over foods may reflect cost effective, recycling and waste reductive strategies. However, serving left-over foods may implicitly diminish service user status, reinforce powerful dynamics of care staff and adversely impact service users wellbeing.

Community care research

Generally, community care research depicts unmet needs surrounding culturally appropriate meals. Family members and carers of adults with learning disabilities frequently comment on culturally inappropriate foods contained within day centres (Hatton et al. 1998) and services more generally (O'Hara, 2003; Report of the Faculty of the Psychiatry of Learning Disability Working Group, 2011). Similarly, studies collecting information from differing perspectives of south Asian older people, carers and service providers depicts failures to cater for dietary needs within community care services (Jewson, Jeffers & Kalra, 2003), inflexibility regarding meals with care and meal provision predominately catering for people of European origin in Australia care settings (Warbuton, Barlett & Rao, 2009). Insensitivity to food needs for minority ethnic older people within mainstream community care services have similarly been noted from carers (Adamson, 1999; Patel, 1999). Furthermore, Manthorpe, Moriaty et al. (2010) noted comments from commissioners of 'not well disguised racism' amongst older people services from some members of staff who were not positive about family members providing food to service users.

Consequently, lack of sensitivity to food needs typically induces barriers for minority ethnic learning disabilities utilizing learning disabilities according to carers (Hatton, et al. 1998). Singh & Orimalade (2009) comments of placement breakdowns following insensitivity to dietary needs. Equally, carers report implementing culturally appropriate foods reflective of individuals cultural and ethnic group would attract more older people from minority ethnic groups (Moon, Lubben & Vialla, 1998) and minority ethnic adults with learning disabilities (Hatton, et al. 1998; Azmi, Hatton, Emerson & Caine, 1996).

3.5.5. Personal care

Cultural norms largely govern our appearance expectations, personal care and strategies utilize to handle dirt and body waste (Quitzau, 2004). Specially, social and anthropological contributions demonstrate cultural variations with hair and skin care, personal cleanliness implementation, dress codes, circumstances of 'unclean' actions and restorative purification actions (Preston & Ritter, 2012). 'Cultural needs' were defined in accordance with bathing, hair care and skin care amongst interviews with minority ethnic young people in dementia care (Daker-White, Beattie, Means & Gilliard, 2002). O'Hara (2003) also noted essential part of personal identity for some minority ethnic learning disability communities is to attune to cultural factors associated with hair and skin care and dress. Furthermore, training in appropriate hair care is particularly important for African-Caribbean people with learning disability populations (Lewis, 1996). Failure to address cultural considerations surrounding personal care and comfort could diminish wellbeing and lead to placement breakdowns (Singh & Orimalade, 2009), thus sensitivity to cultural differences and postponing using

services until absolutely necessary (Yamashiro & Matsuoka, 1997) in personal care is paramount.

Hair and skin care requirements

Healthy hair relies on appropriate hair care and products, particularly considering hair type differences (Roseborough & McMichael, 2009). However, people from divergent ethnicities may possess different hair care requirements. For example, hair for black ethnic groups differs microscopically from Caucasian hair in: shape (McMichael, 2007), structure (Khumalo, Doe, Dawber & Fergson, 2000), hair status according to scalp sites (Loussouarn, 2001), resistance and physical stress on hair shafts (Khumalo et al, 2000). Yet, as Roseborough & McMichael (2009) note, shampoo frequency for people from black ethnic groups depends on hair texture and style. Differences in hair structure may require particular care requirements including increased time in greasing, relaxing and brushing hair (Costa, 2003; Moore & Maclean, 2004) and specific hair styling techniques including heat restructuring, hot combing, chemicals, other hot heat sources (curling irons, blow dryers), plaiting, braiding and cornrows (McMichael, 200 Henley & Schott, 2004).

Varying degrees of skin colour pigmentation resulting from varying melanin levels, amount of UV exposure, genetics, melanosome content skin (Rawlins, 2006), reflect overt ethnicity divergences. Berardesca & Maibach (2003) shows conversely to white skin, black skin depicts increased barrier function, prevalent cell layers, resistance to stripping, increased lipid content and increased electrical resistance. Furthermore, conversely to white skin, black skin is typically more robust to environmental factors and alcohol breakages (Jourdain, Lacharriere, Bastien & Maibach, 2002) and has greater gland pore size, increased apocrine and apoeccrine glands and greater sebum secretion (Rawlings, 2006). Black skin also differs in natural oil skin lubrication resulting in 'ashy' grey, white and dusty appearance when dry (Costa, 2003; Henley & Schott, 2004). Many people with black or dark skin therefore utilize unique cosmetic oils and moisturizers designed to care for black skin (Costa, 2003; Henley & Schott, 2004). Additional lubrication for black skin may also be required during personal care.

Numerous authors recommend sensitively caring for black skin and hair whilst discussing culturally appropriate hair care (Baxter, 1996; Lewis, 1996). Nevertheless, within learning disability service, attending to the needs of the requirements of black skin and hair is grossly neglected (Lewis, 1996). Failure to adhere to black skin and hair requirements potentially leads to placement breakdowns for people from black ethnic groups (Singh & Orimalade, 2009).

Personal cleanliness and comfort

Ascertaining personal cleanliness is arguably time and culturally dependent. Determining precise historical personal cleanliness attitudes is generally problematic given variable reliable historical records, compared with modern emphasis on cleanliness. However, historical evidence frequently depicts changing perceptions of personal cleanliness given the relative low priority of personal cleanliness in the Middle Ages and Elizabethan times which eventually modified due to scientific advances with infection, control and medicine from the eighteenth century. Emphasizing personal cleanliness thus may reflect timed based Westernized norms of eliminating personal dirt and infection control which may differ with cultures within more developing countries without widespread sanitation systems in place.

However, not all cultures prioritize eliminating personal dirt. Anthropological evidence of Turkana cultures in western Kenya utilize mud and dirt during rites of passage ceremonies for boys (Mburu, 2007) and decoration purposes within female hair (Barton, 1921). Immersion of dirt may depict dirtiness and unclean states by some cultures, yet other cultures value dirt as a rite of passage and for decoration purposes. Personal cleanliness reflects an important of part of Judaism, Hinduism, Islam and Sikhism. Table 3.3 summarizes indicators for personal cleanliness, purpose for personal cleanliness and recommendations for service provision for practicing Jews, Hindus, Muslims and Sikhs as depicted from various reviews (Allegranzi, et al. 2009). Table 3.3 typically emphasizes cleanliness and good grooming for hygienic and religious purposes.

Table 3.3 Personal cleanliness practices and religious background

Group	Purpose	Guide of religious restrictions
Judaism	Cleaning	Wash hands immediately after awakening in the morning
	Cleaning	Wash hands before and after each meal
	Ritual	Wash hands before praying
	Ritual	Before the beginning of Shabbat
	Cleaning	Wash hands after going to the toilet
Islam	Cleaning	Left hand is used during toileting
	Ritual	Wash hands before prayer
	Cleaning	Wash hands before and after each meal
	Cleaning	Wash hands after going to the toilet
	Cleaning	Wash hands after touching a dog or shoes or a cadaver
	Cleaning	Wash hands after handing anything soiled
	Cleaning	Perineal area must be washed with running water after using the toilet
Hinduism	Ritual	Wash hands during worship (puja)
	Ritual	Wash hands after prayer
	Cleaning	Wash hands after any unclean act
Sikhism	Cleaning	Left hand is used during toileting
	Cleaning	Wash hands early in the morning
	Ritual	Wash hands before every religious activity
	Cleaning	Wash hands before cooking and entering the community food hall
	Cleaning	Wash hands after each meal
	Cleaning	Wash hands after taking off or putting on shoes
	Cleaning	Long hair requires regular washing and managing. Hair remains uncut
	Grooming	Kangha is used to comb the hair every day

Various religions stipulate several requirements associated with personal cleanliness. Within Hinduism, the caste system interacts with definitions of personal cleanliness, whereby people from upper castes are considered ritually clean. Within extreme examples, touching or being seen together with people from lower castes may elicit contamination feelings amongst people from upper castes, although such beliefs may vary widely across generations and extent of acculturation inferences.

Furthermore, within Judaism, Islam and Hinduism, menstruating women are primarily considered impure, despite nothing inherently impure with menstruation (Guterman, Mehta & Gibbs, 2008). Regardless of how religion reflects patriarchal mediums for oppressing women and social control (Stopler, 2008), attitudes of impure women during menstruation may enhance personal cleanliness routines particularly for religiously observant women. For example, Meacham (1999) notes Jewish women bathe frequently in order to achieve

purification. Dunnavant & Roberts (2012) reviews, ritual acts of ablution for Muslim women and ritual washings for Hindu women.

For some religiously observant individuals, washing with particular hands and washing anatomical parts after lavatory use reflects additional considerations surrounding personal care. Although, Bowes & Wilkinson (2003) found from interviews within Scottish urban settings where facilities within mainstream care homes failed to provide water near toilets and insisted that service users use toilet tissue paper rather than water after using the lavatory. Availability of a bidet or shower hose next to a toilet may reflect a culturally appropriate solution in allowing individuals to wash themselves after lavatory use as opposed to utilizing toilet paper.

Other researchers stress the importance and preferences for same gender staff whilst administering personal care within community care services (Baxter, 1995; Baxter et al. 1990). A male staff worker administering and supporting personal care for a female service user could be deeply distressing and culturally inappropriate amongst some minority ethnic groups. However, as Mir et al (2001) comments, same gender care reflects preferences for most people and deriving assumptions that only minority ethnic populations prefer same gendered care suggests that minority ethnic preferences are different or special and it gives the impression of an additional burden on resources (Baxter, 1996).

Dress

Dress in textiles and skin forms depict fundamentally protective functions, but also install social meanings, group allocation, whilst simultaneously differentiating social groups (Barnes & Eicher, 1992:1). Dress is also considered powerful means of communication and generates statements regarding gender roles of newborn children (Eicher & Roach-Higgins, 1992:8). Getting dressed may actually involve different series of movements in different cultures due to different clothing (Herdman, Fox-Rushby & Badia, 1998). Inability to dress oneself may perceived as more serious in some cultures than in others (Reijneveld, Spijker & Dijkshoorn, 2007).

Social and anthropological contributions show dress codes are inherently dependent upon cultural norms and values. Dress codes to some extent are also distinguishable by affiliation with particular religious faiths and in some cases, membership to certain social caste systems. Literature surrounding dress codes typically covers five areas of dress considerations, including anatomy coverage, obscure and transparency, clothes fitting, clothing colour and clothing items. However, acculturation and generational variations significantly influences adherence to dress codes for religiously observant individuals. Yet, wearing clothes dissimilar to individual's cultural background could distress and irritate individuals. Generally, literature surrounding dress codes is distinguishable for males and females and therefore requires separate consideration.

Females

Older Hindu women traditionally wear saris or Punjabi suits, namely a two piece dress worn over trousers. Similarly, Sikh women sometimes wear Punjabi suits. Sometimes observant Muslims, Hindus and Sikhs wear westernized clothes, although they often wear trousers or long skirts to cover their legs.

Table 3.4 summarizes religious guidelines surrounding dress codes, with specific reference to anatomy coverage, obscure coverage, fitting style, colour clothing and clothing type dress codes for female Jews, Hindus, Muslims and Sikhs. Table 3.4 shows some comparability across religions in terms of preserving modesty for observant women via anatomical coverage, obscure clothing and loose fitting.

Table 3.4- Female dress codes and religious beliefs

Group	**Jewish**	**Hindu**	**Muslim**	**Sikh**
Anatomy coverage	Observant Jews are required to dress modestly. Many orthodox and married women cover their heads with a headscarf or wig. Strictly observant women wear high necklines, long sleeves and clothes covering the knees. Jewish women are required to cover collar-bones, shoulders, upper arms, elbows, torso, upper leg and knees. Lower legs covered with hosiery.	Cover their upper arms and chests and their legs to below the knee.	Muslim women are required to cover their whole body other than the face and hands. More orthodox women cover their face with a veil as well as covering hands.	Cover their upper arms and chests and their legs to below the knee
Obscure and Transparency	Obscure	Obscure	Obscure	Obscure
Clothes fitting	Loose	Generally loose	Clothing must be loose enough not to show shape or outline of the body	Loose
Clothing colour	Jewish women tend to wear dark clothing	Hindu widows tend to wear plain white clothing and avoid bright clothing	Women cover their heads during prayer	Women tend to wear cream or white colours.
Clothing items	Wigs and scarves to cover head	Some Hindus wear bangles or a thread, as well as a red spot on their forehead or scalp.		*Kara*- steel bracelet worn on the right wrist to protect the sword arm and symbolizes eternity. *Kaccha*- shorts worn under clothes to symbolize modesty. Few Sikh women wear a bindi a red dot on forehead for decorative purposes.

Males

Table 3.5 summarizes dress codes surrounding anatomy coverage, obscure coverage, fitting style, colour clothing and clothing type for males practicing Judaism, Hinduism, Islam and Sikhism. Table 3.5 shows considerably less restrictions on dress codes in comparison to

females depicted in Table 3.4. Greater restrictions on dress codes for females may support feminist accounts of patriarchal religion and continued exploitation of women.

Table 3.5 – Male dress code and religious belief

Group	Jewish	Hindu	Muslim	Sikh
Anatomy coverage	Most men over their heads when praying as a gesture of respect to God.		A few men keep their heads covered at all times.	
Obscure and Transparency	Obscure clothing		Obscure	
Clothes fitting	Loose		Loose	
Clothing colour	Many orthodox men wear sedate colours such as black and navy blue		Most Muslim men in the UK wear a western style shirt and trousers.	
Clothing items				Turban used to protect long hair

Investigating whether staff implemented sensitivity to personal cleanliness in terms of appropriate skin and hair care for service users from black ethnic groups, appropriate personal care provision and appropriate dress codes for religiously observant service users, remains largely unexplored. However, authors note numerous guidelines on remaining sensitive to personal care requirements (Henley et al. 2004) for religiously diverse people living within social care which this section explored.

3.5.6. Safety

Western assumptions typically abhors abuse. Chapter two reviewed accounts of abuse within institutions, reductions with abuse following deinstitutionalization and recent worrying recent accounts of abuse in community care settings.

Yet, in other cultures, violence and enduring suffering serves higher purposes beneficial to themselves or their community' (Favazza, 1996:22). Perpetuating violence onto others highlights rites of passage, ascent into adulthood and social acceptance amongst some cultures. Subsequent scaring from violence may provide individuals with safety, security and pride and reminders of group members. Favazza (1996:27) cites numerous ancient shaman examples whereby bodily mutilation enables 'wisdom, special capacities for healing oneself and others and a higher level of existence' and may enable feelings of security. Furthermore, remaining stoic and calm during acts of violence including physical beatings may reflect strength, power and maturity. Conversely, self mutilation may enable individuals to feel cleansed and safe and 'in certain historical and cultural contexts, incidents of self mutilation might have been regarded as socially meaningful or even inspired' (Favazza, 1996:27). Nevertheless, whilst from Westernized medical and psychiatric standpoints, culturally founded beliefs surrounding abuse may receive psychiatric diagnoses and seemingly uncomfortable justifications for violence.

Chapter one showed historically, people from minority ethnic groups received varying degrees of discrimination, racism and persecution. Feeling safe and secure for minority ethnic groups may involve freedom from overt and covert forms of racism. Fears of racism reflect common worries amongst minority ethnic adults with learning disabilities (Mir et al 2001). Examples of actual experiences of racism were reported from south Asian families with learning disability family members (Nadirshaw, 1997). Similarly, findings suggest continued racism and stigma for minority ethnic people with learning disabilities (O'Hara, 2003; Azmi et al. 1997). Communities with less minority ethnic populations typically increase the likelihood of racism and discrimination (Daker-White et al, 2002). Consequently, examples of racism deter people from utilizing learning disability services amongst south Asian communities (Hatton, et al. 1998), reduce service expectations (Griffiths, 1992) and accelerate social isolation (Queensland Department of Communities, 2007).

Furthermore, minority ethnic people may experience other worries to their safety and security which differs from native white British individuals. First, Mir et al (2001) commented minority ethnic adults with learning disabilities, reported safety concerns or worries about care staff failing to be respectful of their culture or religion along with potential sexual abuse and vulnerability. Second, migrant minority ethnic older feared native populations would view them as scroungers (Patel, 1991) or stepping on other peoples toes (Manthorpe & Moriaty et al, 2010). Whilst safety concerns may depict individual worries regardless of cultural background, minority ethnic communities maybe more susceptible to feeling unsafe than native British people.

Religion promotes love, compassion, purity and tranquility. Nevertheless, religion also includes violence, sacrifice, blood, suffering, martyrdom and self mutilation (Favazza 1996:27). As Wellman & Tokuno (2004:291) notes, 'symbolic and social boundaries of religion (no matter how fluid or porous) mobilize individual and group identity in conflict, and sometimes violence, within and between groups'. Iannaccone & Berman (2006:109) note 'religious extremists are willing to murder because they embrace theologies that sanction violence in the service of God'. Subsequently, individuals may fear people associated with particular religious orientations associated with particular conflicts and terrorist acts. Recent deplorable terrorist acts from Islamic extremists have led to xenophobic attitudes and subsequent Islamophobia towards Muslims within UK and abroad (Poynting & Mason, 2007). Subsequent media representations of British Muslims potentially influence wider societal attitudes and behaviours towards practicing Muslims (Malcolm & Bairner, 2010; Jaspal & Cinnirella, 2010). Similarly, Poynting, Nobel & Tabel (2001) review moral panic and media framing of people with Middle Eastern appearances. Existing Islamophobic attitudes amongst community staff may increase abuse against Muslims. Subsequently, Muslims may fear receiving Islamophobic attitudes which subsequently impact service admission rates. Equally, non Muslims from south Asian backgrounds may also experience Islamophobic attitudes.

Embracing pain and suffering may functionally enable feelings of safety and security for more orthodox religiously observant individuals. For example, some self mutilate for sin repentance and religious security (Favazza, 1996). Conversely, some orthodox observant individuals may subject themselves to pain and abuse in order to achieve spiritual closeness, spiritual enlightenment and future afterlife security. Furthermore, brutal exorcisms may functionally obliterate presumed demonic possessions within some religions and ensure safety within families and communities.

Sensitivity to varying caste systems may influence safety feelings. Within Hinduism, some individuals belonging to higher castes including Kshatriyas or rulers or warriors and Brahmans or priests (Stevenson, 1954) fear 'pollution' and 'contamination' from people belonging to lower Untouchable castes. Caste fears maybe particularly prevalent amongst some older Hindus conversely to younger, acculturated and more educated Hindus (Tarakeshwar, Pargament & Mahoney, 2003).

Researchers further highlight people with disabilities typically reflect one of the least accepted populations in religious communities (Selway & Ashman, 1998). Studies show some relatives reluctantly utilize support services due to fears regarding social stigma associated with impairments and disabilities within orthodox Jewish communities (Pinkus, 2000). Given extent of social stigmas regarding disability, some minority ethnic and religious communities maybe particularly fearful of outside communities which may differ for people from cultures without prevalent stigmas associated with disabilities.

3.5.7. Social participation and involvement

Perceptions on quantity and quality of social networks may differ between cultures. Some cultures prefer smaller social networks whereas others embrace considerably larger social networks. Definitions of 'large' social networks may also differ between individualistic and collectivist cultures. Varying industrialization and capitalism inferences may explain favoritism for smaller rather than larger social networks.

Chapter two showed typical social isolation and social disengagement for most service users living within community care services. Nevertheless, given significantly low proportion of people from minority ethnic groups living in care homes, low levels of social engagement could reflect service users and staff belonging to more individualistic cultures rather than collectivist cultures. It remains to be seen whether staff working within community care services within countries with a more collectivist cultural emphasis differ with regards to social engagement and social participation in contrast to staff working within community care services within countries with a more individualistic cultural focus.

Social participation may also differ across different religions. For example, visiting places of worship and participating in group worship is frequently undertaken by some religiously observant individuals. Although increased secularism and economic demands may restrict availability of group worship. Conversely, other religions based around individual meditation and stoicism may favour smaller groups and individual concentration and therefore prefer smaller social groups.

Significance of social participation

Frequent social interaction typically depicts collectivist cultures. Given the importance of social networks amongst some culturally diverse groups, individuals from collectivist cultures may experience considerable more distress following social isolation than individuals from individualistic cultures.

Prevalent social participation may also be particularly important within cultures which rely on others for survival and construct social roles around marriage and children. Subsequently, individuals from different cultures living within more developing countries may perceive the significance of social participation differently from other cultures. Moreover, some

religiously observant people may prefer socializing with others from similar backgrounds. For example, caste system within Hinduism reveals engagement with individuals from lower castes potentially depicts downward mobility, shame and social disintegration, whereas engagement with people from higher castes provides social advancement opportunities.

Similarity and social psychological implications

Social psychological implications of similarity and impression formulation as well as social connectedness were introduced in previous chapters. Friendships and social networks are typically founded amongst people with similar interests and backgrounds. Low levels of minority ethnic populations within community care settings may reflect assumptions of ethnic dissimilarity amongst people living within care which may discourage people from engaging with services. Consequently, relocating into environments with presumed prevalent dissimilarity could reflect difficult and profound challenges. Some studies revealed differing cultural communities including the Jewish community (Bunning & Steel, 2006) provide inclusive and strong social environments for people. Similarly, studies similarly report that minority ethnic older people preferred to socialize with people from their own cultures. For example, Daker-White et al (2002) found from postal surveys and interviews, Polish participants preferred to socialize with other Polish people. From interviews with Chinese older people, Liu (2003) found Chinese older people preferred to socialize where Chinese people gather. Such findings may have important implications for social cohesion, similarity and overall sense of belonging.

Conversely, not being able to socialize with people from similar groups is often cited with loneliness. For example, interview findings showed loneliness was experienced when Nikkei older people lived in setting without other Nikkei people (Machizawa & Lau, 2010). Similarly, life histories depict isolation in care homes due to not being able to talk to anyone (Manthorpe & Moriaty et al, 2010). Isolation was particularly prevalent for recent older immigrants to Australia (Rowland, 2007) and smaller communities from Iraq, Ethiopia and Sudan (Warbuton et al. 2009). Similarly, many people with learning disabilities from African Caribbean communities living in care homes encounter low self esteem due to limited contact with people from similar cultural backgrounds (CVS, 1998; Lewis, 1996).

Social participation expression

Cultures may also differ in expressions of social participation. For example, some people from culturally diverse backgrounds embrace talking loudly, initiate physical intimacy to others and openly request personal information. Conversely, individuals from other cultures may socialize with others within a more subdued, reserved and distant fashion. To socially engage with others contrary to social and cultural etiquette could elicit distress and alienation for some groups. For example, Manthorpe & Moriaty et al (2010) commented some Asian people would talk louder, become more animated and shout which is usual for Asian people, yet in the presence of English people, they were always quieter. Furthermore, some cultures may prefer to socially engage using speech and written forms, whereas people from other cultures prefer to socially engage with music, art, sign language and rely on non verbal communication. Increasingly popular social networking websites depict examples of where some people from westernized developed cultures increasingly communicate. Conversely, people from developing cultures without computerized technology rely on socially communicating in person and within groups rather than through technological mediums.

Social interaction challenges

Participating in social participation presents particular challenges for some minority ethnic communities which may differ for people from majority ethnic groups. First, older migrants may spend most of their time establishing themselves within a new country to assist with newcomers (Thomas, 2003). Second, Warburton et al. (2009) found from Australia that consultation with stakeholders and reviews of literature suggest smaller immigrants may struggle or most recent arrivals may struggle conversely to those with larger established communities and social networks. Third, whilst south Asian societies display characteristics of collectivist communities, migration process and acculturation differences may result in differing social attitudes amongst younger populations than older populations (Ahmad & Atkin, 1996). Fourth, language capabilities as well as racist hostile attitudes may confound social isolation, resulting in south Asian carers caring for adults with learning disabilities as more isolated than their with native peers (Atkin & Ahmad 2000). Fifth, Lee (1999) comments from interviews with older Chinese people recently admitted into care homes within the USA that some older service users preferred to distance themselves from everyone, especially if relocated involuntary. Sixth, Manthorpe & Moriaty et al. (2010) comment from interviews with minority ethnic older people, practitioners, minority ethnic older women become very isolated within families which stipulate that women are prevented to leave homes unaccompanied by a male relative. Seven, findings that older Shin Issei and war brides showed clear preferences and tendencies to interact with fellow Nikkei elders than individuals from other cultural backgrounds (Machizawa & Lau, 2010). Whilst dynamics within care homes typically differ from dynamics within family settings, older women from minority ethnic communities may prefer to stay within services and not socialize within communities, particularly if they feel they would be left to socialize unaccompanied.

Moving to new countries without social networks and contacts may pose more challenges for all, regardless of backgrounds. However, incidents of racial discrimination, language barriers and cultural attitudes associated with gender may make social participation more difficult for minority ethnic communities than people native to Britain.

3.6. Focus on cultural, religious and linguistic needs

So far, this chapter explores cultural considerations surrounding social care outcomes. Content analyses in section 2.10 depicted recent limited community care research investigating culturally diverse populations which suggests research gaps with needs and social care outcomes for minority ethnic and culturally diverse groups. Of the few studies investigating minority ethnic needs, sensitivity to religious and linguistic needs reflects two dominate themes relevant to minority ethnic and diverse cultures.

3.6.1. Religion

This chapter showed how differing cultural and religious beliefs impact definitions, perceptions and experiences of social care outcomes. Chapter two also illuminated significance of religion with adults with learning disabilities and older people more generally.

Sensitivity to non-Christian faiths within services was identified as important from interviews with carers for south Asians with children with disabilities in comparison with white British families (Fatimilehin & Nadirshaw, 1994). Religion is also important for religious identity amongst families with disabled children (Azmi et al. 1997) and young Jewish adults with

learning disabilities (Bunning & Steel, 2006). Some studies depict examples of actual religious participation amongst Muslim older minority ethnic people reported from community workers (Manthorpe & Moriaty et al. 2010). Furthermore, over 50% of families with disabled children participate in religious worship (Azmi et al, 1997). Moreover, Korean older people prioritized religious participation within churches (Hwang, 2008). Given importance of religion amongst some minority ethnic communities calls for sensitivity to non- Christian beliefs and values (Lee, 2007). Nevertheless, case study findings from carers of minority ethnic older people noted incontinence impacted partaking in religious activities (Bowes & Wilkinson, 2003). Despite challenges in religious participation, some people participating in religious worship obtained greater life satisfaction and decreased depression amongst older Korean Americans (Lee, 2007).

Sensitivity to religious needs is also important for quality judgments of services as noted from minority ethnic older people in Bradford (Azam, 2007). Some studies depict evidence of religious sensitivity within community care settings as evident from postal questionnaires with providers note of integrating religious needs project within learning disability services (Starling, Caton, Burton, Azmi & Chapman, 2004) along with religious practices remaining a strong feature of specialist Jewish care homes (Valins, 2002). Other authors include sensitivity to religious worship practices, visits from religious personnel and recognition of cultural and religious festivals within good practice protocols and recommendations for minority ethnic older people (Evans & Cunningham, 1996) and minority ethnic adults with learning disabilities (Azmi et al, 1997). However, other studies depict poor sensitivity to religious beliefs and practices as shown from in depth interviews with minority ethnic Asian older people (Jewson et al. 2003) and short comings within mainstream care including the ability to exercise religious and spiritual beliefs (Patel, 1999).

Determining significance of religious beliefs remains challenging however, given accelerating secularization and acculturation, which may influence affiliation with religious identity. Furthermore, given importance of religion amongst some minority ethnic older people and minority ethnic adults with learning disabilities, generational differences may highlight continued heterogeneity amongst minority ethnic populations.

3.6.2. Language and Communication

Communication is universally applicable across organisms whereby species communicate and announce their existence via verbal, non verbal or written means. Humans possess different dialects, languages and expressions that serve as cultural markers. Communication potentially differentiates groups, illuminates social group membership and poses implications for social membership and identity. Being able to communicate in certain ways, such as being able to read and write, may illuminate social class, power, wealth and rudimentary intelligence markers. Conversely, failing to correctly replicate appropriate communication styles could potentially marginalize, stigmatize and isolate individuals from social groups and inhibit employment and academic advancement.

Cultures possess different rules on social acceptable communication styles whereby, some gestures and symbols portray acceptance and warmth, whereas the same symbols elicit offensive in other cultures (Jones & LeBaron, 2002). Equally, cultures utilize varied written expressions including cave paintings within prehistoric times, symbols and pictograms used amongst Ancient Egyptians, different scripts utilized by different cultures, followed by alphabetized communication styles. Sensitivity to different communicational styles is integral

to effective communication practices and survival. Conversely, assuming superiority of particular communication forms over others potentially oppresses, discriminates and excludes populations.

Equally, communication patterns may differ for religiously observant populations. For example, within more orthodox religious communities, monastic orders and Carthuasian orders, silence or solitude is sought for spiritual purposes. To continually speak in such circumstances may elicit offence and disturb the status quo (Johnson, 2007). Similarly, some religiously observant individuals worship by singing, talking, and writing and silently engage in worship via mediation and silent prayer. To encourage individuals to worship in different ways could alienate and distress some religiously observant individuals.

Good communication with minority ethnic people is necessary for good quality individual care, particularly as many families with learning disabilities from minority ethnic families within limited English comprehension skills (Singh & Orimalade, 2009). Failing to meet language needs directly impacts cultural and spiritual needs (Rawlings-Anderson, 2001). Furthermore, limited availability of translators contributes to the cycle of bad health experiences amongst social care in minority ethnic communities (Butt & Mirza, 1996).

However, significant language barriers were evident from interviews with minority ethnic older people with dementia and their carers (Policy Institute on Ageing and Ethnicity 2004), interviews with Pakistani and Bangladeshi families with severely impaired children (Bywaters, et al. 2003) and encountered by Asian families with relatives with learning disabilities (Nadirshaw, 1997). Similarly, numerous evidence highlights lack of sensitivity to language needs within community care settings. First, lack of sensitivity to language needs within dementia care services within the south west, especially amongst residential and nursing home sectors (Daker-White, Beattie, Means & Giliard 2002; Daker-White, Beattie, Gilliard & Means, 2002). Second, interviews depicted lack of multilingual staff (Bowes et al, 2003). Third, examples from day services revealed none of the minority ethnic people were communicated to due to availability of only English speakers (Manthorpe, Moriarty et al, 2010). Fourth, lunch clubs once a week containing multilingual staff provided the only opportunity for minority ethnic older people to verbally communicate (Manthorpe & Moriaty et al. 2010). Finally, lack of interpretation services from interviews with Asian older people (Jewson et al. 2003).

Availability of translated material in appropriate languages through use of translated leaflets, audio or video cassettes was reported as important in improving awareness and uptake of services from interviews with south Asian carers of adults with learning disabilities (Hatton et al. 1998). However, the existence of translated material within learning disability services is often restricted to hygiene and fertility control and could therefore imply inferior cultural practices (Mir et al. 2001).

Nevertheless, numerous limitations exist with considering translators which warrants consideration. First, mistrusting translators limits translator reliability (Murray, 1992). Second, findings of unprofessional and unethical child translators within learning disability services (O'Hara, 2003). Third, translator unfamiliarity with care home settings for minority ethnic older people (Manthorpe & Moriaty et al, 2010). Fourth, translator censoring noted by older Chinese and Vietnamese immigrants (Ngo-Metzger, Massagli, Clarridge, Manocchia, Davis, Lezzoni & Philips 2006). Fifth, translator censoring of seemingly culturally inappropriate including verbal abuse, sexual behaviour or taboos (O'Hara, 2003). Sixth,

interpreter skills in communicating with people with learning disabilities (Singh & Orimalade, 2009). Seventh, summarizing content rather than representatively disclosing all discussions. Finally, translation is required for some but not all minority ethnic populations.

3.7. Factors influencing culturally sensitive community care service provision

Effectively meeting service users needs depends on numerous factors. As Cambridge (1999:290-291) outlined 'micro-level from the wider elements of the service system, which were potentially relevant to influencing events'. This section explores how other micro, meso and macro level factors potentially influence met needs. Whilst this section considers micro-meso-macro factors separately, factors may interact.

3.7.1. Micro individual level

Chapter one highlighted Carnaby's supporting model and personal centered approaches which centralize individual characteristics including ethnicity, in effectively supporting community care service users. Subsequently, some social care outcome domains pose particular challenges for community care staff given significant challenging behaviour, confusion, dementia and anxiety. Differing factors influencing service provision potentially explains varying culturally sensitive service provision across services. For example, cognitive impairments and high levels of confusion may prevent service users from understanding clothing and personal cleanliness needs. Persistent requests by staff during personal care sessions could result in distress amongst service users, especially if service users built up traumatic memories surrounding personal care. In order to reduce service user distress, staff may abandon morning personal cleanliness sessions. However, to an observer, a visually dirty Muslim female could be seen as highly distressing by Muslim family members considering emphasis of personal cleanliness within Islam.

Furthermore, cultural and ethnic identity variations along with dementia, challenging behaviours, anxiety and confusion may influence individual service user preferences and decisions to comply with cultural and religious considerations. For example, consider a practicing Hindu male with learning disabilities who is heavily influenced by his peers and wishes to try some beef burgers consumed by his peers. As highlighted previously, beef is forbidden within Hinduism, yet this Hindu man may clearly express preferences for beef burgers. Staff may deny this Hindu males requests due to Hinduism beliefs. To go against individuals preferences could elicit distress for this service user especially if he believes staff fail to respect and listen to his requests. In this case, staff may provide this Hindu male with beef burgers in order to reduce onset of challenging behaviours and respect his wishes. Nevertheless, from an outsider perspective, observations of consuming beef burgers by a Hindu inspector maybe met with shock and disgust at the sight of a fellow Hindu consuming beef. Care workers are placed in an ethical and difficult dilemma with respecting service users preferences and also respecting culturally appropriate dietary needs. Furthermore, varying acculturation levels as well as affiliation with cultural identity (Nadirshaw, 1997) may significantly impact affliction with cultural identity which further highlights acknowledgment of heterogeneity amongst minority ethnic populations.

3.7.2. Meso service level

Numerous staffing issues potentially impact lifestyles for service users and explain variations in service user outcomes, lived experiences and cultural diversity sensitivity. First, direct

care staff workloads typically involve multiple tasks including personal care, organizing activities, updating care plans and performing domestic duties. Pressures from senior personnel typically involve completing daily sheets and weekly audits in order to demonstrate compliance with meeting set targets governed by service providers and regional directors. Sensitivity towards needs for minority ethnic groups may depict lower priorities in comparison with meeting targets set by senior personnel.

Second, limited staffing issues may distort culturally sensitive service provision. Shortfalls in recruiting multilingual staff may result in services having to 'make do' with staff on particular rotas. Lengthy delays with criminal record bureau checks for new staff may also influence staffing dynamics and place additional pressures on existing staff. Consequently, monolingual direct care staff remains powerless if faced with service users who prefer to speak in their native language. Furthermore, given shortfalls in recruitment, management may prioritize recruiting people with basic suitable requirements in order to satisfy immediate demands of caring for service users, rather than sensitivity looking at recruiting staff with particular skills such as language abilities. Staff worries and concerns regarding positive discrimination may also influence recruitment processes.

Moreover, given short staffing issues, staff may emphasize completing tasks as quickly as possible in light of any challenging behaviour outbursts. Staff may perceive food separation and separate utensils for different food groups as excessive, time consuming and conflicts with objectives in completing tasks as soon as possible. Furthermore, implementing sensitivity to cultural, religious requirements by using separate utensils and keeping foods separate may be met with resistance from some staff due to challenges, anxieties and stress associated with working with seemingly unpredictable challenging behaviours and psychotic episodes. Costing issues may also result in resistance from staff to utilize additional products to implement culturally appropriate care, particularly given restricted budgets during economic downturns.

Consequently, staffing issues along with varying characteristics of service users may reveal important predictive effects on culturally sensitive service provision; poses difficulties and challenges in implementing person centered service provision and explain variations in sensitivity to cultural needs. Furthermore, given considerable stress caused by working with severe challenging behaviours, care staff may focus on potential cues that predict challenging behaviours. Implementing culturally sensitive service provision may result in resistance and frustration from staff of something else to work with alongside dealing with challenging behaviours. Conversely, in care homes containing less prevalent challenging behaviours, staff maybe more likely to implement culturally sensitive service as their priorities are not otherwise engaged or focused on reducing potential trigger factors for challenging behaviour. Similarly, due to limited and variable training on cultural diversity issues amongst different providers, staff may fail to appreciate that culturally insensitivity may depict key antecedents and trigger factors for challenging behaviours.

Another frequently debated staffing issues concerns availability of minority ethnic staff. Some authors stipulate increasing minority ethnic staff and recruiting minority ethnic staff to support minority ethnic service users yields positive effects on service user admission rates for adults with learning disabilities (Hatton et al. 1998). Matching staff with service user ethnicity has also been requested by Gujarati Asians (Brownfoot Associates, 1998) and considered important for improving uptake amongst older people with dementia (Seabrook & Milne, 2009). Alternatively, lack of minority ethnic staff was cited as admission barriers

(Azmi et al, 1996). Lack of minority ethnic staff within community care services was commented by carers (Poonia & Ward, 1990; Daker-White et al. 2002) including lack of female minority ethnic staff during teenage puberty (Robinson & Stalker, 1992).

Others illuminate several limitations with matching service user ethnicity with staff ethnicity. First, other factors including social class, world views and knowledge of culture reflect more crucial parts of service delivery than ethnicity (O'Hara, 2003). Second, staff from dissimilar backgrounds maybe perceived as less intrusive (O'Hara, 2003). Third, there is no guarantee that language spoken by migrant workers match service users languages (Manthorpe & Moriaty et al. 2010). Fourth, presence of Polish speaking staff triggered traumatic memories for Polish people (Manthorpe & Moriaty et al. 2010). Fifth, minority ethnic staff maybe susceptible to being 'dumped on' by supporting all non white service users (Patel, Mirza, Lindblad, Amstrup & Samaoli, 1998). Finally, minority ethnic staff maybe incorrectly seen as race experts (Azmi et al. 1996) thus discouraging staff from other backgrounds to learn about other cultures and marginalizing bilingual staff (Mir et al. 2001).

National audits of social workforce characteristics (Hussein & Manthorpe, 2012) provide useful ethnicity profile data on frequencies of minority ethnic staff working within social care. Nevertheless, social workforce audits fail to identify relationships between presence of minority ethnic staff and the presence of minority ethnic service users. Ascertaining relationships between presence of minority ethnic staff and presence of minority ethnic service users may improve professional relationships with service users and staff.

3.7.3. Macro societal level

Given widespread macro societal attitudes, researchers are unlikely to obtain reliable insights into macro societal attitudes. However, insight into macro level attitudes is likely to indirectly and directly influence service users lifestyles. Numerous factors at the macro societal level including universalistic attitudes, commitment towards sensitivity to minority cultures and commitment to equality, family attitudes towards community care and service user populations, generational differences and extent of secularism. Macro factors potentially influences definitions and sensitivity to cultural needs, but can be ascertained from how services interact with service users and from family perspectives.

3.8. Service provision and normalization

Chapter two associated normalization with quality of life and wellbeing. Wolfensberger & Nirje (1972) emphasized cultural factors within the original normalization definition, yet culturally normative aspect of normalization generally appears to be neglected from community care research.

Baxter et al. (1990) argued normalization assumes 'white values reflect the norm'. Consequently, needs, wants and wishes of the white majority are considered 'normal' or valued', become part of standard or desired provision and any needs dissimilar from 'white norms' are neglected and ignored. Baxter et al. (1990:15) further comments, concepts central to normalization including having a boyfriend, going to pub/disco and being extrovert typically results in praise and positive feedback by white professionals, yet similar behaviours receive negative attention from some minority ethnic people. Baxter et al. (1990) found concepts associated with normalization including 'living independently', 'relationships with family members, 'leisure time activities' differed for people from the local African-

Caribbean groups and Asian groups conversely to white ethnic managers. Similarly, CVS (1998:30) notes, 'it is hardly normal to be expected to eat egg and chips and wear jeans and a t-shirt in a large predominately white day centre if you happen to come from a traditional Guajarati family'. Similarly, Reading (1999) notes 'it's hardly normal, if religion and spirituality are important to you, to spend most of your time in a secular environment where these issues are either ignored or positively discouraged'.

Normalization and case scenarios

Table 3.6a presents fictional case scenarios illustrating cultural considerations surrounding normalization for service users from different ethnic and cultural backgrounds. Table 3.6 presents characteristics of diverse groups, followed by normality questions and potential questions raised from relocation into mainstream care. Table 3.6b flip this normality point by presenting case scenarios of fictional examples of primarily white British service users relocating to specialist care services. Appendix 7 presents further normalization examples.

Table 3.6a- Case scenarios, normality and mainstream care

	Diverse groups	**Relocation to mainstream care**
Gender and ethnicity	An Orthodox Jewish man spent most of his adult life surrounded by males.	Is it normal to move to a female dominated environment?
Religion and diet	A Sikh woman primarily eats chapattis, chick peas and lentils.	Is it normal to suddenly change to consuming care home menus of egg and chips or fish and chips?
	A Jewish man utilizes separate utensils, cooking equipment and cupboards for diary and meat products	Is it normal to live in environments which use the same utensils, cooking equipment and cupboards for all food groups?
Language needs	A Russian man is verbally fluent in Russian, but cannot understand English at all.	Is it normal to live within an environment where it is not possible to understand the primary language utilized by others?
Activities	An Orthodox Jewish man only watches TV programmes and films that have been approved by a Rabbi. He prefers to watch TV and films depicting Judaism.	Is it normal to live within an environment where the care home plays secular TV programmes such as *The Jeremy Kyle* show which frequently depict promiscuity and debates on child paternity?

Table 3.6b- Case scenarios- normality and specialist care

	White ethnic service users	**Relocation to specialist care home for minority ethnic service users**
Gender and ethnicity	A white British woman spent all of her life living with male relatives.	Is it normal to relocate to a female dominated environment with all south Asian females?
Religion	A Christian woman surrounds herself with images and photos depicting Christianity.	Is it normal to relocate within an environment filled with religious artifacts depicting Hinduism?
Language needs	A White British man only speaks English	Is it normal to relocate to an environment where most people speak Guajarati and very few people speak or understand English?
	A Christian man reads the Bible daily and only reads books written in English.	Is it normal to relocate to environments containing information only presented in Hindi and no information presented in English?
Personal care	A Christian woman bathes daily and washes herself after using the toilet and after prayer.	Is it normal to relocate to environments where people bathe according to restricted bathing timetables set by the care home and with no personal washing facilities for individual use?

3.9. Measurement and culture

Table 3.7 summarizes varying methods which enable access to ethnic and cultural indictors outlined by Thomas (2002). Table 3.7 shows cultural indictors including ethnicity staff, communication styles and needs could be ascertained from various data gathering methods including questionnaires, observations and documents which generally highlight utilization of mixed methods approach. Thomas (2002) further outlines that qualitative methods from interviews and self completion questionnaires provide valuable insights into clients experiences of programs and services and potential conflicts between the cultural styles of service providers and clients.

Table 3.7- Data gathering methods for cultural indicators (Thomas, 2002:54)

	Data gathering methods			
Potential indicators	**Staff questionnaires**	**Service user questionnaires**	**Observation**	**Documents and records**
Content of strategic plan documents and reports	Do they exist? Available to the evaluators? Staff knowledge			Content relevant to cultural appropriateness
Ethnic groups among staff. Cultural competence of staff Attendance at skills training sessions	Staff reports regarding training and competence		Ethnicity of frontline staff	Staff profile. Training program documents
User- friendliness of physical environment Communication styles of front line staff. Culturally component staff for clients. Client satisfaction	Questions about program environment	Client satisfaction including key topics	Description of physical and social environment Observation of staff- client encounters	
Consultants available. Use of consultants for example in supervision and casework meetings	Staff report about how consultants used		Visibility of consultants in program operators	Details of consultants and how used
Needs assessment data Program Audits. Internal monitoring. Client profile. Difference in outcomes	Sources of information about client needs and program impacts	Client satisfaction survey covering program impacts		Audit and other reports. Ethnicity recorded in client data
Communication with consultation with extended families and local communities	Staff reports. Survey of families. Interviews with service providers.	Client reports		Records of consultations
Referrals to or from other agencies. Reasons for referrals.	Staff reports	Client reports		Records of referrals to/from other agencies.

However, interdependence rather than independence amongst collectivist diverse ethnic and cultural groups may influence measurement validity and participant response. People from more interdependent cultures maybe more familiar with discussing their views as a collective response with other family members rather than formulating decisions as individuals ascertained by individualistic measures such as one to one interviews and questionnaires. For people from interdependent cultures, selection of more group based measures such as focus groups may reflect more ecologically valid measures rather than individualized approaches to measurements of quality such as questionnaires and one-to- one interviews. Individualized modes of data collection may elicit unreliable or distorted accounts of reality for collectivist cultures given unfamiliarity with individualized accounts of data collection.

Furthermore, observational approaches may avoid language barriers and relying on unreliable translators. .However, given merits of observations outlined in chapter two, very few studies, utilize observed experiences of minority ethnic service users living in care homes. Most studies exploring minority ethnic service users rely on postal questionnaires and one to one interviews with relatives which potentially portray limited ecological validity in depicting how minority ethnic groups actually experience care homes in real time.

3.9.1. Sensitivity to culturally responsive practice- Measure development

Having conceptualized numerous potential cultural considerations surrounding needs, quality and social care outcomes, as Mir et al. (2001:4) comments, 'what is needed now is commitment to develop services to address those needs'. Drawing from social care domains and additional cultural, religious and linguistic considerations discussed previously, having an understanding of cultural needs and religious laws potentially enables opportunities to ascertain sensitively to cultural needs. For example, for practicing Muslims, accommodation cleanliness is deemed an important part of everyday life. Any evidence of dirty environments ascertained from questionnaires and observations depicts evidence of 'no cultural needs met' in the presence of service users practicing religious beliefs which prioritize cleanliness.

Inspired by Netten and colleagues work on levels of needs, three new levels of cultural need were outlined, namely, 'all cultural needs met', 'some cultural needs met' and no cultural needs. 'All cultural needs met' depicts services responding to all cultural needs, 'some cultural needs' describes some evidence of sensitivity to cultural needs and 'no cultural needs' outlines services with no attempt at meeting cultural needs. 'All cultural needs', 'some cultural needs' and 'no cultural needs' could then be allocated with scores of 2, 1 and 0 respectively for later analyses. Chapter four explores development of this post hoc cultural index in greater detail.

3.10. **Limitations, recommendations and research gaps**

In order to illuminate research gaps and formulate thesis research questions, this section primarily summarizes limitations of relevant community care literature, research recommendations and research gaps of existing community care literature. This section explores populations, design, sampling, methodology and analyses.

3.10.1. Participant populations

.

Of the limited evidence base focusing on minority ethnic experiences of community care settings, most studies typically focus on from one ethnic group including Asian (Hatton et al.

1998), Black (Lewis, 1996) and experiences of dementia for Greek Cypriot and African Caribbean partners (Botsford, Clarke & Gibb, 2011). Emphasizing more prevalent minority ethnic populations is understandable given research parameters and in-depth exploration of themes, needs, experiences and diversity within one group which could generate new interesting research questions. However, focusing on one ethnic group contributes to neglect of failing to consider other minority ethnic groups. Limited UK research explores findings on needs and experiences for people from other non-white minority ethnic groups including Chinese, Middle Eastern as well as white minority ethnic groups including Eastern European, Russia, or for people from other European backgrounds such as from Italy, Greece and France. Consequently, findings may represent particular ethnicities, with little relevance to other ethnic groups. Equally, global homogenizing 'minority ethnic groups' masks heterogeneity within minority ethnic groups. Furthermore, this chapter highlights considerable variability in religious beliefs amongst minority ethnic populations which impacts need conceptualizations and requirements from services.

3.10.2. Design

Researchers typically explore minority ethnic experiences without utilizing comparison groups. Utilizing comparison groups in exploring needs, characteristics and experiences benefits research by exposure of inequalities and disadvantage encountered by some groups (Bhopal & Donaldson 1998:1304; Hatton & Emerson 1999:17). Illuminating inequalities reflects first steps in empowerment practice (Williams et al, 2003) and explores validity of meanings and applicability of measures to different cultural groups (Sue 1999). Furthermore, comparison groups enable testing universality of phenomena, assist with future meta analyses that test the effectiveness of interventions for different ethnic groups, greatly enrich our theoretical understanding of varying cultural groups, and fill important research gaps given neglect of experiences for minority ethnic groups and illuminates minority ethnic homogeneity (Hatton, 2004a). However, limitations of comparative approaches warrant consideration. First, cultural research generates assumptions that only people from minority ethnic groups possess cultural needs (Hatton & Emerson, 1999:17). However, all research can be considered as culturally based, as everyone belongs to a culture (Tillman, 2002:3). Second, such research increases stereotypical views (Ahmad & Atkin, 1996; Hatton, Rivers, Emerson, Kiernan, Reeves, Alborz et al. 1999) and denies socio-economic factors (Hatton et al, 1999). Nevertheless, innovative comparative research and devising strategies to reduce comparative research limitations may produce interesting findings.

3.10.3. Sampling, Methodology and Analyses

Restricting research to particular regions known for prevalent minority ethnic populations contributes to the neglect of people from minority ethnic communities living in areas considered less culturally diverse. Given finding of limited progress for minority ethnic groups living in areas of smaller proportions of older people from minority ethnic groups (Manthorpe, Ilife et al 2009a) highlights the multiregional research. Following Manthorpe, Moriaty et al. (2010), one way of limiting potential geographical variations or potential bias in focusing on regions known for prevalent minority ethnic populations is to utilize data for minority ethnic groups across the UK in order to account for geographically dispersed minority ethnic populations.

Most studies highlighted in this chapter explored needs and experiences of minority ethnic groups within community care settings collected findings from interviews with care home

staff, discussions with service providers, commissioners and service providers at discussion forums and interviews with family members. However, considering recent drives to note the perspectives of care home service users themselves both at the CQC and governmental level as well as increasing moves towards personalization, there is an increasing need to explore the needs and experiences of care homes from the perspectives of care home service users themselves. Ascertaining views from service users themselves may elicit psychological benefits in providing service users with empowerment, happiness and prestige in being singled out by researchers. Furthermore, given extent of social isolation and disengagement reported in chapter two, may allow opportunities and therapeutic advances for service users to vent out frustrations and provide social engagement opportunities which maybe particularly lacking.

Methodology

Researchers typically explore quality findings for minority ethnic groups using either qualitative approaches or questionnaires. In addition, as most studies explored sensitivity to minority cultural needs through use of questionnaires, interviews and focus groups, no or very few studies have applied an observational approach to assess whether care homes were sensitive to the needs of care home service users from minority cultural groups. Predominately utilizing questionnaires and interviews lacks ecological validity, in that findings arguably fail to reflect real-life daily situations within community care settings. An observational approach may clearly identify whether care home staff were sensitivity considering needs and experiences for culturally diverse service users in real time.

Analysis

A further limitation of qualitative research with interviews and discussion groups with providers concerns lack of qualitative analyses techniques, including thematic approaches to explore qualitative data. Even fewer studies into qualitative experiences of minority cultural service users living in care homes apply reliability checks to validate qualitative data analyses.

3.11. Refining the research agenda

Coinciding with the above limitations of previous research and research recommendations, this leads to numerous considerations in refining the research agenda.

3.11.1. Research gaps

Gaps on characteristics of service users, staff and care homes as well needs and experiences of minority ethnic groups living in care homes. To the best of our knowledge, no observational work exists on sensitivity to cultural needs within care homes for adults with learning disabilities and older people. Furthermore, researcher generally fails to undertake qualitative research to unpack meanings of cultural needs.

3.11.2. Population considerations

Population considerations include the following. First, integrating varied minority ethnic populations, including non white minority ethnic groups and white minority ethnic groups. Second, drawing from data collected from adults with learning disability and older people

care homes. Third, extracting information from varied populations including service user themselves, relatives and from key worker staff.

3.11.3. Design

Utilizing comparison groups by comparing findings for people from white ethnic groups with people from minority non-white minority ethnic populations to help anchor and illuminating minority ethnic experiences. Furthermore, considering impact of cultural factors at the micro, meso and macro levels depicts a more comprehensive coverage of cultural considering within community care research given that most studies seem to focus on singular levels.

3.11.4. Sampling, Methodology and Analyses

Collecting data from across the UK and utilizing mixed methods research could avoid limitations of geographical variations and limitations of mono- methods research. . Development of questionnaire and observational tools to assess competency of care home staff in responding to the cultural, religious and linguistic needs of minority ethnic groups living in care homes.

3.11.5. **Preliminary ground work**

Preliminary ground work was undertaken before implementing this research into practice. First, debates on specialist versus mainstream care homes requires some preliminary work into the numbers of specialist care homes for adults with learning disability and older people which specialize in providing care for minority ethnic populations. Chapter one presented a specialist care homes review of UK care homes to explore the extent and prevalence of specialist homes. This directory could be used as a resource to collect information on needs and experiences for minority ethnic groups living in care homes and could avoid limitations of accessing hard to reach minority ethnic populations. Second, in accessing minority ethnic communities, recruitment of minority ethnic translators will be necessary, especially with minority ethnic older people who may have had limited acculturation experiences and language training. Third, developing contacts and networks with organizations across the UK may improve access to minority ethnic communities, resources and utilize expertise and knowledge from experienced professionals, particularly in light of any gate keeping issues. Fourth, linking with other large care home studies allows opportunities to obtain large samples of minority ethnic groups. Fifth, measurement tool development used to assess cultural sensitivity may require meetings with various organizations and professionals which may pose practical, ethical and financial constraints.

3.12. Thesis aims and objectives

This PhD research originates from two primary concerns. First, lack of research conducted with minority ethnic adults with learning disabilities and minority ethnic older people living in care homes. Second, continued lack of sensitivity to the needs and lived experiences of minority ethnic people living in care homes for adults with learning disabilities and care homes for older people. This thesis primarily aimed to generate awareness and debate in meeting the needs of minority ethnic populations and to illuminate experiences of care homes for minority ethnic groups.

3.13. Research approach, research questions and research models

Chapter one and two showed the MOPSU study collected data on care home, staff and service user characteristics along with data on service quality, social care outcomes and associated quality of life indicators adults with learning disabilities and older people living in care homes. Linking data collection from this thesis with data from MOPSU study, allowed exploration of characteristics for minority ethnic service users, care homes and care home staff as well as the lived experiences of minority ethnic groups living within both learning disability and older people care homes. It also allowed opportunities to integrate new designed measures investigating competency in sensitivity to cultural needs and collect findings on sensitivity to cultural needs within care homes across England.

Integrating part of the current thesis data collection with the larger MOPSU study enabled three opportunities. First, reporting findings on people from minority ethnic groups living in care homes from across England potentially limits geographical variations biases and limitations of focusing on one geographical area. Second, describing findings from adults with learning disabilities and older people reflects new contributions to community care knowledge, as to the best of our knowledge, no other published study collected findings from minority ethnic populations living in care homes for adults with learning disabilities and care homes for older people and noted comparisons in needs and experiences between the two population groups. Third, integration of new questionnaire and observational measures on cultural needs and sensitivity to cultural needs integrated into the MOPSU study, enabled opportunities to collect information from large care home samples for adults with learning disabilities and older people. To the best of our knowledge, very few empirical studies, if any, utilized structured quantitative observation of care home practices to investigate cultural sensitivity of minority ethnic groups for adults with learning disabilities and minority ethnic older people living in care homes. Without the support and agreement from primary investigators from the MOPSU study, the above research agenda aims would have exceeded the capacity and resources of an individual PhD candidate. Furthermore, given support from numerous organizational bodies including the CQC, allowed access to larger care homes samples and therefore makes this study unique.

However, it was also intended to conduct work separately from the MOPSU study. Large scale studies such as the MOPSU study benefit in shear scope and potential for generating large pools of information. However, large scale projects pose constraints with funding, fieldworker resources, primary objectives along with restrictive agendas set by funding bodies. Conducting work external to the MOPSU study allowed greater flexibility, scope for integrating and refining more personalized research agendas, arguably more control of data collection, data cleaning and data analysis and opportunities to develop sophisticated advanced research skills.

Research questions and research models

This study addresses two overall groups of research questions. First research questions surrounding characteristics of service users, care homes and care staff. Second, research questions exploring defining cultural needs and sensitivity to cultural needs.

3.13.1. Characteristics of service users, care homes and care home staff

1. **Research question 1 (RQ1)**

   - Were there any variations in service user characteristics for non-white minority ethnic care home service users in comparison with white ethnic care home service users?
   - Were there any variations in service user characteristics for service users from differing minority ethnic groups?

2. **Research question 2 (RQ2)**
   - Were there any variations staff characteristics in care homes containing at least one non-white minority ethnic service users in comparison with care homes containing only white ethnic service users?
   - Were there any variations in staff ethnicity in relation to service user ethnicity?

Supplementary research question (SupRQ)

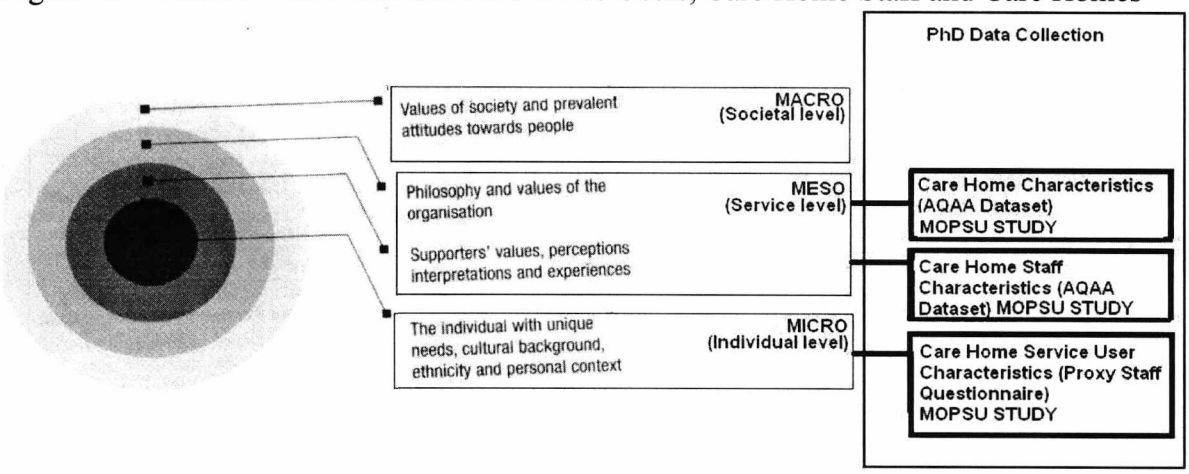
A supplementary objective with RQ1 and RQ2 involved investigating differences between learning disability and older people care homes on service user characteristics and care home workforce data.

- Were there any variations in characteristics for care homes, care home staff and service users between earning disability and older people services?

Presence of any significant differences between learning disability and older people services were utilized as evidence to conduct separate analyses for learning disability and older people services.

Figure 3.1 summarizes how RQ1 and RQ2 maps onto Carnaby's layers of influence model as well as micro and meso factors outlined in section 1.1. Figure 3.1 shows characteristics for service users, care home staff and care homes were collected from MOPSU study through proxy questionnaires and care home datasets completed by the care home including Annual Quality Assessment (AQAA).

Figure 3.1 – Model- Characteristics for Service Users, Care Home Staff and Care Homes



3.13.2. Cultural needs and sensitive community care service provision

3. Research question 3 (RQ3)

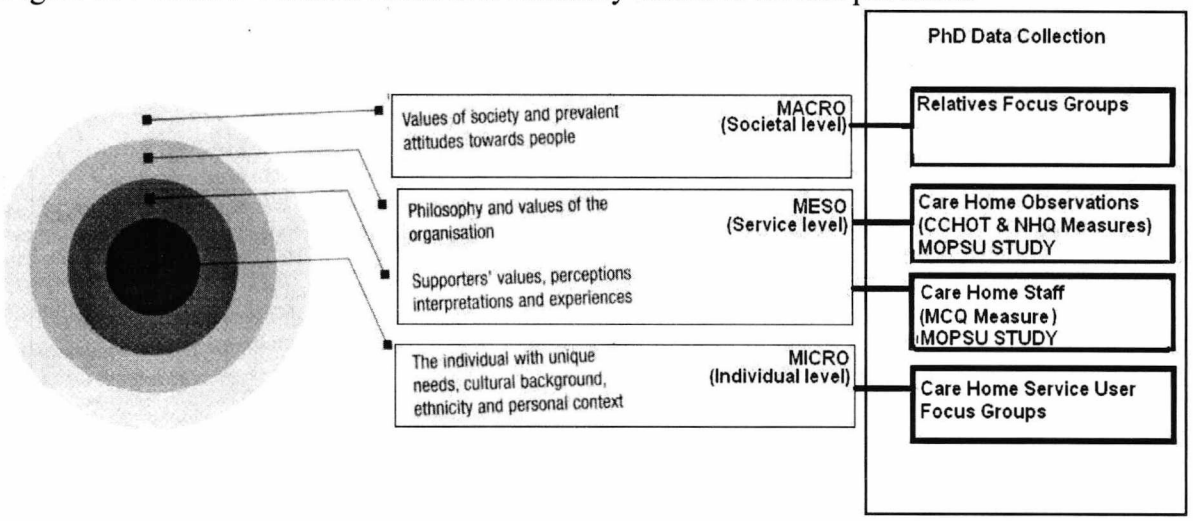
- How did older non-white minority ethnic care home service users and their relatives define 'cultural needs' and experience care homes?

4. Research question 4 (RQ4)

- Did staff working within care homes for adults with learning disabilities and care homes for older people respond to the cultural, religious and linguistic needs of minority ethnic care home service users?

Figure 3.2 summarizes how RQ3 and RQ4 maps onto Carnaby's layers of influence model and macro, meso and micro factors. Figure 3.2 shows cultural needs and sensitivity to cultural needs were collected from focus groups with relatives and service users as well as from staff proxy questionnaires and observations collected from the MOPSU study. The Minority Cultural Questionnaire (MCNQ) and the Cultural Care Home Observational Toolkit (CCHOT) were designed by the author and integrated into the MOPSU study.

Figure 3.2- Model- Cultural needs and culturally sensitive service provision



3.14. Conclusion

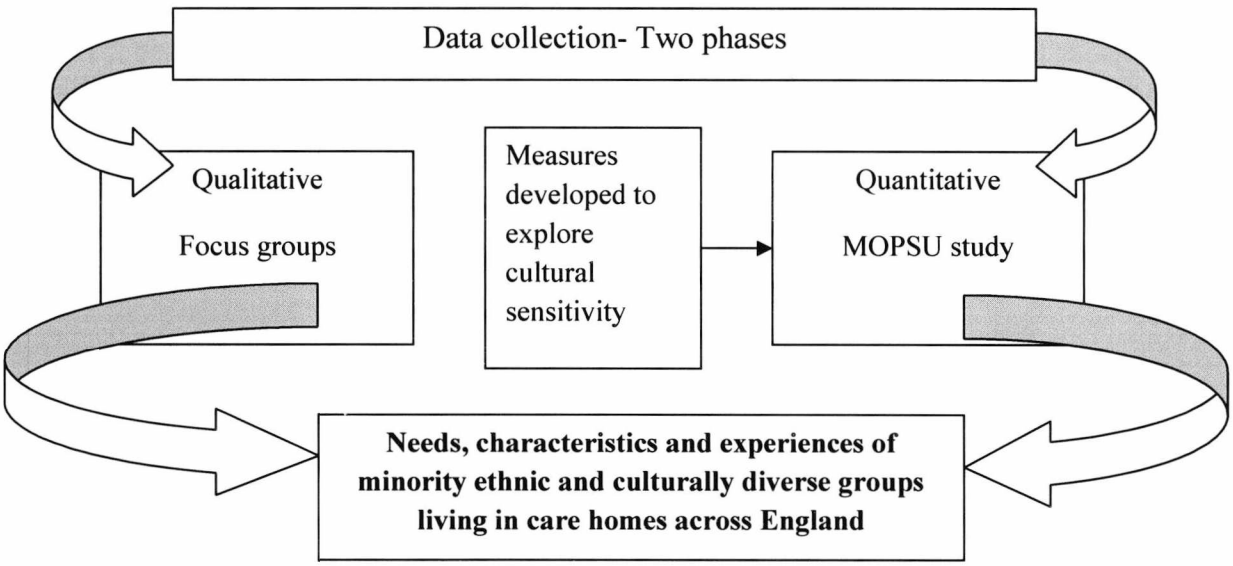
This chapter explores cultural considerations surrounding social care domains. This chapter considers various micro, meso and macro factors which poses challenges in implementing effective community care. This chapter outlined how key social care domains including engagement, choice, social participation and meals depict relevance and significance for ethnically and culturally diverse groups. Findings relating to language and religion also illuminate significant areas for minority ethnic populations. To disregard individual differences and cultural aspirations surrounding social care outcomes may confound service user outcomes quality of life and wellbeing. This chapter further highlights considerable heterogeneity between and within minority ethnic groups which highlights challenges for service users, justifies implementing person centered approaches. This chapter concluded with research questions and models which overall aim to fill a neglected research gap into needs, characteristics and experiences of minority ethnic adults with learning disabilities and minority ethnic older people living in care homes.

4. Chapter Four- Methodology

4.1 Introduction

Previous chapters revealed limited evidence surrounding needs, characteristics and lived experiences of care homes in England for minority ethnic adults with learning disabilities and minority ethnic older people. Extracting data from the MOPSU study and focus groups enabled unique opportunities to address a research gap on the needs, characteristics and experiences of minority ethnic adults with learning disabilities and minority older people living in care homes. Specifically, whether needs and characteristics differed for non-white minority ethnic groups in comparison with white ethnic groups living in learning disability and older people care homes and whether care home staff implemented culturally sensitive service provision. Figure 4.1 presents an overview of the current study. Figure 4.1 resembles a 'two pronged' attack in exploring significance of culture within community care research.

Figure 4.1- Overview of investigation strategy



Originally, it was intended to follow Hatton (2004a) recommendations of firstly conducting an emic study to explore different diverse cultures in detail, followed by an etic study to compare findings from different diverse cultures. The original objective involved implementing an emic qualitative phase to identify themes important for minority ethnic groups in order to develop measurement tools. It was then intended to conduct an etic study utilizing quantitative data collected from the MOPSU study. However, due to focus group delays during the initial research stages, increasing time constraints and demands of the MOPSU study, as shown from Figure 4.1, the quantitative and qualitative phases were conducted independently.

Developing measures independently from focus groups depicts acknowledged limitations with this PhD research. However, developing measures from previous research findings illuminates two advantages. First, designing tools from previous research enables access to opinions, thoughts and findings from numerous authors with years of professional experience within the UK and internationally. Second, independence of quantitative and qualitative approaches allowed in-depth exploration of the significance of culture in community care from two different methodological standpoints. Furthermore, the independent quantitative

and qualitative phase potentially enabled greater exploration of key topics. Moreover, as this thesis addresses a relatively neglected gap within community care research, this thesis depicts an explorative study into the significance of cultural considerations in community care research.

4.2 Method justification

This thesis reports findings from two phases. First, findings collected from the MOPSU study via observations, questionnaires and staff proxy questionnaires. For the purposes of exploring care home sensitivity to cultural needs, observational tools, staff questionnaire tools were developed by the author and integrated into the MOPSU study. Second, separately from the MOPSU study, focus groups enabled qualitative exploration of south Asian and African Caribbean perspectives.

Observation, proxy questionnaires and focus groups

Chapter two reviewed notable observational advantages including reporting findings on actual observed interactions between staff and service users. Moreover, proxy benefits include insights and unique in-depth knowledge of particular service users. Furthermore, focus groups enabled group interactive discussions on relevant issues.

Mixed methods approach

This thesis utilizes mixed methods which enables access to an arguably fuller picture conversely to mono method research (Barker, 1984). Others highlight the superiority of mixed methods conversely to mono-method research (Johnson, Onwuegbuzie & Turner, 2007). As Hatton et al. (1995) note, evaluation reviews (Emerson & Hatton, 1994) and quality of life literature (Felce & Perry, 1995a) highlight benefits of multiple measures in providing comprehensive accounts of service outcomes. Similarly, Schalock (2004b) comments mixed method research is important for measuring quality of life. Furthermore, Tashakkori & Teddlie (2002) notes, collection and combination of quantitative and qualitative data benefits from neutralizing sizeable method disadvantages.

Other considered measures

Case studies, life histories and in-depth unstructured interviews methods were initially considered to investigate thesis aims. Case studies depict detailed examinations of single institutions, communities or social groups. Nevertheless, case studies occasionally ignore interaction qualities and benefits ascertainable from focus groups. Life histories reflect particular case studies depicting insights into varying lifestyles. Life histories benefit from building pictures of how individuals construct their own world. Yet, cognitive and memory impairments typically encountered by some care home service users may confound the viability of life histories. Similarly, numerous studies highlighting unreliability of eye witness testimonies (Christianson, 1992; Loftus, 1975; Robinson & Johnson, 1996) further illuminate life history limitations. Unstructured in-depth interviews were considered, but later rejected due to constraints on coding, transcribing and over reliance on interpreters. Given limitations associated with case studies, life histories and interviews, these thesis reports findings from observations, questionnaires and focus groups.

4.3 Overview of research approach

Table 4.1 presents an overview of research questions, data collection source and relevant finding chapters. Table 4.1 shows the MOPSU study and focus groups enabled exploration of research questions into needs, characteristics and experiences of minority ethnic people living in care homes. An acknowledged limitation of this thesis concerns the sizeable percentage of data collection collected from the MOPSU study. However, as shown from Table 4.1, focus groups conducted separately from the MOPSU study, remained instrumental for investigating research questions.

Table 4.1- Research questions, mode of data collection and findings chapters

Research questions		**Data collection**	**Chapter**
1. Characteristics of care homes, care staff and care home service users			
RQ1	Were there any variations in demographics and physical, social and cognitive needs from non-white minority ethnic care home service users in comparison with white ethnic care home service users?	MOPSU study	5
RQ2	Were there any variations in care home and staff characteristics in care homes containing at least one non-white minority ethnic service user in comparison with care homes containing only white ethnic service users? Were there any variations in staff ethnicity in relation to service user ethnicity?		
SupRQ	Were there any variations in characteristics for care homes, care home staff and service users differ between learning disabilities and older people?		
2. Cultural needs and sensitivity community care service provision			
RQ3	How did older non-white minority ethnic care home service users and their relatives define 'cultural needs' and experience care homes?	Focus groups	6
RQ4	Did staff working within care homes for adults with learning disabilities and care homes for older people respond to the cultural, religious and linguistic needs of minority ethnic care home service users?	Focus groups	6
		MOPSU study	7

4.4 . Theoretical underpinnings

The universalist paradigm typically explores the impact of culture on needs, characteristics and experiences and remained instrumental throughout the research process. Findings from this thesis enable insights into multiculturalism which emphasized acceptance and respect for varied cultural needs across varied social groups. Conversely, integration and assimilation perspectives promote expectations of integrating and modifying cultural beliefs in order to comply with mainstream culture. However, postmodernists question the viability and reality of mainstream culture given varying levels of societal approaches and viewpoints. Yet, postmodernist ideologies highlighting a lack of mainstream culture poses limits in deriving comparison groups for research analyses. The anti-racist view takes a rather extreme viewpoint of inherent ingrained racism within society. Nevertheless, findings from this thesis may support anti-racist ideologies of potentially exposing racism within different institutions.

Furthermore, qualitative thesis findings potentially support postmodernist views by providing a voice for South Asian and African-Caribbean people. This thesis entails initial support for postmodernist ideologies given thesis emphasis on heterogeneity and illumination of different viewpoints of populations. Thesis emphasis on individual experiences arguably relates to current polices depicting person-centered approaches, along with individual liberation in exploring varying viewpoints.

4.5 . Ethical considerations

In 2007, the Tizard Centre Research Ethics Committee at the University of Kent granted ethics approval for the MOPSU study and this PhD research. Participant consent was obtained from as many service users as possible, using adapted consent forms and project information forms. Where informed consent was unobtainable from service users themselves, consent was obtained via proxy either from family relatives or key worker staff. Any behavioural indications depicting distress, anxiety and uncomfortable feelings amongst service users was used as evidence of withdrawal of consent and prompt termination of research participation. To ensure confidentiality, only authors and researchers involved with the MOPSU study accessed project material and research findings. Prior to data collection, participants were informed their participation was completely voluntary and they had the right to terminate research participation at any time.

4.6 MOPSU study

4.6.1 Care homes

The MOPSU study collected findings from care homes with a range of home types, service user characteristics and dependency. Principle investigators of the MOPSU study aimed to achieve a final sample of 200 care homes including 100 care homes for older people and 100 care homes for people with learning disabilities. Data collection covered four UK geographical regions including the North West, West Midlands, London and South East. Care homes with recent CQC inspections and care homes with forthcoming inspections during January and December 2008 were used as initial eligibility criteria. As shown from Table 4.2, from a sample of 444 homes, data was collected from 173 homes which represented a response rate of 39 per cent. Care homes for adults with learning disability homes had a higher research response rate than care homes for older people, reflecting 43 % and 35 % respectively.

Table 4.2- Care homes and response rate- MOPSU study (Netten et al, 2010:15).

	Care homes for adults with learning disabilities	Care homes for older people	All homes- Care homes for adults with learning disabilities and care homes for older people
Selected sample	209	235	444
Consent to participate not obtained	119	151	270
Later dropped out	0	1	1
Responding homes	90	83	173
Response rate	43	35	39

Considering this thesis objective of exploring the needs, characteristics and experiences of care homes for people from minority ethnic and culturally diverse backgrounds, any care home without ethnicity data for service users were largely excluded from the analysis. A small proportion of care homes were defined as specialist care homes including, ten care homes provided specialist care for practicing Christians and three care homes provided care for observant Jewish service users. From the specialist care homes identified across England as outlined in section 1.9 and appendix 12, this reflects 5.6% of Christian homes and 5.3% of Jewish homes nationally.

4.6.2 Participants

Initial sample size estimates included 500 adults with learning disabilities 500 older people. Due to variations in occupancy and staffing ratios within care homes, care home staff frequency typically depended upon care home size. Eligibility participant criteria included permanent service users living within care homes for adults with learning disabilities and care homes for older people. Respite service users were excluded.

Focal and non focal samples

The MOPSU study collected findings on service user characteristics, service quality and social care outcomes from each care home. Furthermore, the MOPSU study collected detailed service user data from up to five service users, hereafter defined as the focal sample.

The five focal service users were selected using stratified sampling from each of the consenting homes Annual Quality Assurance Assessment (AQAA). The AQAA reflects a compulsory two part form including a self-assessment and data set. The AQAA is a compulsory requirement from CQC completed by all care home managers. The AQAA contains a table within the data set part which illustrates service facts and figures. This table lists up to twenty five service users using individual codes rather than service user names. The care home manager allocates basic information on each service user including demographical data, such as age and ethnicity.

After initial conversations with care home managers to ascertain interest and consent, PSSRU researchers requested the AQAA forms from each care home manager. Using stratified random sampling, researchers at the PSSRU utilized the AQAA to select five focal service users. Given the research aims of this PhD, depending on demographical composition of service users within each care home, a sampling bias was implemented which involved selecting at least one minority ethnic service user for the focal sample from each care home AQAA. here service users or their representatives withdrew their consent; PSSRU researchers replaced service users with other service users from each AQAA. Detailed questionnaires and observational measures were collected from each of the consenting five focal service users per home only. All focal service users were identified by unique codes for later data analyses.

Non focal sample

In order to establish an insight into non focal service users within each care home, basic information was collected from all other service users identified from the AQAA. Initial data included demographical data including age, ethnicity and gender along with initial questions on physical dependencies.

4.6.3 Measures

4.6.3.1 Measures- MOPSU study

The MOPSU study collected finings on service user characteristics, service quality and service user outcomes from questionnaires, semi-structured interviews and overt observational methods. Table 4.3 summarises a selection of measures utilized within the MOPSU study and depicts findings reported in this thesis. Netten et al (2012) provides a complete profile of all MOPSU measures. Information on cultural needs and sensitivity to cultural needs were developed by the author and integrated into the MOPSU study.

Table 4.3. MOPSU study- measure overview.

Themes	MOPSU measure
Service user characteristics	All service user participants • Demographical questions, age, gender, ethnicity • Service user impairments • Measures of dependency including a number of Activity of Daily Living (ADL) from the Barthel index (Mahoney & Barthel, 1965) and cognition from the Minimum Data Set Cognitive Performance Scale (MDS-CPS) (Morris, Fries, Mehr, Hawes, Philips & Lipsitz, 1994).
	Measures of dependency for adults with learning disabilities only. • Short Adaptive Behaviour Scale- SABS (Hatton, Emerson, Robertson, Gregory, Kessissoglou, Perry et al. 2001). • Quality of Social Interaction question originally taken from the Schedule of Handicaps, Behaviours and Skills (Wing & Gould, 1978). • Aberrant Behaviour Checklist- ABC (Amman & Singh 1986; Aman, Burrow & Wolford, 1995) and a series of communication questions.
Care Home and Staff characteristics	• Home AQAA. Care home, staff characteristics and demographical information for a sample of care home service users within each care home.
Care home environmental and service quality characteristics	• Homelikeness Scale, obtained from the Revised Residential Services Setting Questionnaire (Welsh Centre for Learning Disabilities, 2003). • Selected questions from the *Nursing Home Care Quality Instrument* (adapted) (Rantz, Mehr, Petroski, Madsen, Popejoy, Hicks et al. 2002; Aud, Rantz, Zwygart- Stauffacher & Manion, 2004). • Questions from the Therapeutic Environment Screening Survey for Nursing homes (Sloane, Mitchell, Weisman, Zimmerman, Foley, Lynn et al, 2002).
Cultural needs	• Minority Cultural Questionnaire (MCNQ) • Cultural Care Home Observational Toolkit (CCHOT) *Developed by the author and integrated into the MOPSU study.*

1. **Service user characteristics**

Focal service users

Characteristic measures for focal service users included questions on age, ethnicity, impairments, health status, physical and cognitive factors, mobility along with care and nursing needs.

Adaptive behaviour, social impairment and challenging behaviour

Adaptive behaviour, social impairment and challenging behaviour were collected for adults with learning disabilities only. Adaptive behaviour was measured by the Short The Short form of the Adaptive Behavior Scale (SABS) Part 1 (Hatton et al. 2001; Nihira, Leland & Lambert, 1993). Dichotomous classifications of social impairment were obtained from the Quality of Social Impairment question from the Schedule of Handicaps Behaviours and Skill (Wing & Gould, 1978). Finally, the Aberrant Behaviour Checklist (ABC) (Aman et al. 1995) assessed challenging behaviour.

Physical dependencies, cognitive impairments and psychopathology

Information on ADL continence, mobility and instrumental activities of daily living (IADLs) were used in a number of studies (Darton 1998; Wittenberg, Pickard, Comas-Herrer, Davies & Darton, 2000). The Barthel dependency measure (Mahoney & Barthel 1965) assessed physical dependency. The Minimum Data Set Cognitive Performance Scale (MDS-CPS) (Morris, et al. 1994), was developed for older people with cognitive impairment and validated against the mini-mental state examination. Moreover, an added dichotomous question on short term memory was added along with two psychopathology items on anxiety and depression used in previous research (Darton, 1998). Data on physical dependencies, cognitive impairments and psychopathology items were collected for both adults with learning disabilities and older people.

Non focal sample

In order to ensure that the five focal service users were representative in terms of age, health and social care needs, less detailed service users characteristics were collected from the non focal sample via the shorter 'AQAA questionnaire. The AQAA questionnaire collected information from up to 15 other service users identified from each care home AQAA. The AQAA questionnaire items included data on age, ethnicity, ADLs and MDS and psychopathology. As with all participants, all service user information identified from the AQAA was annoymised and did not contain any identifying information including names, date of birth.

All service users

The AQAA dataset for each care home contained numbers of service users within the entire care home, including demographical information on ethnicity. Data from all service users obtained from the AQAA data set within the entire care home was defined as the 'AQAA sample'. The AQAA sample provided a more complete ethnicity profile of all care home service users within each care home. This AQAA sample was used to work out the following grouping variables for later analyses. First, care homes containing at least one minority ethnic service user. Second, care homes containing service users from white ethnic groups only. Third, care homes containing at least one service user from a south Asian background. Fourth, care homes containing at least one service user from a black ethnic background. Finally, care homes containing at least one service user from an 'other' ethnicity category. Percentages of service users from ethnic groups per care home were calculated from the total number of service users per home. However, differences in timing between when the AQAA data set was completed and when the MOPSU measures were collected may not have

provided a completely accurate ethnicity profile of care home service users. However, the AQAA sample provided a comprehensive profile of ethnicity data than the selected samples from the focal and non focal samples.

2. **Care home and staff characteristics**

For each care home, the AQAA dataset included information on care home and staff characteristics. Care home characteristics included region, status and private or public funding source. Staffing characteristics included details on ethnicity, frequencies of full time staff, part time staff along with demographical details of age and gender. Other staff characteristics included number of staff with national vocational qualifications (NVQ) over level 2, number of qualified nurse hours provided in the week, care staff hours provided for personal care in the week, care staff hours for support not personal care in the week, and other staff providing support in the last week.

3. **Environmental characteristics**

Environmental characteristics were primarily obtained from the observational Homelikness Scale (Welsh Centre for Learning Disabilities, 2003). The Homelikness Scale assessed whether bedrooms, living and dining rooms, bathrooms and gardens depicted homelike environments. Furthermore, environmental characteristics items from the observable indicators of *Nursing Home Care Quality Instrument* (Rantz et al. 2002; Aud et al. 2004) collected data on environmental characteristics. The term Nursing Home Quality Scale (NHQS) was used for the environmental adapted scale. Questions from the *Therapeutic Environment Screening Survey for Nursing Homes* (Sloane et al. 2002) assessed environment safety by including observation questions on slippery surfaces, presence of handrails and comfortable temperatures.

4. **Sensitivity to cultural needs**

Measures designed to ascertain information on sensitivity to cultural needs was ascertainable from literature reviews, discussions with minority ethnic organisations and exploration of needs as outlined through religious texts. Chapter three presented detailed information on cultural considerations surrounding social care outcomes and provided the necessary foundation for measuring sensitivity to cultural needs. Two minority ethnic measures were integrated into the MOPSU study, namely the Minority Cultural Needs Questionnaire (MCNQ) and the Cultural Care Home Observational Toolkit (CCHOT). Appendix 10 presents the MCNQ and appendix 11 presents the CCHOT and CCHOT guidance material.

Minority Cultural Need Questionnaire (MCNQ)

The Minority Cultural Need Questionnaire (MCNQ) is a staff administered self report tool designed to ascertain information on service user ethnicity, religious belief and practice, language comprehension and other needs in relation to skin and hair care. The MCNQ enables a preliminary insight into minority cultural needs for care home service users. The MCNQ provided some initial baseline information on service users cultural needs, namely, ethnicity, religious belief and language requirements. Care home staff completed the MCNQ for any service users with ethnic backgrounds other than white British. This initial information from the MCNQ enabled identification of specific cultural needs which prompted fieldworkers to consider specific sections within the CCHOT observational tool.

The MCNQ is divided into three sections including, Section A depicting communication needs, Section B listing religious beliefs and Section C outlining additional needs.

Communication needs- Section A

The communication needs section included questions on service users main language along with levels of understanding and comprehension with English. These questions could provide preliminary insights into the potential isolation and loneliness of an individual within a predominately English speaking world.

Religious needs- Section B.

The religious needs section consists of questions relating to religious beliefs. As outlined in previous chapters, each religion promotes varied religious doctrines. Service users religion and participation in worship identified from the MCNQ immediately alerts the fieldworker of consideration of particular cultural needs associated with particular religions.

Additional needs Section C

Section C outlines questions on 'additional needs' designed to ascertain information on dietary requirements, skin and hair products, clothing requirements, and social participation activities. Depending on minority ethnic backgrounds, specific questions will apply in order to initially explore sensitivity to cultural needs.

Cultural Care Home Observational Toolkit (CCHOT)

The CCHOT depicts an overt observational tool designed to ascertain sensitivity to cultural needs amongst care home staff practices and general care home observations. Specifically whether cultural needs identified from the MCNQ, in terms of language, religious and additional needs, were sensitively addressed by care home staff. In conjunction with the CCHOT measure a guidance manual was developed which provides further insights, clues and prompts from observers to collect information indicating sensitivity to cultural needs. Appendix 11 presents the CCHOT. The CCHOT is divided into five sections. The first CCHOT section explores the quality of staff supports and cultural needs.

The first section includes questions on whether quality of staff support differs between minority ethnic service users and other service users. This section includes questions on dignity and respect, communication, staff knowledge and teamwork. The second section ascertains whether aspects of the physical care home environment sensitively adhered to cultural needs, particularly with service users religious belief. Questions focused on location of religious items, bathroom facilities, and prayer locations. The third CCHOT section includes detailed questions on the quality of care for culturally diverse groups. Questions focused on personal cleanliness, privacy, personal care, questions on clothing for male and female service users. The clothing sections were especially detailed to ascertain the dress codes for both male and female service users. Clothing items included a description of clothing type, anatomical coverage, ascertaining whether clothes were tight fit or loose fit and anatomical obscurity that is the transparency of clothing items. The fourth CCHOT section includes observational questions on health and nutrition, particularly on types of foods consumed, meal preparations and meal times. The final CCHOT section explores sensitivity

to religious practice and worship and whether care home staff celebrated religious festivals for religiously observant service users.

Appendix 11 shows the CCHOT guidance manual which accompanies the CCHOT measure. For each of the CCHOT questions, the CCHOT guidance material provides descriptions, tables, and pictorial information relating to cultural needs. Along with prompts and examples of observations within care homes which indicate sensitivity to cultural needs.

4.6.3.2 Post hoc measures- Cultural Index

Given a key aim of the current study was to explore cultural needs and sensitivity to cultural needs for minority ethnic populations living within care homes, a post hoc *Cultural Index* (CI) was devised and applied to relevant findings. The CI converts selected questions from the MCNQ and from other MOPSU observational tools into sensitivity to cultural needs quantitative cultural index score.

The MCNQ was used as a baseline measure to ascertain extent of cultural needs, religious participation and language comprehension. In conjunction with service user needs, a three point scale was integrated to each question indicating information on sensitivity to cultural needs. Generally, lower scores on the CI indicate lack of sensitivity to cultural needs and higher scores indicate sensitivity to cultural needs. For example, questions from the MCNQ included extent of language and religion participation. The CI converts observational findings from MOPSU observational tools into a three point scale of 0 indicating 'no cultural needs met', score of one for 'some cultural needs met' and a score of two for 'all cultural needs met'. The CI allocates a three point scale rating to each question depicting information to sensitivity to cultural needs.

For example, in the case of religiously observant individuals identified from the MCNQ , high levels of personal cleanliness, culturally appropriate diet requirements, appropriate modest dress codes and high sensitivity to religious needs received the maximum score of 2 reflecting 'all cultural needs met' for each question. Conversely, likert responses from the overt observational toolkit that reflected no evidence of culturally specific needs would receive a minimum score of zero reflecting 'no cultural needs met'. An example of 'no cultural needs met' would be serving pork to a religiously observant Muslim male. Other examples include providing no translator for multilingual service users. Likert items from MOPSU measures which produced findings in between the two end points of 'no cultural needs met' and 'all cultural needs met' were defined as 'some cultural needs met'. Decisions surrounding whether 'all cultural needs met', 'some cultural needs met' and 'no cultural needs met' were primarily governed by literature reviews of religious doctrines outlined in chapter three.

However, an acknowledged limitation of exploration of cultural needs for religiously diverse groups is that in practice, overt observations that appeared to be associated with 'no cultural needs met' such as observation of consumption of 'harem' or forbidden foods or drinks such as pork and alcohol drinks for Muslim service users may reflect individual preferences. Furthermore, as outlined in chapter three, for some particularly vulnerable groups, service users from religiously diverse groups may not practice particular cultural needs due to illness and degree of impairment. Any evidence of individual choice, individual preference or information indicating lack of compliance to religious practice were taken into account whilst

ascertaining care home staff sensitivity met the needs of minority ethnic and culturally diverse service users.

The CI was divided into three sections which included a cultural index for service users for whom English was not their first language (CI-FL), a cultural index for religiously diverse (CI-RD) and a cultural index for service users from Black ethnic groups (CI-HS).

4.6.4 Procedures

Once the care home manager consented to take part with these research projects, PSSRU researchers instructed the care home manager to send the latest version of the care home AQAA. Once PSSRU received the care homes AQAA, the five focal service users were selected through stratified random sampling. In order to establish whether this level of dependency of the five focal service users were representative of the remaining service users within the home, short AQAA questionnaires were completed by staff for the remaining selected service users from the AQAA.

Having identified the five sampled participants, consent for each of the five focal service users was sought by sending the home manager a covering letter, information leaflets and consent forms for the service users selected. Consent was obtained either directly from the service user or, if the person lacked capacity to give consent, through their representatives, be it from key workers or family members. If consent was denied, PSSRU researchers selected another service user from the AQAA. This process was repeated until five service users with consent or exhausted the lists of possible service users (for example in small homes) were obtained. This had to happen quickly to ensure that data collection occurred within two weeks of a formal inspection.

The questionnaires for focal service users were sent to care home managers in advance of fieldworker visit for key workers to complete on behalf of each of the five focal service users. The completed questionnaires were collected and checked by the fieldworkers at the beginning of the visit to allow for any problem solving during the visit. It was anticipated that the questionnaires took approximately 30-45 minutes to complete.

During the MOPSU data collection, fieldworkers visited sampled care homes for a maximum of two days. On the first day, researchers met the care home manager and checked through consent forms and questionnaires. Fieldworkers then asked for a tour around the care home and meet the service users and staff. Fieldworkers were instructed to complete some of the environmental sections of the observational toolkit throughout the two day visit. Fieldworkers were instructed to complete the environmental characteristics observational sections and the CCHOT tool during day one and day 2 of the scheduled care home visits.

In order to check inter-rater reliability, 10-15% of data collection visits were accompanied by two researchers who independently completed the measures. Two rounds of inter-rater visits were implemented including, one at the very start of the fieldwork process and one approximately mid-way through the fieldwork process. Inter rater reliability and observer agreement between the two raters was calculated by researchers at the University of Kent. Inter rater reliability for the CCHOT tool was calculated by the author.

4.6.5 Statistical analysis

Questionnaire and observational measures from the MOPSU study was converted into format suitable for formic machine readable software at the Tizard Centre. Appendices 10 and 11 presents formic example of the CCHOT and MCNQ measures. Scanned data was processed and cleaned by researchers at Tizard and PSSRU. The Statistical Package for Social Sciences (SPSS) version 17 and Stats Direct were used to conduct statistical analyses. Inter-rater reliability for all MOPSU observational tools was conducted using Kappa statistic at two time points.

For the current study, due to the large number of analysis, findings significant at the $p<.01$ significance level were discussed. Findings significant at the $p<.05$ level which were of interest to the research questions were discussed. The '$p<.01$' means there is a 99% chance of true findings, whereas the '$p<.05$' finding has a 95% chance of true findings. In order to allow for further analyses, in particular, future meta analyses, exact significance levels were presented rather than reporting either significant at the $p<.01$ or $p<.05$ level.
Kolmogorov–Smirnov test were used to explore distributions of study variables. As most of the variables violated the assumption of normality, non parametric tests were used. Mann Whitney U- Tests were used to explore whether non white minority ethnic service users differed from white ethnic service users. Kruskall Wall Tests were used to explore responses from care home service users from different minority groups. Chi square tests explored nominal level data and Fisher-Freeman-Halton exact tests were used for nominal data with less than 5 cases.

As Walsh et al (2010:141) noted , further research needs to disclose effect sizes in order to determine impact of variables. Briefly, effect sizes determine the strength of association between variables. It was thus decided to conduct effect sizes in order to further illustrate strengths between variables in line with Walsh et al (2010) recommendations. Utilizing Cohen (1969) interpretations, effect sizes of $r=.10$, $r=.30$ and $r= .50$ reflected small, medium and large effect sizes respectively. Effect sizes for ordinal, interval and ratio data were explored by converting a z score into the effect size estimate by dividing z-scores with the square root of the number of observations for each variable (Rosenthal, 1991). Microsoft Excel was used to calculate all effect sizes in order to avoid human error with calculations. In order to explore relationships between variables such as service user characteristics and outcomes, Spearman's rank order correlations were conducted for ordinal level data and Pearson Product Moment Correlations were conducted for interval or ratio data. Coefficients of determinations were presented as percentages for correlation analyses significant at the $p<.05$ and $p<.01$ level in order to explore how much variance were shared between two variables.

4.6.6 Reliability- MOPSU measures

Reliability checks were implemented throughout the MOPSU study. As Netten et al (2010:34) outline, inter-observer/rater reliability was available for 113 service users (the exact number of users included in each analysis varies slightly depending on the measure) in 28 services. Full details of reliability checks are available from Netten et al (2010) but are briefly summarized here as the observational tools collected from the MOPSU study were utilized within this thesis. As discussed in Netten et al (2010, p.39) 'Reliability of measures at the individual level was generally good with average Kappa statistic values around 0.6 and percentage agreement over 0.8. Reliability was poorer on the measures which were rated at service level, for example, on the NHQS. Similarly homelikeness seemed difficult to rate reliably'.

Table 4.4: Inter-rater reliability of MOPSU observational toolkit sections

	n	Kappa mean (range) all questions/ categories	Percentage agreement (total)	Spearman's correlation co-efficient (mean)
Section 3 Environment	28 services	0.631 (0.47 – 0.78)	86% (75-96%)	
Homelikeness	28 services	0.4 (0.2 – 0.5)	53% (48-64%)	0.66
Section 4 Nursing home quality scale (NHQS)	28 services	0.35 (0.12 – 0.76)	55% (33-91%)	n/a

4.6.7 Reliability- minority ethnic measures integrated into MOPSU study

Table 4.5 outlines inter reliability from the CCHOT tool. Table 4.5 depicts some examples of good reliability within the CCHOT tool, particularly for physical environmental items and female clothing items with Kappa values for both rounds of reliability above 0.6. Poorer rates of agreement were noted with more individual clothing items as opposed to more tangible physical qualities of care homes. Although given the variability, caution needs to be applied in interpreting findings presented from the CCHOT.

Table 4.5: Inter-rater reliability of CCHOT observational toolkit sections. Time 1 & Time 2

	Time 1	Time 2	Total:
Section 6.1: Quality of staff support and cultural needs (Q1-11)			
Valid cases	32	29	61
% Agreements	65.625	72.41	68.85
Kappa	0.547	0.617	0.58
Spearman Rho	**0.854****	**0.828****	**0.843****
Section 6.2-Physical environment (Q12-14)			
Valid cases	9	9	18
% Agreements	88.89	77.78	83.33
Kappa	0.75	0.64	0.69
Spearman Rho	**0.818****	**0.820****	**0.796****
Section 6.3-part 1 (Q15-23)			
Valid cases	27	26	53
% Agreements	55.56	61.54	58.49
Kappa	0.44	0.532	0.486
Spearman Rho	**0.509****	**0.726****	**0.613****
Section 6.3-part 2(Q24a- Clothing-Female service users only)			
Valid cases	171	35	206
% Agreements	85.38	85.71	85.44
Kappa	0.69	0.68	0.68
Section 6.3-part 2(Q24b-Clothing- male service users only)			
Valid cases	33	66	99
% Agreements	72.73	78.79	76.76
Kappa	0.43	0.59	0.54
Section 6.3-part 4- Clothing-(Q25- All service users)			
Valid cases	12	14	26
% Agreements	83.33	85.71	84.62
Kappa	0.00	0.44	0.246
Spearman Rho		0.531	0.246
Section 6.4- Health and diet			
Valid cases	10	14	24
% Agreements	90	71.42	79.167
Kappa	0.839	0.537	0.665
Spearman Rho	**0.947****	**0.661***	**0.784****
Section 6.5- Religion and other cultural needs			
Valid cases	2	3	5
% Agreements	100	66.67	80.00
Kappa	Invalid	0.00	0.00

**= Correlation coefficient significant at the 0.01 level; *= Correlation coefficient significant at the 0.05 level NS= Not significant at 0.05 level

4.7 Focus groups

4.7.1 Care homes

Two focus groups were conducted. First, focus groups with minority ethnic service users. Second, focus groups with relatives of service users.

In order to formulate the focus groups, it was decided to consult with organizations on sampling processes and use existing support groups as far as possible. It was assumed that existing networks would be utilized by both service users and carers or families. Focus group implementation involved using a list of support organisations identified from the literature and various networks, which addressed minority ethnic issues. Examples of organisation contacted included: People First Lambeth-cultural group; Black Friendly group and the minority ethnic elders forum. For the south Asian focus groups, the Confederation for Indian Organisation (CIO) were recruited to assist in setting up the focus groups and acted as translators . The CIO works with south Asian organisations in the UK and aims to provide and develop high quality services that strengthen these organisations and be a strong voice on policy issues that affect the south Asian community. In total, six focus groups were conducted within the East Midlands.

4.7.2 Participants

Six separate focus groups were carried for south Asian and African Caribbean individuals. In addition, the following criteria will be used:

- Service user (focus groups): Individuals who had some experience with UK care home services designed for people with learning disabilities and/or older peoples.
- Relatives (focus groups): Individuals who had relatives who've had experience with care home services designed for people with learning disabilities and older peoples.

Each focus group continued 6-8 group members. Given the potential language barrier for older people south Asian participants, a translator (fluent in all south Asian languages) was recruited to assist with the focus groups. In terms of the completed service user focus groups, participants were all older people and mostly female. Of the relatives focus group, participants were all male from south Asian descent.

In total, 23 older people care home service users and seven relatives from south Asian and African Caribbean groups participated in six focus groups. Six focus groups were conducted with four service user focus groups and two relatives focus groups. The service user focus groups including a focus group for practicing Hindu south Asian group, a practicing Muslim South Asian group, a practicing Sikh south Asian group and a group of African-Caribbean service users. The two relatives focus groups comprised of a practicing Hindu south Asian relatives group and relatives from African- Caribbean groups. All participants from the relatives focus groups had a parent living in a care home. South Asian care home service users and relatives lived in the East Midlands and African- Caribbean service users and relatives lived in the West Midlands. The vast majority of south Asian service users focus groups preferred the focus groups to be conducted in Gujarati, Hindi or Punjabi, although very occasionally, some of the Muslim service users discussed some of their views in English. Content discussed from the south Asian service user focus groups were translated into English. All relatives focus groups and the African Caribbean service user focus group preferred the focus groups to be conducted in English.

The majority of south Asian service users were female, aged over 65 and from Indian and other Asian backgrounds. The majority of African-Caribbean service users were male and aged over 65. All of the Hindu relatives were male and aged between 35-54 and all of the African-Caribbean relatives were male and aged between 55-64, the length of the focus

groups ranged from 25 minutes to 1 hour 30 minutes for the South Asian focus groups and 30 minutes to 45mins for the African-Caribbean focus group

4.7.3 Focus group measures

The overall objective of the focus groups was to determine, whether care homes staff were aware of and actively responsive to needs of minority ethnic groups.

As pointed out previously, the aims of the focus groups included:

- Qualitative exploration of the feelings, attitudes and beliefs towards care homes for minority ethnic groups
- Qualitative exploration of the feelings, attitudes and beliefs associated with individual needs and requirements within care homes
- Qualitative exploration of the feelings, attitudes and beliefs associated with the components of a good quality service
- Qualitative exploration of the respondents experiences of services

In order to achieve these aims, the focus group schedule followed a three part structure. First, introduction scheduled for ten minutes. This section included a warm up session and an 'ice breaker' session for respondents. Second, discussion surrounding needs, scheduled for maximum of forty five minutes. This section included a detailed exploration of minority ethnic needs for service users within care homes. The objective was to find out what needs people from minority ethnic backgrounds require from services. Third, discussions surrounding quality service scheduled for a maximum of forty five minutes. This section consisted of a detailed exploration of what constitutes a good quality service. The objective was to determine a minority ethnic perspective concerning the components of good quality service. The final section focused on experiences of care homes. This section consisted of a brief discussion regarding peoples experiences within care homes and their viewpoints surrounding care homes.

4.7.4 Procedures

Implementation of the focus groups involved contacting a list of support organizations identified from a literature search of various networks, which addressed specialist or have an interest in minority ethnic issues with community care service users. Agencies or organizations were initially be approached by letter, including a face-to-face meeting with a manager of the organization. Preference for organizations included organizations with regularly scheduled meetings with minority ethnic service users. Once an organization agreed to take part, invitation letters, consent forms and information letters were sent to potential participants. Easy read versions and translated papers were included and distributed to participants if organizations felt this was necessary. On the focus group date, each group was planned for a total of two hours for 6-8 members. Each session was tape recorded. After the focus group session, debriefing and compliant forms were sent to each focus group participant.

4.7.5 **Analysis**

An important qualitative method regularly employed in educational and social research depicts Grounded Theory (Glaser & Strauss 1967). Grounded theory poses several important advantages over other qualitative methods such as ethnographical methods. For example,

Grounded Theory presents a single, unified, systematic method of analysis. Other qualitative methods often rely upon the application of general principles rather than systematic method, making their application and interpretation more difficult. Methods for validating findings and can integrate well with quantitative methods are also provided by Grounded Theory, in fact, both forms of data are necessary in many instances (Glaser & Strauss 1967). Grounded Theory is also well documented and had been used systematically in studies since the 1960s (Strauss & Corbin, 1994). These factors assist the rapid application of the methods of Grounded Theory and also provide a framework for the interpretation of results. Furthermore, quantitative researchers are becoming less satisfied with purely quantified results and are turning increasingly to supplementary qualitative analyses according to Strauss & Corbin (1994). The process of grounded theory begins with selecting research questions. In relation to the current study, the research questions relate to the aims of the project, namely to explore needs and experiences of care homes, specifically, cultural needs and culturally appropriate service provision. Following the principles of induction therefore, theories relating to what constitutes a good quality service and minority ethnic needs were developed from these research questions, rather than deductively proposing set needs and constitutes of quality service. Through grounded theory therefore, the intention was to follow service users and relatives from minority ethnic groups to determine what was the most important needs and components of a quality service. In other words, the intention was for participants to spontaneously discuss which aspect of needs and quality was most important to them and allow for participants to discuss why such a domain is important to them.

4.7.6 Reliability

In order to check reliability codings from the focus groups, a reliability table was constructed as shown in Appendix 8. Coding of qualitative data from two focus groups was checked by an independent coder. Agreement for the first round of coding was at 65%, whereas the coding for the second round of coding increased to 82%.

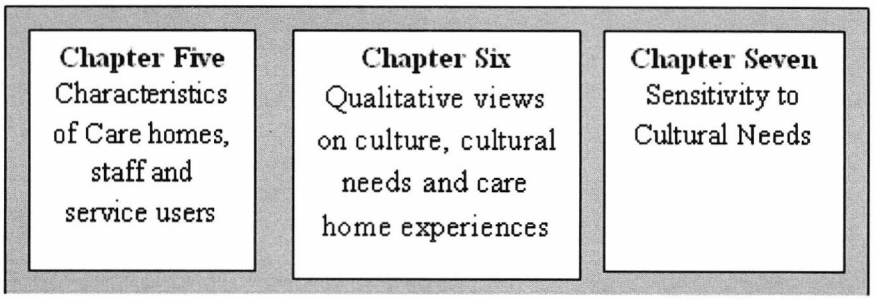
4.8 Conclusion

This chapter shows this study utilizes a mixed methods research design to fill research gaps surrounding minority ethnic populations living in learning disability and older people care homes in England. This study focuses on two areas of investigation. First, describing characteristics of care home service users and care home staff as collected from the MOPSU study collected from a sample of 173 care homes for adults with learning disabilities and care homes for older people. This will primarily involve investigating variations in needs and characteristics for non-white service users in comparison with white ethnic service users. Moreover, variations in staff characteristics within care homes containing at least one minority ethnic service user in comparison with care homes containing only white ethnic service users. The second objective focuses more on cultural needs and sensitivity to cultural needs for minority ethnic populations living in care homes in England. This involves qualitative exploration of definitions of cultural needs from South Asian and African Caribbean older people and their relatives collected from focus groups. From measures developed and designed to collect data on cultural needs and sensitivity to cultural needs and integrated into the MOPSU study, this study then intends to explore observational findings of whether care home staff were observed to implement culturally sensitive service provision for diverse culturally and ethnically diverse service users living in care homes for adults with learning disabilities and care homes for older people.

PART B

RESEARCH FINDINGS

Part B presents empirical research findings from this PhD research endeavor. Chapter five explores characteristics of care homes, care staff and service users. Chapter six presents qualitative findings from focus groups depicting service users and relatives definitions on culture needs as well as sensitivity to cultural needs within community care services. Chapter seven outlines observational findings from the MOPSU study on sensitivity to cultural needs within care homes for adults with learning disabilities and care homes for older people.



5. Chapter Five. Characteristics for care homes, care home staff and service users

This chapter outlines findings on characteristics for care homes, care home staff and service users collected from the MOPSU study. Each characteristics section presents findings on comparisons between learning disability and older people followed by ethnicity comparison findings.

5.1. Care home characteristics

5.1.1. Care home characteristics- comparing learning disability and older people

Table 5.1 compares service category, region, CQC star quality ratings and national minimum standards ratings between care homes for adults with learning disability and older people care homes. Table 5.1 shows the majority of adults with learning disabilities and older people lived in residential care homes reflecting 99% and 63% respectively.

A statistically significant geographical regional difference was found within care homes for adults with learning disabilities and older people. South East England and London contained the two highest percentage proportions of care homes for adults with learning disabilities reflecting 39% and 34% respectively. North West England contained the lowest percentage proportion (7%) of care homes for adults with learning disabilities. Conversely, North West England and South East England contained the two highest percentage proportions of care homes for older people depicting 34% and 30% respectively. London contained the lowest percentage proportion (15%) of care homes for older people.

The majority of homes received good CQC ratings for both care homes for adults with learning disabilities care homes for older people reflecting 55% and 53% respectively. The majority of care homes for adults with learning disabilities and care homes for older people met all NMS standards, but there were no statistically significant difference between the two types of homes.

Furthermore, care homes for adults with learning disabilities reported a statistically significant higher percentage of NMS lifestyle standards in comparison with care homes for older people.

Table 5.1- Care home characteristics- comparing learning disability and older people homes

Frequencies and percentages	**Learning disability homes**	**Older people homes**	
N = 173	**90**	**83**	
1. Service category			**Fishers Exact Test significance= p<.0001**
Nursing home	1 (1%)	30 (36%)	
Residential home	83 (99%)	50 (63%)	
2. Region			**χ^2 = 20.858, d.f=3, phi=.358, p<.0001**
London	28 (34%)	12 (15%)	
North West	6 (7%)	27 (34%)	
South East	32 (39%)	24 (30%)	
West Midlands	17 (21%)	17 (21%)	
3. CQC Star Quality Ratings			Fisher-Freeman-Halton exact= p<.2825
Zero stars- Poor	0 (0%)	4 (5%)	
1 star- Adequate	21 (26%)	19 (24%)	
2 star- Good	44 (55%)	42 (53%)	
3 star- Excellent	15 (19%)	14 (18%)	
National Minimum Standards			
Percentage of all standards met. Mean and Range	81.7 (38-100)	81.8 (27-100)	U= 3366.00, Z= -.508, r=-.04 p<.611
Percentage of lifestyle standards met. Mean and Range	91.8 (29-100)	44.7 (0-50)	**U= 268.000, Z= -10.890, r=-.84 p<.0001**

5.1.2. Care home characteristics- Differences between care homes with at least one minority ethnic service user and care homes with service users from white ethnic groups only

In terms of learning disability homes, Table 5.2 shows significant associations between regional locality between care homes with white ethnic service users only and care homes with at least one minority service user.

Table 5.2 showed higher percentages of care homes with at least one minority service user were located within the London and South East region, whereas, most care homes with only service users from white ethnic groups were located within the South East and West Midlands region. There were no significant differences between care homes with at least one minority service user and care homes with service users from white ethnic groups only with service category, namely nursing and residential care homes and CQC quality ratings.

Table 5.2 shows with older people homes, a statistically significant difference existed between care homes with at least one minority service user and care homes with only white ethnic service users. Namely, 75% of care homes with at least one minority service user were classified as nursing homes in contrast to 24% of care homes with only white ethnic service users. No significant differences were found between care homes with at least one minority service user and care homes with only white ethnic service users for service category, namely, nursing and residential homes and CQC star quality ratings. Although, care homes with only white ethnic service users reported statistically significant higher percentage of lifestyle standards met in comparison with care homes with at least one minority ethnic service user.

Table 5.2- Care home characteristics- comparing care homes with at least one minority ethnic service user with care homes with only white ethnic service users.

Frequencies and percentages	**Care homes with at least one minority**	**Care homes containing only white ethnic**	
Learning disability (N= 89)	**36 (40.4%)**	**53 (59.6%)**	
1. Service category			Fishers Exact significance, phi=-.139, $p<.386$
Nursing home	1 (3%)	0 (0%)	
Residential home	31 (97%)	51 (100%)	
2. CQC region			Fisher-Freeman-Halton exact, P = 0.0105
London	17 (55%)	11 (22%)	
North West	0 (0%)	5 (10%)	
South East	10 (32%)	22 (43%)	
West Midlands	4 (13%)	13 (26%)	
3. CQC Star Quality Ratings			Fisher-Freeman-Halton exact- P = 0.9511
Zero stars- Poor	0 (0%)	0(0%)	
1 star- Adequate	9 (29%)	12 (25%)	
2 star- Good	16 (52%)	27 (56%)	
3 star- Excellent	6 (19%)	9 (19%)	
National Minimum Standards			
Percentage of all standards met- Mean and Range	79.8 (47-100)	82.9 (38-100)	U= 720.500, Z= -.1.316 , r=-.14 p<.188
Percentage of all standards met- Mean and Range	91.2 (29-100)	92 (29-100)	U= 812.500, Z= -.617 , r=-.07, p<.537
Older people (N =81)	**21 (25.9%)**	**60 (74.1%)**	
1. Service category			**χ^2 = 16.472, d.f=1, phi=-.460, $p<.0001$**
Nursing home	15 (75%)	14 (24%)	
Residential home	5 (25%)	44 (76%)	
2. CQC region			Fisher-Freeman-Halton exact, P = 0.1337
London	6 (30%)	6 (10%)	
North West	4 (20%)	23 (40%)	
South East	7 (35%)	17 (29%)	
West Midlands	3 (15%)	12 (21%)	
3. CQC Quality Ratings			
Star ratings			Fisher-Freeman-Halton exact, P = 0.4493
Zero stars- Poor	0 (0%)	4 (7%)	
1 star- Adequate	7 (37%)	12 (21%)	
2 star- Good	9 (47%)	32 (55%)	
3 star- Excellent	3 (16%)	10 (17%)	
National Minimum Standards			
Percentage of all standards met.	76.9 (27-100)	83.4 (32-100)	U= 533.000, Z= -.948, r=-.11, $p<.343$
Percentage of all lifestyle standards met. Mean and Range	41.1 (0-50)	45.8 (13-50)	**U= 479.500, Z= -2.017 , r=-.23, p<.044**

5.2. Staff characteristics

5.2.1. Staff characteristics- frequencies- demographics

Table 5.3 presents staff demographical data reported from care homes for adults with learning disabilities and care homes for older people. Table 5.3 shows the majority of staff were from white ethnic groups, were female and aged between 25-54.

Table 5.3 also shows a sizable proportion (32%) of care home staff were from minority ethnic groups, which was higher than the 2011 census figure of 13% minority ethnic individuals nationally.

Table 5.3 depicts care homes for adults with learning disability contained a higher percentage of minority ethnic staff in comparison with care homes for older people depicting 38% and 29% respectively. In terms of minority ethnic groups, most staff working within learning disability and older people homes were from black minority ethnic groups reflecting 58% and 45% respectively. For learning disability homes, staff from south Asian ethnic groups represented the lowest percentage proportion of minority ethnic staff (16%) whereas for older people homes, staff from 'other' minority ethnic groups represented the lowest proportion of minority ethnic staff (23%).

Table 5.3- Staff demographics working in learning disability and older people care homes and comparisons with national statistical data

Staff characteristics-demographics	**Adults with learning disability homes**	**Older people homes**	**Total (Learning disability and older people homes)**	**All social care workers from independent sector NMDS- SC (Hussein, 2009)**	**UK 2011 census. Ethnicity (ONS, 2011a).**
Grand N	**1077**	**2321**	**3398**		
Ethnicity					
1. **White ethnic groups only (White ethnicity groups)**					
White ethnic groups only N (%- grand N)	668 (62%)	1657 (71%)	2325 (68%)	83%	**87%**
2. Non-white minority ethnic group					
Minority- N (%- grand N)	409 (38%)	664 (29%)	1073 (32%)	17%	**13%**
South Asian Frequency and percentage from minority-N	66 (16%)	207 (31%)	273 (25%)	5%	7% (54%)
Black ethnic groups. Frequency and percentage from minority-N	239 (58%)	302 (45%)	541 (50%)	8%	3% (23%)
Other ethnic groups- Frequency and percentage from minority-N	104 (25%)	155 (23%)	259 (24%)	4%	3% (23%)
Gender (% from total gender)					
Male	274 (25.9%)	235 (11.4%)	509 (19.4%)	14.1%	
Age (% from total age)					
18-24	101 (11.6%)	185 (10.2%)	286 (10.7%)	10%	
25-34	233 (26.7%)	425 (23.5%)	658 (24.6%)	20%	
35-44	202 (23.2%)	463 (25.6%)	665 (24.8%)	24%	
45-54	217 (24.9%)	448 (24.8%)	665 (24.8%)	26%	
55-64	102 (11.7%)	239 (13.2%)	341 (12.7%)	17%	
65+	17 (1.9%)	46 (2.5%)	63 (2.4%)	3%	
Working patterns (% from total working patterns)					
Permanent staff	991 (90.4%)	1731 (91.7%)	2722 (91.3%)		
Agency staff	105 (9.6%)	156 (8.3%	261 (8.7%)		
Education (% from total education)					
Permanent staff with NVQ +2	507 (92.2%)	992 (93.5%)	1499 (93%)		
Agency staff with NVQ +2.	43 (7.8%)	69 (6.5%)	112 (7.0%)		

5.2.2. Staff characteristics- differences between learning disability and older people homes

Table 5.4 outlines whether staff demographics, working patterns and qualifications differed between care homes for adults with learning disability and care homes for older people. Table 5.4 shows that learning disability care homes contained significantly more male staff and full time staff conversely to older people homes.

Furthermore, staff working within older people homes carried out more personal care hours and more hours devoted to other tasks conversely to staff working in learning disability homes. Moreover, staff working within older people homes carried out more qualified nurse hours and more hours devoted to non personal care than staff working in learning disability homes.

Table 5.4- Staff demographics, working patterns and qualifications- comparisons between learning disability and older people homes

Staff characteristics- - Per care home	**Adults with learning disability**	**Older people**	
Percentage of Male staff Mean and Range	22.3 (0-75)	11.2 (0-47.8)	**U=1552.500, Z= -5.725, p<.0001, r=-.45**
Percentage of minority ethnic staff Mean and Range	44.1 (0-100)	29.3 (0-96)	U=2743.000, Z= -.2.384, p<.017, r=-.18
Percentage of staff from Black ethnic groups- Mean and Range	24.4 (0-100)	12.0 (0-91)	U= 2777.500, Z= -2.385, p<.017, r=-.18
Percentage of staff from South Asian ethnic groups- Mean and Range	6.9 (0-100)	9.2 (0-67)	U=2895.000, Z= -.2050, p <.040, r=-.16
Percentage of staff from Other ethnic groups- Mean and Range	10.8 (0-80)	6.7 (0-51.7)	U= 3377.000, Z= -.376, p<.707, r=-.03
Percentage of staff aged 18-24 Mean and Range	10.4 (0-63)	9.6 (0-38)	U=2305.500, Z= -.885, p<.376, r=-.07
Percentage of staff aged 25-34 Mean and Range	27.3 (0-100)	23 (0-57)	U=2195.500, Z= -1.325, p <.185, r=-.11
Percentage of staff aged 35-44 Mean and Range	21.6 (0-60)	25.5 (0-56.4)	U= 2249.500, Z= -1.105, p<.269, r=-.09
Percentage of staff aged 45-54 Mean and Range	25.5 (0-83)	23.8 (0-85)	U= 2426.500, Z= -.382, p <.703, r= -.03
Percentage of staff aged 55-64 Mean and Range	13.8 (0-67)	13.5 (0-58)	U= 2229.500, Z=-.198, p <.231, r= -.10
Percentage of staff aged 65+ Mean and Range	1.4 (0-13)	4.2 (0-100)	U= 2119.000, Z= -1.997, p<.046, r= -.17
Percentage of full time staff Mean and Range	63.7 (0-100)	37.3 (0-83)	**U= 1344.500, Z= -6.253, p<.0001, r= -.50**
Qualified nurse hours Mean and Range	2.3 (0-75)	120.9 (0-761)	**U= 1552.000, Z= -3.839, p<.0001, r=-.33**
Staff hours- personal care in the week Mean and Range	231.2 (0-2695)	605.9 (10-1608)	**U= 833.000, Z=-7.436, p<.0001, r=-.61**
Staff hours- not personal care in the week - Mean and Range	233.1 (0-1078)	75.6 (0-700)	**U= 1665.500, Z= -4.171, p<.0001, r -.34**
Other staff hours provided in the last week- Mean and Range	45.1 (0-456)	256.2 (0-975)	**U= 782.500, Z= -7.815, p<.0001, r=-.63**
Percentage of permanent staff- Mean and Range	91.5 (55.6-100)	91.7 (57.6-100)	U= 2857.000, Z= -.895, p<.371, r= -.07
Percentage of permanent staff- with NVQ level 2 or more - Mean and Range	92.5 (50-100)	93.8 (66.7-100)	U= 2817.500, Z= -.318, p<.751, r= -.03

5.2.3. Ethnicity - care home staff and care home service user

Table 5.5 outlines frequencies of care homes with at least one minority ethnic staff member and care homes with only white ethnic staff. Table 5.5 shows over 79% of care homes for adults with learning disability and care homes for older people contained at least one minority ethnic staff member.

Table 5.5: Frequency of care homes with staff from white ethnic groups only and care homes with at least one minority ethnic staff

	Care homes with at least one minority ethnic staff	**Care homes containing all staff from the white ethnic groups only**	**Total**
Care homes for adults with learning disabilities	67 (79%)	18 (21%)	85
Care homes for older people	68 (83%)	14 (17%)	82
Care homes for adults with learning disabilities and care homes for older people	135 (81%)	32 (19%)	167

Table 5.6 outlines percentages of staff from minority ethnic groups working within care homes with at least one minority ethnic service user and care homes with service users from the white ethnic groups only. Table 5.6 includes findings for both care homes for adults with learning disabilities and care homes for older people.

Table 5.6 shows care homes for learning disability service users with at least one minority ethnic service user contained a higher percentage of staff from south Asian backgrounds in contrast to care homes for learning disability service users that contained all service users from white ethnic groups.

Similarly, care homes for older people with at least one minority ethnic service user contained a higher percentage of staff from minority ethnic groups and black ethnic groups in contrast with older people care homes containing service users from white ethnic groups.

Table 5.6- Percentages of staff from minority ethnic groups- differences between care homes with at least one minority ethnic group with care homes with service users from white ethnic service users only.

Staff ethnicity- per home	**Care homes with at least one non white minority ethnic service user**	**Care homes contained service users from white ethnic groups only**	
Adults with learning disability homes			
N(89)			
Percentage of staff from minority ethnic groups- total- Mean and Range	52.2 (0-100)	35.4 (0-100)	U=596.500, Z= -2.429, p<.015, r=-.27
Percentage of staff from Black ethnic groups- Mean and Range	29.5 (0-88)	21.1 (0-100)	U=678.000, Z=-1.746, p<.081, r=-.19
Percentage of staff from Asian ethnic groups- Mean and Range	12.0 (0-100)	3.2 (0-38)	**U=543.500, Z= -3.348, p<.001, r= -.37**
Percentage of staff from Other ethnic groups- Mean and Range	10.7 (0-80)	11.1 (0-76)	U=813.500, Z= -.514, p<.607, r= -.06
Older people homes			
N (90)			
Percentage of staff from minority ethnic groups- total- Mean and Range	43.5 (0-96.4)	23.1 (0-91.3)	**U= 359.000, Z= -2.856, p<.004, r= -.32**
Percentage of staff from Black ethnic groups- Mean and Range	20.5 (0-64.3)	9.2 (0-91.3)	**U= 351.000, Z= -3.139, p<.002, r=-.35**
Percentage of staff from Asian ethnic groups- Mean and Range	13.6 (0-66.7)	7.9 (0-58.1)	U= 486.000, Z= -1.519, p<.129, r= -.17
Percentage of staff from Other ethnic groups. Mean and Range	9.4 (0-51.7)	6.0 (0-50)	**U= 420.500, Z=-2.292, p<.022, r= -.26**

Table 5.7a and Table 5.7b present numerous analyses on service user ethnicity and staff ethnicity. First, whether a higher percentage of minority ethnic staff were reported in care homes with at least one minority ethnic service user in comparison with care homes with only white ethnic service users. Second, whether a higher percentage of Asian staff in homes was found with care homes containing at least one Asian service user, in comparison with care homes containing no Asian service users. Third, whether higher percentages of staff from black ethnicity backgrounds existed with care homes containing at least one service user from a black ethnic background in comparison with care homes containing no service users from black ethnic groups. Finally, whether a higher percentage of staff from other minority ethnic groups were reported in care homes containing at least one service user from other minority ethnic groups in comparison with care homes containing no service users from other minority ethnic groups. Separate analyses were conducted for care homes with adults with learning disabilities and care homes for older people.

Care homes with adults with learning disabilities

Table 5.7a shows adults with learning disability homes with at least one south Asian service user contained a significantly higher percentage of south Asian staff in contrast to adults with learning disability care homes with no south Asian service users.

Table 5.7a- Minority ethnic staff working in learning disability care homes and service user ethnicity

Staff ethnicity- per care home	**Service user group**		
Adults with learning disability			
	Number of homes with no minority ethnic service users (N=50)	**Number of homes with minority ethnic service users (N=34)**	
Percentage of minority ethnic staff. Mean and Range	22 (0-100)	35 (0-84.44)	U=621.500, Z= -2.092, p<.036, r= -.23
	Number of homes with no black service users (N=66)	**Number of homes with black service users (N=18)**	
Percentage of staff from black ethnic groups. Mean and Range	21.5 (0-100)	36.2 (0-87.50)	U=430.500, Z= -1.851, p<.064,r=-.20
	Number of homes with No Asian service users (N=66)	**Number of homes with Asian service users (N=18)**	
Percentage of staff from South Asian groups. Mean and Range	6.1 (0-100)	10.3 (0-46.15)	**U=372.000, Z= -2.797, p<.005, r= -.31**
	Number of homes with service users from other ethnic groups (N=74)	**Number of homes with service users from other ethnic groups (N=10)**	
Percentage of staff from other ethnic groups. Mean and Range	11.1 (0-80)	9.3 (0-29.2)	U=337.000, Z= -.513, p<.608, r=-.060

Care homes with older people

Care homes for older people with at least one minority ethnic service user contained significantly higher percentages of minority ethnic staff in contrast to older people care homes with no minority ethnic service users.

Table 5.7b- Minority ethnic staff working in older peoples cares homes and service user ethnicity

Staff ethnicity- per care home	**Service user group**		
Older people			
	Number of homes with no minority ethnic service users (N=59)	**Number of homes with minority ethnic service users (N=21)**	
Percentage of minority ethnic staff. Mean and Range	23.1 (0-91.3)	43.5 (0-96.4)	**U=359.000, Z= -2.856, p<.004, r=-.32**
	Number of homes with no Black service users (N=69)	**Number of homes with Black service users (N=11)**	
Percentage of staff from black ethnic groups. Mean and Range	10.9 (0-91.3)	19.8 (0-64.29)	U=224.000, Z= -2.323, p<.020, r= -.26
	Number of homes with no Asian service users (N=73)	**Number of homes with Asian service users (N=7)**	
Percentage of staff from South Asian groups. Mean and Range	8.6 (0-67)	17.2 (0-53.6)	U=210.000, Z= -.806, p<.420, r= -.09
	Number of homes with service users from other ethnic groups (N= 69)	**Number of homes with service users from other ethnic groups (N=10)**	
Percentage of staff from other ethnic groups. Mean and Range	6.3 (0-51.7)	10.2 (0-41.4)	U=208.000, Z= -2.132, p<.033, r= -.24

5.2.4. Staff characteristics- differences between care homes with at least one minority ethnic service user with care homes with service users from white ethnic groups only

Care homes for adults with learning disabilities

Table 5.8a shows with care homes for adults with learning disability, no significant differences were found between staff characteristics working in care homes with at least one minority ethnic service user and care homes with only white ethnic service users. However, for care home for older people homes with at least one minority ethnic service user, there were significantly higher percentages of qualified nurse hours and staff performing personal care in the week in contrast to older people homes with only white ethnic groups.

Table 5.8a- Staff characteristics- differences between learning disability care homes with at least one minority ethnic service user and care homes containing white ethnic service users only

Staff characteristics- per home	**Care homes with at least one non white minority ethnic service user**	**Care homes with service users from white ethnic groups only**	
Adults with learning disability only			
N(89)			
Percentage of Male staff – Mean and Range	22.5 (0-75)	27 (0-57)	U=689.500, Z= -.994, p<.320, r= -.11
Percentage of staff aged 18-24- Mean and Range	11.2 (0-63)	9.7 (0-58)	U=536.000, Z= -.614, p<.539, r=-.07
Percentage of staff aged 25-34- Mean and Range	28.7 (0-78)	25.2 (0-100)	U=560.500, Z= -.297, p<.766,r= -.04
Percentage of staff aged 35-44- Mean and Range	23.2 (0-60)	20.5 (0-50)	U=560.000, Z=-.304, p<.761 ,r= -.04
Percentage of staff aged 45-54- Mean and Range	27.3 (0-83)	24.5 (0-57)	U=585.00, Z=.000, p<1.000, r=0.0
Percentage of staff aged 55-64- Mean and Range	8.6 (0-30)	18.3 (0-67)	**U=422.500, Z= -2.029, p<.042, r= -.24**
Percentage of staff aged 65+- Mean and Range	.99 (0-13)	1.9 (0-11)	U=504.500, Z=-1.350, p<.177, r= -.16
Percentage of full time staff – Mean and Range	70.5 (41-100)	57.5 (0-100)	**U=584.500, Z=-1.970, p<.049, r= -.22**
Qualified nurse hours- Mean and Range	.23 (0-37)	4.1 (0-75)	U=498.500, Z=-.729, p<.466, r= -.09
Staff hours- personal care in the week - Mean and Range	145.5 (0-627)	307 (0-2695)	U=549.000, Z=-1.068, p<.285, r=.13
Staff hours- not personal care in the week - Mean and Range	209 (0-756)	239 (0-1078)	U=540.500, Z=1.134, p<.257, r= -.13
Other staff provided support in the last week- Mean and Range	33.6 (0-368)	55.9 (0-456)	U=576.000, Z= -.973, p<.331, r= -.11
Percentage of permanent staff- Mean and Range	90 (58-100)	92.9 (56-100)	U=727.500, Z= -.093, p<.926, r= -.01
Percentage of permanent staff- with NVQ level 2 or more - Mean and Range	90 (50-100)	95 (67-100)	U=617.000, Z=-.630, p<.529, r= -.07

Care homes for older people

Table 5.8b explores whether staff demographics, staff work patterns and staff with NVQ qualifications differed for care homes for older people with at least one minority service user and older people care homes with all service users from white ethnic groups only. As shown from table 5.8b, older people care homes with at least one minority ethnic service user depicted higher frequencies of qualified nursing hours and staff participating in personal care in the week than older people care homes with service users from white ethnic groups only.

Table 5.8b- Staff characteristics- differences between older people care homes with at least one minority ethnic service user and care homes with service users from white ethnic groups only

Staff characteristics- per home	**Care homes with at least one non white minority ethnic service user**	**Care homes with service users from white ethnic groups only**	
Older people homes			
N(90)			
Percentage of Male staff – Mean and Range	13.8 (4-37)	10.3 (0-48)	U= 480.500, Z= -1.336, p<.181,r=-.15
Percentage of staff aged 18-24- Mean and Range	11.9 (0-38)	8.8 (0-29)	U= 459.000, Z=-.121, p<.903, r= -.01
Percentage of staff aged 25-34- Mean and Range	26.7 (8-43)	22.5 (0-57)	U= 328.000,Z= -.1.882, p<.060,r=-.22
Percentage of staff aged 35-44- Mean and Range	28.8 (13-45)	24.1 (0-56)	U=363.000,Z=-1.412, p<.158, r= -.17
Percentage of staff aged 45-54- Mean and Range	20.4 (5-50)	24.9 (0-85)	U= 396.000, Z=-.968, p<.333, r=-.12
Percentage of staff aged 55-64- Mean and Range	10.0 (0-47)	14.7 (0-58)	U= 381.500, Z=-1.165,p<.244, r= -.14
Percentage of staff aged 65+- Mean and Range	2.1 (0-11)	5.0 (0-100)	U=461.500,Z=-.100, p<.921, r= -.01
Percentage of full time staff – Mean and Range	40.1 (0-68)	36.1 (0-83)	U= 467.500,Z=-1.379, p<.168, r=-.16
Qualified nurse hours- Mean and Range	242.1 (0-761)	74.9 (0-591)	**U=264.000,Z=3.110 , p<.002 r=-.37**
Staff hours- personal care in the week – Mean and Range	891.3 (310-1608)	526.3 (10- 1325)	**U= 303.500,Z=-3.183p<.001, r=-.37**
Staff hours- not personal care in the week - Mean and Range	114.9 (0-700)	61.1 (0-464)	U=545.500, Z=-.136,p<.892, r= -.02
Other staff provided support in the last week- Mean and Range	329.4 (0-878)	228.0 (0-975)	U= 430.500, Z=-1.802, p<.072, r=-.21
Percentage of permanent staff- Mean and Range	90.0 (58-100)	92.3 (58-100)	U= 478.000,Z= -1.160, p<.246,r= -.13
Percentage of permanent staff- with NVQ level 2 or more - Mean and Range	90.1 (66-100)	95.2 (70-100)	U=400.000, Z=-2.289, p<.022, r=-.26

5.3. Service user characteristics

5.3.1. Service user characteristics- comparisons of focal, non focal, whole sample and the UK census

Ethnicity

Table 5.9 summarizes percentage proportions of ethnicity for service users from minority ethnic groups and white ethnic groups.

For the focal sample, Table 5.9 shows learning disability homes contained higher percentage proportions of minority ethnic service users than focal service users in older people homes with 13% and 3% respectively. As Table 5.9 indicates, focal minority service users were most commonly from black ethnic groups for learning disability homes and older people homes representing 53% and 54% of minority service users respectively. Focal south Asian service users represented the lowest percentage proportion of minority service users with 20% from learning disability homes and 15% from older people homes. A similar trend was found with non focal samples whereby learning disability homes contained higher proportion of minority service users of 9% in contrast to 2% of older non focal service users. However, for non focal learning disability service users, service users from south Asian, black and 'other' minority service users were equally represented with 33% respectively. Whereas, of non focal older peoples, service users from black groups and 'other' minority groups represented the two most frequent minority groups for older peoples with 50% and 29% respectively.

In terms of comparing findings with the 2001 ONS census, percentage proportion of minority ethnic learning disability service users from the focal and AQAA sample appeared to be higher than the percentage proportion of minority ethnic individuals from the 2001 census.

Exploration of minority ethnic groups

Table 5.9 outlines focal learning disability sample contained, 24 African-Caribbean service users, 12 other minority service users and 9 south Asian minority service users which reflected 53%, 27% and 20% of minority service users respectively. Although sample size of 45 minority ethnic service users reflects small samples, as each of the minority ethnic groups exceeds the frequencies of 5, in addition to comparing minority ethnic service users as a singular group with the white ethnic groups only, it was decided to explore whether characteristics differed for service users from south Asian, black and other minority ethnic groups for learning disability service users only. However, analyses for separate minority groups needs to be treated with caution given small samples for minority ethnic service users.

Gender and age

Table 5.9 also shows for learning disability homes, most service users were male, although within older people homes; most of the service users were female. Furthermore, most learning disability care home service users appeared to be aged between 35-54, whereas older people were aged over 65. In terms of age, in terms of learning disability service users, most of the focal and non focal samples were aged between 40-59. In terms of older people, for both focal and non focal samples, most service users were aged 80 and over.

Table 5.9- Demographical characteristics- MOPSU study and census 2011 (ONS, 2011)

	Focal sample		**Non focal sample**		**Whole sample (focal and non focal)**		**UK 2011 census. Ethnicity (ONS, 2011a).**
	Learning disability	Older people	Learning disability	Older people	Learning disability	Older people	
1. Ethnicity							
White ethnic groups only							
Total %- White ethnic groups only- White service users	**315 (88%)**	**362 (97%)**	**123 (91%)**	**656 (98%)**	**438 (88%)**	**1018 (97.4%)**	**87%**
Non white minority group							
Total minority group %	**45 (13%)**	**13(3%)**	**12 (9%)**	**14 (2%)**	**57 (12%)**	**27 (2.6%)**	**13%**
South Asian group – total minority group %	9 (20%)	2 (15%)	4 (33%)	3 (21%)	13 (3%)	5 (0.5%)	7% (54%)
Black ethnic groups-total minority group %	24 (53%)	7 (54%)	4 (33%)	7 (50%)	28 (6%)	14 (1.3%)	3% (23%)
other –total minority group %	12 (27%)	4 (31%)	4 (33%)	4 (29%)	16 (3%)	8 (0.8%)	3% (23%)
2. Gender							
Male %	207 (58%)	112(30%)	-	-	-	-	
4. Age							
18-19	1(.3%)	0 (0%)	0 (0%)	0 (0%)	1 (0.2%)	0 (0%)	
20-29	55 (15.4%)	0 (0%)	18 (13.5%)	0 (0%)	73 (15%)	0 (0%)	
30-39	59 (16.5%)	0 (0%)	13 (9.8%)	0 (0%)	72 (15%)	0 (0%)	
40-49	105 (29.4%)	4 (1.1%)	34 (25.6%)	2 (.3%)	139 (28%)	6 (1%)	
50-59	76 (21.3%)	5 (1.4%)	34 (25.6%)	10 (1.5%)	110 (22%)	15 (2%)	
60-69	50 (14.0%)	21 (5.7%)	24 (18.0%)	29 (4.4%)	74 (15%)	50 (5%)	
70-79	8 (2.2%)	72 (19.5%)	9 (6.8%)	107 (16.4%)	17 (3%)	179 (19%)	
80-89	2 (.6%)	156 (42.2%)	1 (.8%)	169 (41.2%)	3 (1%)	325 (35%)	
90 and over	1 (.3%)	112 (30.3%)	0 (0%)	236 (36.1%)	1 (0.2%)	348 (38%)	

5.3.2. Service user characteristics- differences between focal and non focal samples

Table 5.10 shows with learning disability service users, the non focal sample were significantly older and exhibited more signs of anxiety than service users from the focal sample. Furthermore, the focal sample exhibited more problems communicating with others than service users from the non focal sample. In terms of older people service users, Table 5.10 show the non focal sample was significantly older than the focal sample. However the focal sample showed more signs of anxiety and displayed more problem behaviour than the non focal sample. Table 5.10 shows no significant differences with ethnicity for both the focal and non focal sample.

Table 5.10- Service user demographics and characteristics - focal and non focal

	Focal	**Non focal**	
Learning disability service users			
N	**366**	**135**	
Mean age (range)	45.6 (19-101)	49.0 (21-84)	**U=20355.500, Z= -2.429,p<.015 , r= -.15**
Ethnicity % minority groups	45 (79%)	12 (21%)	χ^2 = 1.257, d.f=1, p<.262, phi=.050
Signs of anxiety – Mean and Range	1.8 (1-4)	2.2 (1-4)	**U=18993.500, Z= -3.279, p<.001, r= -.15**
Signs of depression- Mean and Range	1.7 (1-5)	1.9 (1-5)	U=22475.000, Z= -1.274, p<.203, r= -.06
Display problem behaviour- Mean and Range	2.4 (1-4)	2.5 (1-4)	U=24313.500, Z= -.138, p<.890, r= -.01
Ability to communicate with others- Mean and Range	2.6 (1-4)	2.2 (1-4)	**U=2-277.500, Z= -3.021, p<.003, r= -.14**
Short term memory problems- percentage %	120 (35%)	37 (29%)	χ^2 = 1.755, d.f=1, p<.185, phi=-.061
Older people service users			
N	**375**	**670**	
Mean age (range)	84.3 (43-104)	85.9 (43-104)	**U=109263.000, Z= -2.542, p<.011, r=-.08**
Ethnicity % minority groups	13 (48%)	14 (52%)	χ^2 = 1.812, d.f=1, phi=-.042, p<.178
Signs of anxiety Mean and Range	1.9 (1-4)	1.7 (1-4)	**U=113206.500, Z= -2.427, p<.015, r=-.08**
Signs of depression Mean and Range	1.6 (1-5)	1.6 (1-5)	U=119574.000, Z= -1.165, p<.244, r=-.04
Display problem behaviour- Mean and Range	2.0 (1-4)	1.8 (1-4)	**U=115810.500, Z= -2.294, p<.022, r=-.07**
Ability to communicate with others- Mean and Range	2.0 (1-4)	1.9 (1-4)	U=122689.000, Z=-.434, p<.664, r=-.01
Short term memory problems- percentage %	189 (50%)	363 (51%)	χ^2 = 1.623, d.f=1, p<.203, phi=-.061

Note= Higher scores for anxiety, depression, problem behaviour and ability to communicate with others reflect higher levels of impairment

5.3.3. Service user characteristics- differences between adults with learning disabilities and older people

Table 5.11 shows for minority ethnic service users, focal older peoples were significantly older than focal learning disability service users. Table 5.11 also shows conversely to focal older people sample, minority ethnic focal learning disability service users exhibited more impairments in terms of ADLs and cognitive performances. Furthermore, there was a statistically significant difference in short term memory impairments for the focal older people service users with over 92% of older people exhibiting short term memory problems in contrast to 42% of learning disability service users displaying memory impairments.

Table 5.11-Focal service user characteristics – comparing adults with learning disability and older people

	Learning disability	**Older people**	
Gender- % Male	207 (58%)	112(30%)	**χ^2= 57.236, df= 1, p<.0001, phi=.279**
Age Mean and Range	46 (20-101)	85 (47-104)	**U=2639.000, Z= -22.416, p<.0001, r= -.83**
ADLs- Barthel Index Total - Mean and Range	13.3 (0-20)	9.8(0-20)	**U=47135.500, Z= -5.975, p<.0001, r= -.22**
Signs of anxiety Mean and Range	1.8 (1-4)	1.9 (1-4)	U=61401.000, Z= -1.695, p<.090, r= -.06
Signs of depression- Mean and Range	1.7 (1-5)	1.6 (1-5)	U=65974.000, Z= -.529, p<.597, r= -.02
ABC Total- Mean and Range	18.5 (0-43)	15.1 (0-38)	**U=38235.000, Z= -10.361, p<.0001, r= -.38**
Display problem behaviour- Mean and Range	2.4 (1-4)	2.0 (1-4)	**U=50156.000, Z=-6.448, p<.0001, r= -.24**
Ability to communicate with others- Mean and Range	2.5 (1-4)	2.0 (1-4)	**U=45043.000, Z= -8.100, p<.0001, r= -.30**
Cognitive performance- MDS- Mean and Range	2.4 (1-3)	2.1 (1-3)	**U=47142.500, Z= -5.354, p<.0001, r= -.20**
Confusion- MDS- Mean and Range	2.5 (1-3)	2.1 (1-3)	**U=46417.000,Z= -6.054, p<.0001, r= -.23**
Short term memory problems- percentage %	120 (35%)	189 (50%)	**χ^2= 16.323, df= 1, p<.0001, phi= -.151**

Note= Anxiety, depression, communication cognition and confusion, - High scores reflect more impairment (1-5); ABC- Higher scores indicate less challenging behaviour. Higher ADL scores reflect more independence.

5.3.4. Service user characteristics- collected from focal service users- comparing minority ethnic service users with white ethnic groups only

Table 5.12a explores whether service user characteristics differed for adults with learning disabilities from minority ethnic groups in comparison with adults with learning disabilities from white ethnic groups only.

Adults with learning disabilities

Table 5.12a shows the minority ethnic group were significantly older than white ethnic groups only. There were no significant differences between minority ethnic and white ethnic

learning disability service users with gender, ADLs, signs of anxiety, signs of depression, adaptive behaviour, challenging behaviour, exhibition of problem behaviour, ability to communicate with others, cognitive performance, levels of confusion and short term memory problems.

Table 5.12a- Focal learning disability service user characteristics- ethnicity

	Non white minority ethnic	**White ethnic groups only**	
Learning disabilities			
N			
Gender % male	24 (55%)	183 (59%)	χ^2 = .293, d.f=1, p<.626, phi=-.029
Age Mean and Range	46 (19-101)	40 (21-59)	**U=4915.000, Z= -2.947, p<.003, r=-.16**
ADLs- Barthel Index Total – Mean and Range	14.2 (0-20)	13.2 (0-20)	U=5428.500, Z= -1.607, p<.108, r=.09
Signs of anxiety – Mean and Range	1.8 (1-4)	1.8 (1-4)	U= 6066.000, Z= -1.148, p<.251, r=-.26
Signs of depression- Mean and Range	1.6 (1-4)	1.7 (1-5)	U= 6648.500, Z= -.542, p<.588, r=-.10
SABS Total- Mean and Range	49.3 (9-100)	47.4 (1-106	U= 5988.500, Z= -.726, p<.468, r=-.04
ABC Total- Mean and Range	20.0 (0-64)	18.1 (0-59)	U= 6929.000, Z= -.209, p<.834, r=-.01
Display problem behaviour- Mean and Range	2.3 (1-4)	2.4 (1-4)	U= 6952.500, Z= -.145, p<.885, r=-.01
Ability to communicate with others- Mean and Range	2.6 (1-4)	2.5 (1-4)	U= 6880.000, Z= -.045, p<.964, r= -.00
Cognitive performance- MDS- Mean and Range	3.4 (1-6)	3.4 (0-6)	U= 5909.500, Z= -.317, p<.752, r=.00
Confusion- MDS- Mean and Range	2.5 (2-3)	2.4 (1-3)	U= 5985.000, Z= -.203, p<839, r=-.02
Short term memory problems- percentage %	18 (42%)	102 (35%)	χ^2 = .840, d.f=1, p<.359, phi=-.050
Social impairment	27 (69%)	219 (73%)	χ^2 = .186, d.f=1, p<.667, phi=-.023

Note= Anxiety, depression, communication cognition and confusion, - High scores reflect more impairment (1-5); ABC- Higher scores indicate less challenging behaviour. Higher ADL scores reflect more independence.

Older service users

As shown from Table 5.12b, older non-white minority ethnic service users were significantly more impaired with the following: service users ability to communicate with others, cognitive performance. Non-white minority ethnic older people exhibited higher levels of confusion than older people from white ethnic groups only. Furthermore, non-white older minority ethnic service users depicted significantly higher occurrences of short term memory problems than white ethnic service users, whereby over 92% of minority older people reported short term memory impairments in contrast to over 48 % of white ethnic older people.

Table 5.12b. Focal older people service user characteristics- ethnicity comparisons

	Non white Minority	**White ethnic groups**	
Older people			
Gender	3 (23%)	109 (30%)	Fishers Exact = p<.762, phi=-.028,
Age	81.5 (68-96)	84.4 (43-104)	U= 1757.000, Z= -1.488 , p<.137, r=-05
ADLs- Barthel Index Total. Mean and Range	6.3 (0-16)	10.4 (0-20)	U= 1544.500, Z= -1.945, p<.052, r=.10
Signs of anxiety. Mean and Range	1.9 (1-4)	2.0 (1-4)	U=1907.500, Z= -1.204 , p<.228, r=-.06
Signs of depression. Mean and Range	1.4 (1-2)	1.6 (1-5)	U= 2818.000, Z= -.505, p<.614, r=-.03
ABC total Mean and Range	12.7 (0-53)	9.3 (0-83)	U= 1619.500, Z= -1.921, p<.055, r=-.10
Display problem behaviour. Mean and Range	2.0 (1-4)	1.9 (1-4)	U=1880.000, Z= -1.327, p<.185, r=-.07
Ability to communicate with others. Mean and Range	3.6 (3-4)	1.9 (1-4)	**U= 959.000, Z= -3.500, p<.0001, r=-.18**
Cognitive performance- MDS. Mean and Range	4.5 (0-6)	2.5 (0-6)	**U=970.000, Z= -3.253, p<.001, r= -.17**
Confusion- MDS. Mean and Range	2.7 (1-3)	2.1 (1-3)	**U= 1228.000, Z=-2.683, p<.007, r=-.17**
Short term memory problems- percentage %	12 (92%)	177 (49%)	**Fishers Exact, p<.003, phi=-.159**

Note= Anxiety, depression, communication cognition and confusion, - High scores reflect more impairment (1-5); ABC- Higher scores indicate less challenging behaviour. Higher ADL scores reflect more independence.

5.3.5. Service user characteristics- differences between minority ethnic and white ethnic service users

Given the sample size of 45 minority learning disability service users as presented in Table 5.9, Table 5.13 shows initial comparisons to explore whether service users from within minority ethnic groups differed in terms of demographics and levels of ability for minority learning disability service users only. Table 5.13 shows that ADLs, anxiety, adaptive behaviour, challenging behaviour, exhibition of problem behaviour, cognitive performance, levels of confusion, short term memory impairments and social impairments were comparable for service users from south Asians, black and other minority ethnicity groups. However, signs of depression significantly differed for service users from within minority ethnic groups. Mann Whitney tests were used to follow up this finding. A Bonferroni correction was applied so all effects are reported at a .0167 level of significance. It appeared that signs of depression were significantly higher for south Asian minority service users compared to black service users (U= 46.500, p<.004, r= -.50) and for south Asian minority service users and other minority service users (U=27.000, p<.038, r= -.45), although signs of depression for black service users and other minority service users did not statistically differ (U=131.500, p=.592, r= -.09). Utilizing Bonferroni corrections, south Asian service users showed significantly higher signs of depression in comparison with black service users.

Table 5.13- Focal learning disability service users- minority ethnic comparisons

	South Asian service users	**Black ethnic groups**	**Other ethnic service users**	
N				
Gender – Male- %	3 (33%)	13 (57%)	8 (67%)	Fishers Exact Test= p<.374
Age- Mean and range	44 (25-59)	41 (25-51)	35 (21-48)	*H* =4.475, d.f= 2, *p*<.107
ADLs- Barthel Index Total - Mean and Range	13.8 (1-20)	14.5 (0-20)	15.7 (8-20)	*H* =1.407, d.f= 2, *p*<.495
Signs of anxiety – Mean and Range	1.8 (1-3)	1.0 (1-5)	1.7 (1-4)	*H* =.759, d.f= 2, *p*<.684
Signs of depression- Mean and Range	2.3 (1-4)	1.3 (1-4)	1.4 (1-3)	***H* =8.741, d.f= 2, *p*<.013**
SABS- Mean and Range	49.8 (19-77)	47.4 (16-75)	57.4 (23-100)	*H* =.425, d.f= 2, *p*<.808
ABC Total. Mean and Range	85.2 (75-99)	85.8 (62-100)	89.3 (80-99)	*H* =.609, d.f= 2, *p*<.738
Display problem behaviour. Mean and Range	2.2 (1-4)	2.6 (1-4)	2.1 (1-3)	*H* =1.762, d.f= 2, *p*<.414
Ability to communicate with others. Mean and Range	3.0 (2-4)	2.7 (1-4)	2.2 (1-4)	*H* =1.941, d.f= 2, *p*<.379
Cognitive performance- MDS- Mean and Range	3.4 (2-5)	3.5 (1-6)	2.9 (1-5)	*H* =1.207, d.f= 2, *p*<.379
Confusion- MDS. Mean and Range	2.6 (2-3)	2.5 (2-3)	2.4 (2-3)	*H* =.541, d.f= 2, *p*<.763
Short term memory problems- percentage %	3 (33 %)	13 (54%)	2 (20%)	Fishers Exact Test , p<.181
Social impairment- percentage %	5 (56%)	14 (78%)	8 (67%)	Fishers Exact Test , p<.497

Note= Anxiety, depression, communication cognition and confusion, - High scores reflect more impairment (1-5); ABC- Higher scores indicate less challenging behaviour. Higher ADL scores reflect more independence.

5.4. Conclusion

This chapter primarily explores characteristics for care home service users, care homes and care home staff collected from the MOPSU study. Drawing from research questions outlined in chapter two, analyses included comparisons between learning disability and older people, followed by comparisons between non-whites versus white ethnic samples. This chapter also explored comparisons within minority ethnic learning disability samples given that 45 minority ethnic service users were collected from learning disability care homes.

Learning disability and older people comparisons

In terms of statistically significant variations in characteristics between learning disability and older people care homes. In contrast to older people care homes, learning disability care homes contained more residential learning disability care homes, were more prevalent within London and South East regions and depicted higher percentages of NMS lifestyle standards met. Moreover, conversely to staff working in older people care homes, with learning disability staff, there were more men, full time staff and staff devoted more time to non personal care hours. Conversely, staff working in care homes for older people was more likely to participate in qualified nursing hours, personal care and other staff hours. With

focal samples, conversely to older people, learning disability samples contained more men, were more likely to be independent, exhibited more challenging behaviour, displayed difficulties in communicating with others as well as more cognitive and confusion impairments. Furthermore, conversely to learning disability populations, older people were older and exhibited more memory problems.

Non-white minority ethnic and white ethnic comparisons

Non white minority ethnic learning disability service users were older than white ethnic learning disability service users. Furthermore, conversely to white ethnic older people, non-white minority ethnic older service users displayed significantly more impairments with communicating with others, higher cognitive impairments, higher rates of impairment and more short term memory problems.

With learning disability care staff characteristics, care homes with at least one minority ethnic service user contained higher percentages of Asian staff than care homes with white ethnic service users only. Moreover, care homes with at least one Asian service user contained higher percentages of Asian staff than care homes with no Asian service users. Furthermore, conversely to care homes with only white ethnic service users, care homes containing at least one minority ethnic service users contained a lower percentage of staff aged 55-64 and contained higher percentage of full time staff. Conversely, with older people care staff, conversely to care homes with only white ethnic service users, care homes containing at least one minority ethnic service user contained a higher percentage of minority ethnic staff, contained higher percentages of black ethnic staff and contained higher percentages of staff participating in qualified nursing hours and personal care.

Non-white minority ethnic within comparisons

As there were only sufficient numbers of minority ethnic adults with learning disabilities to explore variations within minority ethnic service users, south Asian learning disability service users displayed significantly more signs of depression than black and other ethnic learning disability service users.

6. Chapter Six- Qualitative views on culture, cultural needs and care home experiences

6.1. Introduction

This chapter reports qualitative findings on definitions of cultural needs, experiences of care homes and comments on sensitivity to cultural needs ascertained from focus groups with south Asian and African Caribbean service users and their relatives. Focus groups were conducted in two specialist care homes for older people from minority ethnic backgrounds.

6.2. Overview of themes

The thematic analysis produced three major themes or defined as 'higher order' clusters with attendant sub-themes. First, definitions and conceptualizations of culture. Second, views associated with specialist and mainstream care homes. Third, definitions and conceptualizations of needs and quality.

6.3. Views on culture

Table 6.1 presents and overview of conceptualizations of culture and summarises the main themes identified by both minority ethnic groups and themes mentioned by one minority ethnic group.

Table 6.1- Conceptualizing culture- comparing south Asian and African-Caribbean service users (SU) and relatives

	South Asian focus groups service users (SU) and relatives				**African-Caribbean focus groups**	
Theme	**South Asian-Hindu-SU**	**South Asian-Muslim-SU**	**South Asian-Sikh-SU**	**South Asian-Hindu-Relatives**	**African-Caribbean-SU**	**African-Caribbean-Relatives**
Homogeneity and similarity				√		√
Heterogeneity amongst cultures						
Segregation implications		√		√	√	
Culture-Amalgamation				√		
Minority disadvantage						√

Homogeneity, similarity and culture

Table 6.1 shows service users and relatives from both minority ethnic groups discussed similarities and differences or segregation between different ethnic or cultural groups. Both relatives from south Asian and African-Caribbean groups commented that care home service users were part of a collective group or culture. For example, a few south Asian relatives discussed service users from similar ethnic groups were part of a collective group:

'I think we all come under the same umbrella of the Asians (Participant 5).

Similarly, an African-Caribbean relative commented all African-Caribbean service users living in the care were:

Accustomed to their Caribbean way of life (Participant 1)

Heterogeneity amongst cultures

For both south Asian participants and African- Caribbean service users, there also appeared to be differences within minority ethnic groups. For example, one Muslim service user commented (in English) that in Africa, all south Asians from Hindu and Muslim faiths reflect one homogenous group which implies differences between Hindu and Muslim communities.

A few south Asian relatives discussed differences within the south Asian community. For example, one south Asian relative discussed the possibility of restricting funding according to the separate south Asian communities, faith groups and caste systems in favour of a 'community care home' for service users from particular South Asian communities. For this south Asian relative, there appeared to be differences between south Asian individuals from Hindu religious backgrounds and south Asian individuals from Muslim religious backgrounds as illustrated below:

> *Participant 5: It might be a good idea to have a community of care sort of being sorted because there's so many big communities like we all have the Hindus have lets say for instance, Mistery's have hotels in another community, Shah's have a different community.*

One south Asian relative commented during childhood, every individual has certain socialization or 'upbringing' which implies difference between cultural groups.

> *You would have had a Polish upbringing. If you're English of course you would have had an English upbringing and so on, Sikh, West Indian, whatever it is (Participant 1)*

Segregation implications

Other south Asian relatives commented that specialist homes provided service users with 'their own little world' which perhaps implies segregation from other cultural groups.

It does create your own kind of little world you know (Participant 1)

Furthermore, all African-Caribbean relatives commented it was important for their relative to be 'amongst his own kind of people' as it reflects the life in which they had become accustomed which similarly implies distinctness from other cultural groups.

> *He needs care and he needs people who care for him and he needs because he's a West Indian and there are many West Indians here and they get together here (Relative 1)*

Moreover, almost all south Asian relatives agreed that segregation from other cultural groups was necessary for their parents.

Although we live in a multiracial society, but I still believe we still segregate among our own kind and we have a little world of our own you know (Participant 5)

Similarly, one African-Caribbean relative commented it was important for their parent to be with their own kind of people and the relative also commented that other minority ethnic groups such as Chinese groups and the Jewish population have their own care homes.

I would prefer him to be in with his own people. Like I mean the Chinese don't mix. The Chinese have their own care home. The Jews do. I've never seen a china man in a bank and they have got money (Participant 2)

Amalgamation

Some south Asian relatives discussed cultures may 'merge', or 'blurring of the boundaries' and an 'amalgamation of communities'.

Also in the future, because your now getting an amalgamation of communities between people of different faiths and colours. Going forward, I think because there is going to be a more blurring of the boundaries there might be a more homogenous kind of service provision you know where some of things are not going to be that marked

Disadvantage

One relative from African-Caribbean focus groups commented 'African Caribbean people' do not receive a fair share by the council and the government.

Black people don't get their fair share they should have got from the council and the government share (Participant 2)

6.4. Views on care homes

6.4.1. Overview

Table 6.2 summarizes themes of care home views. Both south Asian and African-Caribbean participants discussed the following themes: care home service users and level of ability; comments on whether mainstream care homes successfully met or failed to meet the needs of service users; preferences for specialist care homes; comments on successfulness of specialist care homes, benefits of specialist care and discussions surrounding the future of care. Furthermore, Table 6.2 shoes unlike African-Caribbean participants, south Asian participants also discussed the following themes: distress over care home admissions; stigma attached to care homes; and discussions on how an 'English' person would struggle whilst living within a specialist care home.

Table 6.2- Views of care homes overview- comparing South Asian and African-Caribbean service user (SU) and relatives participants.

	South Asian groups				African-Caribbean groups	
Theme	**South Asian-Hindu-SU**	**South Asian-Muslim-SU**	**South Asian-Sikh-SU**	**South Asian-Hindu-Relatives**	**African-Caribbean-SU**	**African-Caribbean-Relatives**
Care homes service users- levels of ability		√	√	√		√
Mainstream care homes						
Admission into mainstream care homes	√	√		√		
Successful at meeting some or all of service users needs		√		√		√
Fails to meet service users needs	√				√	
Specialist care homes						
Admission into specialist care homes- distressing experience for relatives				√		
Stigma attached to care homes				√		
More awareness of specialist care homes			√			
Preference	√	√		√		√
Successful at meeting minority ethnic needs	√			√	√	√
Specialist care home- benefits				√	√	√
Specialist care home- unmet need for 'English' people				√		
Future of care homes				√	√	√

√= Identified; √√= Identified and explicitly identified as important

6.4.2. Care home service users

This section describes themes mentioned by both south Asian and African-Caribbean service users and relatives with a focus on needs characteristics for care home service users.

Both service users and relatives from south Asian groups and African-Caribbean groups commented on levels of ability, particularly physical dependencies and levels of physical impairment.

My mum is lucky medically she's relatively ok but some of the people are in a bad way (Participant 1)

Similarly, as one of the African-Caribbean relative commented,

Well about care homes. It's only facilities for when you get old and you can't look after yourself either in your own home you got to find somewhere and that's the place you have to think of what else can you do (Participant 2)

6.4.3. Mainstream care homes

Both south Asian and African-Caribbean individuals discussed mainstream care homes in terms of 'met needs' and unmet needs'. Furthermore, one African-Caribbean relative implied that living in a mainstream care home would be more successful in meeting his parents needs.

If possibly they were in another home, possibly he would be feeling better Participant 2)

However, both south Asian and African Caribbean relatives commented mainstream care homes contained considerable unmet need. Levels of unmet need within mainstream care homes or 'English care homes' as defined by south Asian groups, was heavily emphasized throughout the focus groups, particularly from the South Asian relatives group.

If my mother was to live in an English care home she would die within six months.... assure you. (Participant 3).

Similarly, some of the south Asian service users commented that:

They stay here, they say they can see everything of their liking here.... they wouldn't dare go to another home. (Service user 3)

One African-Caribbean relative implied due to 'mixture' of care home service users from different cultural backgrounds, mainstream care homes contained a certain degree of unmet need.

I don't think so. Well he might be because I can't speak for him but really, but I don't think so. He was in a different home. It was a lot harder because they had more, well not even more, but they had a mixture and so their needs were a bit more changed like, because when you have different people to look after you have to treat them differently (Relative 1)

6.4.4. Specialist care homes

Admission

One south Asian relative relocated to a different region which contained care homes supporting older people from south Asian communities.

That was one of the reasons of moving because you know there was carers who used to come but they were all English speaking...Because we're in (East Midland city) are

like the gentleman said .... people in (East Midland city) we've got like Gujarati like my mum but in (South East region) we couldn't have that (Participant 3).

Stigma

Almost all south Asian relatives commented on negative stigma attached to care homes within south Asian communities:

I've found is that socially Asians do not accept their parents to go into a home.....You know if you go and ask your mum in there they would say that's the best thing they ever did.....but the community does not accept that (Participant 3)

One relative commented the social stigma attached to care homes within the south Asian community is historically founded:

You're right there is still a social stigma right you know because they equate it the oh your mum has had to go into a residential care home equating it back to the Asram yeah situation i.e. that weren't they left with in a position couldn't you have looked after them. You know it's like a failing on your part (Participant 1).

For most south Asian relatives, placing a parent into a care home elicited distress, particularly in response to stigma within south Asian communities.

Participant 5: I cried when I put my mum in the house. I was crying in the office. I did. I had tears in my eyes when I came first time.

Awareness of specialist care homes

Despite stigma and relatives stress following admissions into care homes, almost half of south Asian relatives discussed there should be more awareness of south Asian specialist homes for south Asian older people.

I think there should be more awareness with the council as well you know how many Asian centres exist as well you know and these sorts of homes. I don't think they really know....That's like I said they should be put on a map. They should. The city council should have a map of the Asian homes as well to understand which is which is which are the centres which for the Asians (Participant 5)

Preferences and met need

One south Asian relative discussed living in care home has allowed their relative to experience: psychological benefits such as improvements in mood and increased confidence as the quotations below illustrate:

I think my mum has changed a lot since over the period because she was totally illiterate and stubborn in her own ways.....but, she's much more calmer than before II can see the other side the improvement and the confidence she has got on her own to live on her own you see (Participant 5)

A few of south Asian relatives discussed specialist care home for south Asian service users was the best place to be, was comparable to a 5- star hotel and preferred future destination for the relatives.

Participant 3: So many people have said that.....this is like a 5 star hotel really.

One African- Caribbean relative also implied a preference for a specialist care home for African-Caribbean service users.

I would prefer him to be in with his own people (Relative 1)

Unmet need for 'English' people

Almost half of south Asian relatives agreed if an older people from white ethnic background lived within the specialist home, given that the specialist home targeted the needs and customs of the South Asian community, or someone from a white ethnic background or 'English person' would feel out of place.

(Participant 1) I think if you turn it on its head right, let's imagine for a second right and I think we all know what happens in this house right. If you had an English person to come and live here they would feel like a fish out of water...

Future of care homes

Future of specialist care homes were discussed by both south Asian and African- Caribbean relatives. Some south Asian relatives commented on moving older people back into the community as a result of funding issues.

My ongoing future concern however, is something like a governmental move away from providing full on residential care to try to get people back into the community where the parent's families look after them. Kind of like a quasi residential care in the sense that you know unless you're really ill you're not admitted. (Participant 2).

The issue of care home closure was raised by a few African-Caribbean service users commented that their care home was forecasted to close at anytime.

Their going to close it and then they get the money and the move this place wherever they want....the government and the council it can happen anytime (Service user 8)

6.5. Needs and quality

6.5.1. General definition of quality

Deriving a singular definition of quality was challenging for most focus group participants, however, most focus group participants disclosed care home aspects that constituted good practice and quality.

Quality comes down to gearing the care : for the needs of the individual if you can do that then I think you can get quality .....Poor quality would be providing care which is not geared to the care the needs of the individual (Participant 1)

A few south Asian relatives linked service quality with providing a service that caters for the 'particular cliental'.

I think their first priority should be to cater for their particular cliental. The home has to gear itself to its cliental. It has to otherwise it just doesn't work. (Participant 5)

Similarly, one south Asian relative discussed that meeting the needs of care home service users was comparable to meeting the needs of customers within businesses.

Maybe the person who is setting up the care home has to focus on what they are going to provide for their clients essentially that are what they are because a lot of these are businesses (Participant 3)

6.5.2. **Defining needs and quality- overview of themes**

Table 6.3 shows both south Asian and African Caribbean identified the following components as important in meeting needs and quality conceptualizations: accommodation, choice, engagement in activities, meals and nutrition, personal cleanliness, safety and social participation. Religion was also mentioned by both south Asian and African-Caribbean service users and relatives. Staff characteristics in terms of particular traits were identified by both south Asian and African Caribbean participants. Multilingual communication capabilities were further mentioned as important in meeting peoples needs and for quality conceptualities, but for the south Asian focus groups only. Table 6.3 also shows engagement in activities and meals were explicitly categorized as important for both south Asian relatives and African Caribbean service users. Personal cleanliness, religion, social participation and staff possessing the adequate and appropriate communication needs were important to south Asian relatives. Dress codes were mentioned by south Asian Hindu and Muslim service users, following questioning and prompts into dress codes.

Table 6.3 Overview of defining and conceptualizing service quality- comparing South Asian and African-Caribbean service user (SU) and relatives participants.

	South Asian focus groups				**African-Caribbean focus groups**	
Themes	**South Asian-Hindu-SU**	**South Asian-Muslim - SU**	**South Asian-Sikh-SU**	**South Asian-Hindu-Relatives**	**African-Caribbean-Service user**	**African-Caribbean-Relatives**
Accommodation	√	√		√	√√	√
Control and choice	√	√	√	√	√	√
Engagement in activities	√	√	√	√√	√	√
Meals and nutrition	√	√	√	√√	√√	√
Personal care and cleanliness	√	√	√	√√	√	√
Personal care (Dress codes***)	√	√				
Religion	√	√	√	√√	√	√
Safety	√			√	√	
Social participation	√		√	√√	√	√
Staff characteristics						
Features of good staff	√	√		√	√	

√= Identified; √√= Identified and explicitly defined as important ***= **Prompt only**

6.5.3. Accommodation

Accommodation was mentioned by most minority ethnic service users and relatives in defining service quality. The following themes attracted considerable discussion; homelikness, clean and comfortable accommodation, technological products or devices used within the care home and accommodation within a mainstream care home.

Homelikeness

South Asian service users from Hindu faiths discussed importance of living in a home that made them feel like they were at home.

> *T: They feel like their at home.... they feel like home here.*

Accommodation cleanliness

Most Hindu service users discussed accommodation cleanliness in defining service quality.

> *T: You can come and inspect and check it yourselves, our rooms are very clean*
> *T: They empty the dustbin everyday. They do the whole home every week*
> *T: They clean the bath as well and washing as well*

Some Hindu service users commented that inspections take place by more than one member of staff on a weekly basis to check accommodation cleanliness.

> *T: There's a single staff that goes round each room and makes sure the rooms are properly cleaned, there's no dirt left, so the junior staff does the cleaning, but the senior staff come and inspect as well.*

One Muslim service user commented if rooms were dirty, a member of staff would clean rooms.

> *T: If there is more dirt there they can always request someone to come and do the cleaning*

Most of the Muslim service users also commented on accommodation cleanliness as good things about the home

> *T: Their all saying the same, come and look at my room, you can see for yourself. He's saying I'm not lying or anything. It's very clean. We have nothing to hide he said, everything is good, it's very clean*

Furthermore, for Muslims, one service user, defined quality in terms of clean accommodation.

> *Service user- Cleanliness, morning come start cleaning. You can't find any dirt in the home*
> *T: Quality of the cleanliness is good*

Similarly, one African-Caribbean relative commented on importance of clean accommodation in supporting their relative.

> *There's always somebody there cleaning up and whatever it may be and they look after the service users (Service user 1)*

Comfortable accommodation

Other Hindu service users also commented on preferences for comfortable temperatures in variable weather conditions.

> *T: If its cold, if its very warm they get start a fan as well.*
> *T: Every room. There's a heater as well for the warmth, and they've got a fan if its particularly hot at night. They can use the fan as well.*

Furthermore, a few south Asian relatives the importance of comfortable rooms, with good lighting, heating and well ventilated environments.

> *T: It's good very very comfortable room*
> *T : Lighting...heating*
> *T: It's ....quite ventilated. It's good it's a nice comfortable room.*

One male Muslim service user also noted the good things about his bedroom including a well lit room and good furniture.

> *Service user- my room is not in the dark. Daylight comes in.*
> *T: Ok so brightness*
> *T: Furniture is good also, furniture*

Furthermore, in discussing what qualities service users liked about their rooms, another female Muslim service user commented that she had a bed from Bombay.

> T*: She's got a bed from Bombay*

Furthermore, a few south Asian Muslim service users commented on technological devices within their rooms. For example, electrical controlled beds, televisions and music systems such as 'HiFis'.

> *T: He's got his own bed. It's electric controlled bed. So he can raise the bed and go down.*

Furthermore one south Asian Muslim service user commented his accommodation was 'first class' as his bedroom contained his own television and hifi system.

> *Service user- First class (accommodation)*
> *T: TV, Hifi, he has his own hifi system.*
> *T: They said he will give him a bigger hifi but he said he doesn't need it*
> *Service users- my best one*

Some south Asian relatives commented on the importance of comfort associated with care home facilities such as special types of baths.

> *I would suggest is actually, just a general level of comfort, within the care home, you know the facilities, the special types of baths for people to get in and out of (Participant 1)*

One south Asian relative commented it was in the relatives interest to ensure their south Asian relative was as comfortable as possible.

We're there to try and help them give them the best comfort as possible. I think it's in every children's interest to make sure that their parents are comfortable and their looked after in the right manner (Participant 5).

6.5.4. Control and choice

Choice and control was mentioned by both South Asian and African Caribbean participants. One South Asian relative commented on freedom of choice provided throughout the home.

Freedom of choice is there all the time anyway (Participant 5)

Choice was associated with engagement of activities, yet, some south Asian older people 'don't have the choice' to visit their country of origin. Other south Asian relatives discussed choice in relation to meals and nutrition.

I think the service users should be given the choice to make up their own menus and things like that (Participant 3).

6.5.5. Engagement in activities

Activities were mentioned by both south Asian and African-Caribbean participants. The following engagement aspects were discussed; importance and significance of activities, types of activities, activity personnel, restrictions in activities due to service user characteristics, restrictions of activities due to care home and safety and organisational restrictions and disengagement and need for more activities.

Importance and significance of activities

From south Asian relatives, it was important to engaging their relatives in some form of activity. For example,

I also think you need like activities. This is something that needs to be looked at. Because I think most of the time, once they come here, they just get totally discouraged (Participant 3)

One south Asian relative further commented it was important to keep their relatives engaged as they were becoming more like children.

Why not have some form of show where they enjoy because they eventually all of the generations are becoming more like children so you need some form of entertainment (Participant 5)

One south Asian relative commented that South Asian older people should perform activities on their own in order to build their confidence levels.

I think the important part is when they start doing it themselves on their own and they have the confidence and that's an important part their of their life line you know

One African-Caribbean relative commented activities were important in order to improve physical health.

but at the same time, you should have activities for them whether they, I know some of the homes have somebody come in to do something with the women, like sewing or whatever it is, to keep their fingers a bit nimble because after a time when you start getting old, arthritis starts kicking in and things can't move as they should. If you sit and do nothing all your joints cease up (Service user 1)

Types of activities

One African- Caribbean relative mentioned activities as a particular need for service users and also discussed a series of games which was important for brain stimulation.

They play dominos. You know different games. It helps their brain a bit because you've got to put the right domino against the other one that's there so they think a bit so they've got to put a five against a five, a six against a six and that sort of a thing so some of them they play dominos, they play different games (Service user 1)

On a related point to activities, some south Asian relatives commented South Asian older people have differing numerical and literacy skills in contrast to other older people.

That's like with my mother , she can count, I mean she'll turn around she's illiterate she can't read or write but when it comes to counting the money and whatever she's got she can (Participant 1)

Similarly, due to inability and apprehension to use technological devices including telephones, along with fear of using electricity.

A lot of South Asian people in particular in the home like my mum used to be dead scared of electricity. She wouldn't even turn a switch as she would be dead scared to touch the plug as she would think she would get an electric shock. But over time as she's lived here now she's done that. (Participant 1).

On a related point, almost half of south Asian relatives discussed tailoring activities to the south Asian specific cultural and communication needs of south Asian older peoples. A few of south Asian relatives discussed the importance of culturally appropriate television channels such as Zee TV.

Participant 1: Also I think you know Zee TV. They've got Zee TV here....It's an Indian channel and that I think is a very very important life line for the people that live here because they all watch Zee TV they don't really watch BBC and ITV much they do a little bit but I think Zee TV is kind of a life line for them.

A few relatives commented on south Asian older people visiting their country of origin.

I think the issue I think if the homes are able to provide enough care or even by their children contributing to an overseas visit to their home land or something like India or something like that or maybe they could converse already or with a home in India or something that they could go and visit or during a winter month again or 2 weeks or (Participant 3)

Activity personnel

On a related point almost all South Asian older people discussed it was necessary to employ an additional professional to facilitate activities for south Asian older people including an activities co-coordinator or dietician.

But I think the activities side of it I think that's were you need to look at the voluntary sector.

Service user characteristics and activities

Some south Asian relatives discussed activities should be geared towards service users capabilities and levels of dependency.

I think to bring some activities out where they are actually trying whatever their able to use. If their able to use their hands let them create something, like you go to a day care centre or wherever you go. They will be made to do things to be given a project so that they could be proud of something

However, a few South Asian relatives commented some older South Asian older people may not wish to partake in activities due to South Asian older people being 'stuck in their ways'. Nevertheless, for other South Asian relatives, they felt South Asian older people would try to perform activities. However, one relative also commented that activities were mainly dependent on service users dependency and 'active' levels.

Participant 1. Well it all depends. You can't expect them to be active, bat the same time, you should have activities for them

Safety and organizational restrictions

Also, some south Asian relatives discussed constraints that prevent the home from performing activities such as small numbers of staff and robust detailed CRB checks with any additional personnel supporting South Asian older people.

Having said that and from a legal point of view because you've got the CRB checks and working with adults and vulnerable children aspect yeah, that could pose a slightly you know. For example this gentleman might volunteer to take the people out on a trip to Bradley park lets say yeah, but that person I guess will need to be vetted nowadays, yeah, CRB checks and so on (Relative 1).

Disengagement and need for more activities

Some south Asian relatives commented there needed to be more emphasis on engagement in activities within the care home.

I definitely think activities it is lacking ....and the activities are a major problem in the homes (Participant 5)

6.5.6. Meals and Nutrition

Foods were frequently mentioned by both south Asian and African-Caribbean service users and relatives.

Food significance

Almost all relatives discussed importance of good quality meals and nutrition or 'dietary input' in order to maintain a healthy existence for care home service users as the quotations below illustrate:

Your dietary input has got to be important, because if you don't get the right input of food, your nutritional input is going to be weak, its going to make you feel worse it could have an effect overall on your standard of life, yeah (Participant 1)

For one Hindu service user, food was the most important need for care homes to consider.

T: Food she said, the diet. The diet is very important to them

For both Hindu and Muslim service users, the service users stated food was 'first class' and high quality.

T: She said their happy all round. Everything. Food is good, quality is good. He said he's very happy here he said.

Furthermore, almost all relatives commented and agreed on the care homes ability to produce enjoyable food as indicated by some of the relatives choosing to dine at the care home.

Actually you can come any day and have lunch. I've done it once or twice and I must say the food is excellent (Participant 3

Food groups

Foods groups were also mentioned by almost all of the Hindu service users, most of the Muslim service users and a few of the Sikh service users.

From the Hindu group, almost all service users described food groups consumed by Hindus.

T: She's a vegetarian. She gets proper vegetarian food
T: She said she basically gets chapattis, rice, Dahl, vegetables, curry and she gets sweet dish three times a week.
T: Most of the things are common right, so there is a meat curry, there a vegetarian curry, which are separate.

With Muslim service users, most of service users discussed the care home provided food groups that were mainly consumed by Muslims such as Biryani.

I: What's so good about the food, what do you like about it?
Service user- Biryani
T: They make Biryani which is a typical Muslim diet
Service user- Curry, Lamb curry, Chicken, everything

Furthermore, other Muslim service users commented on foods that are integral to South Asian cuisine such as breads such as Roti, Chapatti and other foods such as egg salad, lamb, chicken, fish and prawns.

T: Roti, Chapatti,
Service users
T: He remembers his mums Roti it was that good. It was like my mums.
Service users- Sweet Roti
T: Occasionally they make sweet Roti which is a stuffed Roti with sugar
Service user
T: Boiled egg salad, they have boiled egg salad as well today.

Service user
T: It's only lamb, chicken
Service user- fish, prawns

Most of the Sikh service users also commented on foods consumed.

T: Their very happy with their curry
T: They get Dahl, vegetable curry here
T: They've got a sweet dish today

In addition in discussing foods, almost all of the South Asian relatives provided examples of South Asian foods.

> *So if you have Kanna which is hard they would find it ....its Chickpeas which would be very difficult to eat or if its got things like Loengha which is cloves and things like that she'll find that difficult to manage ok (Participant 1)*

All Caribbean relatives commented on foods which reflected Caribbean culture, such as plantains, yams and 'West Indian' soup.

> *Well, there accustomed to their Caribbean foods ok..... The food as I've said before is right for them (Service user 1)*

Most of the Muslim service users also discussed that the care home does not cook pork at all.

T: But you don't get pork. They don't make pork at all

Food preparation

Moreover, in defining service quality, some South Asian relatives commented it was important for care homes to modify and prepare foods according to whether service user could consume solid foods.

> *From a dietary point of view it does need to be cooked in a particular way although it might be Gujarati food but there are different ways of cooking Gujarati food to cater specifically for people who do have eating. (Participant 3).*

One relative commented it was important for staff to be 'accustomed' to preparing Caribbean foods.

> *Yes, you have to be accustomed to this kind of thing. Because when your cooking certain foods like spuds, they don't cook very long to cook and there are others, the bananas they cook different times, so you put them into the pot at different stages. Because if you put them in at the same time, some will cook before the others and they would be too soft, but you've got to know how to and they have a thing called yam, that takes a bit longer (Service user 1)*

One Muslim service user associated food prepared at the come with 'home' and foods resembling relatives meals.

Service user- Like home food
T: Just like home cooking. Just like my wife used to make

Religion and food

Relatives also very briefly mentioned the types of foods consumed by Muslims.

Oh right Halal meat applies to Muslims. They will only eat Halal meat (Participant 1)

Furthermore, almost half of the Muslim service users commented that staff prepares halal meat in order to meet the needs of Muslim service users.

T: Three times a week they get halal meat

Almost all Hindu service users discussed separating non vegetarians from vegetarians and vegetarian during meal times.

T: When the vegetarians are eating, they don't eat the food as well, so they can't see the meat. They finish first then the non vegetarians come
T: Yeah, vegetarians first and then they come so that their not offended so they keep their religious beliefs very intact. Some people don't like to see meat as well on the table.

Furthermore, it was important for care homes to prepare foods in accordance with religious faiths. Almost all south Asian relatives distinguished vegetarians and non vegetarians, which in general divided south Asian groups from Hindu and Muslim faiths. Furthermore, a few south Asian relatives commented on the care home differing the timing of meals according to whether the service user were vegetarians or non vegetarians.

Even we're talking about three religions here we've got food. You've got the vegetarian and the non-vegetarian. We're all the same we're South Asian we're not talking about English people, but still the non-vegetations eat separately. Because my parents would not eat with non-vegetarians... (Participant 1).

One Muslim service user briefly commented if a Muslim consumes a forbidden food or a food considered to be 'harem', then God forgives.

Service user- They can't eat pork
Service user: on occasion they don't see, but God forgives

Almost half of the relatives discussed the example of a strict vegetarian in illustrating food needs for people who practice Hinduism as illustrated below:

Because their strict vegetarians they wouldn't eat even onion or garlic some of them are very restrict even within the vegetarianism like visor you know (participant 2)

They avoid diary produces I think (participant 2)

Anything grown underneath like lets say for instance garlic grows under the soil so it so it doesn't grow on the top so they will not eat that because they feel that that the element of that type of food obviously makes you a bit more rational a bit more pedantic? Maybe (participant 2)

Moreover, religion appeared to be associated with eating customs whereby people from the South Asian community consume foods with their hands rather than with cutlery.

> *We don't eat with knife and fork at home because even that issue obviously is we do clean our hands before we sit down to eat, I think a lot of people will think your barbarous you shouldn't be eating with your hands. But they believe that God has given you the hands to eat it (Participant 5)*

In addition, a few south Asian relatives discussed strict vegetarianism was associated with how strict south Asian older people adhered to their religious belief.

> *Everybody there are so many different various religions but obviously how strict they are (participant 5).*

Food restrictions

From the Hindu service user group, one service user commented the care home restricts food groups.

> *T: When it's a sweet they don't get fruit. When it's a sweet dish they don't get fruit.*

However, one African-Caribbean relative felt his relative was not getting the adequate foods he required due to councils reluctance to pay for the type of foods that he would have consumed outside of their own home.

> *The only thing there they wont get the type of food outside their own home. Because as you know the council don't want to spend their own money that's one thing or the government itself (Service user 2)*

Furthermore, a few Hindu service users commented choice was associated with foods consumed for example:

> *T: They said they don't force us. They tell us exactly how much you want.*

Furthermore, one African Caribbean relative commented foods were restricted to what was provided by the home.

> *Relative 2. : Not really, they come round with a chart and ask you what you want tomorrow afternoon, dinner afternoon, but they only bring round some cornflakes in the morning with cold milk. I don't drink cold milk.*

Food in mainstream care homes

Furthermore, similarly to almost all south Asian services, one relative commented mainstream care homes would not respond to foods needs for South Asian older people.

> *It would be an issue in an English home. It wouldn't be happening. They would have a separate kitchen for the health and safety or whatever the implications are made to the homes but I don't think things would be separate (Participant 3).*

6.5.7. Personal care and cleanliness

Another need identified by most of the Hindu service users and a few of the Muslim service user's related to personal care. Personal care discussions focused on the following areas: same sex carers, usage of special baths in order to accommodate physical impairments, importance of personal cleanliness and personal cleanliness routines in line with country of origin.

Staff gender

Almost all Hindu service users commented female service users strongly preferred personal care from female staff, whereas male service users preferred care from male staff. Furthermore in providing support for female service users, occasionally, a male staff member accompanies female staff, but female staff are always available.

> *T. Only ladies can bath them. That's very important. Ladies will come bath them, not male.*
> *T. Occasionally what happens there is a lot of need is required, two people to do that, if two females are not possible, they have a male to accompany but there should always be a female there.*

Similarly, for Hindu male service users, mainly male staff supported male service users.

> *T: There is always a male member of staff taking him as well.*
> *T. Mostly the men will take him*

One Muslim service user commented different staff supported him through personal care, whereas he would prefer to have one member of staff rather than different unfamiliar staff members.

> *Service user- Different staff, different staff*
> *T: But do you prefer different staff or do you prefer the same staff?*
> *Service user- I prefer one staff, but sometime their on holiday*

Personal care- Equipment

Some service users commented on individual differences with baths and showers.

> *T: Some people have showers, some have baths.*
> *T. They've got special baths as well*
> *T: Shower is comfortable. Sometimes they don't want to get in a bath. Getting in and out is uncomfortable.*

One service user commented the care home provided personal cleanliness facilities which reflected their country of origin.

> *There are special facilities like they have a chair, they can sit on the chair, there's a bucket there as well so they can use the bucket. Like they used to do in Africa*
> *T: It's the same in Africa they had a bath like that.*
> *T: More people have a shower as it's easy*

Cleanliness importance

All Hindu service users commented on importance of personal cleanliness. For some service users, it was important to be clean before meal times, although other service users commented they would be happy to have tea or coffee after a bath.

> *T. We take a bath everyday. It's very important. Personal care is very important.*
> *T: She said sometimes they won't have a tea or coffee or anything before they have a bath.*
> *T: She's very flexible she can eat and drink before a bath.*

In addition, for African-Caribbean relatives, personal cleanliness was mentioned as something that was important for care homes to take into account.

> *Well as I said, he's 101, so therefore he needs help with his washing, showing and washing and so on. Every morning, there is someone assisting him, take him to the bath or the shower and fix him up, put his clothes on and their clothes are changed every day and they staff they do that..... She makes sure that things are done up to scratch and that their clean and their clothes daily (Service user 1).*

6.5.8. Personal care (Dress codes)

In discussions surrounding personal care, Hindu and Muslim service users were prompted to discuss particular dress codes.

Traditional dress

Almost all Hindu service users commented it was important to wear traditional clothing that reflected their national beliefs.

> *T: This is very important for them to wear their national dress, like saris, their national dress.*

A few Hindu service users and one female Muslim service user also discussed dress codes in light of physical impairments which prevents service users wearing traditional dress such as saris. Some service users discussed traditional clothing items such as saris are like an 'art form', due to levels of physical impairment, they wear clothing items that still reflect their 'Indian culture'.

> *T: They have accepted that if their very ill they need like a gown it's easier to undress them, take them off*
> *T. This particular lady has suffered from a stroke its easier for her to wear a gown....with saris it's an art as well it takes time.*

One Muslim service user commented she would prefer to have worn a sari, but due to physical impairments she was unable to wear a sari.

> *T: She can't wear the sari now, she wants to wear sometimes but because she's now of the disabled it's difficult to handle the sari but she doesn't complain about it she doesn't mind.*

Forehead markings

In discussing dress codes within the Hindu culture, some Hindu service users discussed significance of small circular red markings on the forehead of female Hindu observers. As highlighted in the quotation below, the circular red markings worn on the foreheads of Hindu females reflected married status, whereas widows do not wear the circular forehead marks.

> *T: That's the significance of the red mark on their head. If they've got husbands. If their widows they don't have the red mark. That's the significance of Hindus, widows can't do that.*
> *T: They can't do the red mark they can do a saffron mark which is religious.*
> *T: Red is not permitted so once you become a widow you can't wear the red mark.*

The Hindu female service users also commented on different colours associated with forehead markings, with yellow forehead markings reflecting visiting a temple.

> *T: So if they go to the temple there, but this will be a different colour. Yellowish colour.*

Coloured clothing

Almost all Hindu females discussed significance of colours associated with dress codes. Some Hindu service users commented that only colourful clothes are worn by married Hindu females, whereas as Hindu widows wear mainly lighter colours, or predominately white clothing. A few Hindu service users stated within Hindu traditions, coloured clothing was associated with attractiveness, which may therefore appear to be inappropriate for widowed Hindus.

> *T: They like to wear lighter colours. If their married they wear other colours like red colours that should be known to the staff.*

Jewellery

Most Hindu females discussed the significance of jewellery within Hindu culture. For Hindu females, particularly with older Hindu females, wearing jewellery was associated with marriage. Conversely, Hindu widows seldom wear jewellery.

> *T: They don't wear too much jewellery if their widow. It's very limited.*
> *T: The bangle like the one she's wearing is a symbol of marriage.*
> *T: She said that's very important as jewellery is a part of marriage, the significance of marriage. They wear a lot of jewellery when their married. They keep that tradition.*

Gender differences

Few Hindu service users discussed differences between males and females and Hindu dress codes. As shown below, a Hindu service user discussed dress codes mainly apply to observant females, whereas males are more westernized.

> *T: Males are more westernized you know they don't mind even wearing trousers you know. They don't really wear traditional*
> *T. He said he's quite content with that*

6.5.9. Religion

Religious needs were also frequently mentioned by almost all South Asian service users from Hindu and Muslim faiths and a few Sikh service users. Religion was also frequently mentioned by both African-Caribbean service users and relatives.

Importance and significance

Religious belief appeared to be very important for a few Muslim service users.

> *Service user- Oh yes. Muslims today, religion is a very strong power*

A further theme discussed by most south Asian relatives was significance of religious beliefs.

> *Religion is an important issue because as they get older, they turn to religion, most people do and the ultimate aim of all the religion is to find a peace of mind (Participant 5)*

Furthermore, for one relative, acknowledgement of religious beliefs was also mentioned as a particular need for their relative.

> *My dad and my mum are Pentecostal Christians and they brought us up in a Christian home. At the moment like an assistant to the pastor of the church up the road there. But it is important because. God is important in everyone's life*

Lived experiences and religion

A few Sikh service users commented on television religious programmes presented throughout the day.

> *T: in the morning they have their prayers on the TV, they've got the special religious songs from the Sikh religion. They've got the special song which is like Songs of Praise. They listen to that in the morning.*

A few South Asian relatives commented living in a religiously orientated environment resulted in their relative feeling more religiously minded.

> *I think coming here it has opened up you know religiously much more religious minded now (Participant 3)*

Furthermore, a few South Asian relatives commented religion played an important role at the beginning of the morning routine and religious beliefs appeared to be associated with personal care:

> *Most of them will get up in the morning and will have a shower they will bath themselves before they even say the prayer, the secondary thing will be prayer to the God of the temple place they will be saying their prayers. Thirdly I think will be eating us all eat (Participant 5).*

Worship

Most Muslim service users also discussed the significance of prayer. For example some Muslim service users commented they worshipped daily and no one disturbs them during prayer.

Service users- Nobody disturbs us
Service users- I can pray daily

Facilities for prayer were also pointed out by one Muslim service user which allowed service users to pray whilst remaining seated.

Service user- we've got the facility so that we can pray sitting.

Furthermore, one Muslim service user commented during prayer it was important for the individual to have a clean heart.

T: He saying he was with a Muslim mate in another home he used to say I pray, but he was always having mischief with the nurses and the care staff, so he was saying that's not right, its wrong. If you pray you shouldn't be messing around with young girls you know its like their your daughters you know and he said you shouldn't do that you know and he stopped and he became not talking to him any more.

Religious objects

Almost all Hindu service users, some Muslim service users and most African-Caribbean service users and relatives commented on religious items used to facilitate prayer. Religious items included live lamps, shrines, burning of incense, prayer books, prayer beads and relevant television programmes.

A few Hindu service users discussed lighter lamps which was important for. Service users also commented on conflicts between health and safety maintained within the care home as well as physical impairments and practicing of religious objects such as 'live lamps' such as a naked flame similar to a candle.

T: Normally in the Hindu religion, there is a lamp, the lighter lamp when they do the prayers
T: Because of health and safety they are not allowed that is something which is, they agree now, but I think because they become their hands are very unstable they might put a fire, you know, they might drop a match box on the floor and cause a fire you

As a compromise to 'live lamps' and health and safety regulations, a few Hindu service users commented on usage of an electrical lamp which was used for prayers.

T: They have an electrical lamp which is the same only looks like lamp but without, it's not a live lamp you know, a fire, it's an electrical lamp so less chances of happening a fire. They have them.

Other Hindu service users discussed the role of shrines of Gods and Goddesses instead of live lamps used to facilitate prayer.

T: She's got a little shrine of the Gods and Goddesses, instead of a live lamp; she's got an electrical lamp.
T. They sit in front of the shrine and pray every day, but now the lamp isn't important because they understand the significance

A few Hindu service users also discussed that during prayer within the Hindu faith, the burning of incense and joss sticks was sometimes performed to show loyalty to God. Although service users commented that due to sensitive smoke alarms, service users were prevented from burning incense or joss sticks.

T. You can't allow joss stick

T. Jos stick isn't allowed because of the smoke it will trigger the smoke alarm

One Muslim service user commented that she reading prayer books facilitates worship.

T: She reads her prayer book everyday.

T: in the mosque she can't bend down any more, because of her health so she reads the book, the Quran.

Similarly, African- Caribbean service users and relatives commented on the Bible in order to facilitate worship.

Everyone who chose to read the Bible can read. It's the same thing here, we have a service here and (when we go to the day centre) the van come and picks us up and takes us home in the evening. It's still alright unto now (African-Caribbean service user)

A few Muslim service users commented on Islamic prayer beads. These beads were presented during the focus groups. The beads were used to facilitate prayer for the purposes of 'Dhaka' which is an Islamic devotional act typically involving the repetition of the name of God.

T: He's got beads. Two thousand times.

One Muslim commented that due to physical deformities she was unable to hold the beads, but counted on her fingers for the purposes of Dhaka.

T: She can't hold. She can do with counting the fingers like that. Because she can't hold the beads.

6.5.10. Safety

Safety was frequently mentioned by south Asian relatives and service users. Some participants discussed safety within different contexts including safety from family conflicts, within the community, awareness of media depiction demonstrating abuse, risks of financial abuse and fall prevention.

Safety from family conflicts

Some South Asian relatives discussed that living in care homes allowed service users to feel safe and secure away from conflicts within the family structure.

You're your own person right if lets say this gentleman wanted to argue with his mum at the end of the day she knows ok you've argued with me for two hours but he's gone. I'm here on my own, I'm safe and I'm well. Nobody could touch me. You know (Participant 1).

Safety in the wider community

Safety was also associated with engagement in activities with care home staff ensuring the safety of service users visiting the wider community.

> *I must say about this house is that it was very well done and the staff went with him all the time and when he wanted to join the library they were all for him you know (Participant 2).*

Awareness of media depictions and abuse

One south Asian relative commented on TV programmes exposure of abuse within care homes but all relatives were in agreement that their relatives safety was not at risk within the specialist care home.

> *Personally, I've never had within this setting at least I don't feel that her safety is at risk but I'm sure that's not necessarily true throughout the land in all the different care homes because you hear on the TV about people getting abused you know hidden cameras where they show people getting abused*

Risk of financial abuse

Almost all south Asian relatives commented feeling legally and financially secure as well as feeling secure regarding service users wills which was defined in terms of feeling safe and secure. Furthermore given problematic dynamics within family structures, almost all south Asian relatives commented on a need for a third party objective professional in order for their relative to feel legally and financially secure.

> *Participant 2- I'll take my own situation you know, it's the fact of the life my mum she is like worried about I'm going to die tomorrow what will happen to my things and I'll say I'll look after it. Its not you only in family. Got other sons and two daughters also. So she needs to talk but her wont talk to me because she thinks that I'll be bias because I'll say do it in my name. Put everything in my name....*

Fall prevention

South Asian relatives commented on trained staff involved with moving south Asian older people for socializing visits in order to prevent falls.

> *But the person who takes them when they off load them up at the other end needs to know how to do that properly. Because if they don't and that person falls of the edges.*

6.5.11. Social participation

Related to engagement of activities, most south Asian relatives discussed socializing as an important part of services. Socializing with people from similar cultures and ethnic groups were mentioned by both south Asian and Caribbean participants.

Most South Asian relatives discussed socializing in relation to socializing with other south Asian older people in other specialist south Asian homes.

You can get a mini bus driver to take them lets say to (another South Asian specialist care home) ... to have kind of an intermingling day. (Participant 4)

Some south Asian relatives discussed activities in terms of visiting other specialist homes for south Asian older peoples.

When they had an outing with the other different South Asian homes they all get together like a family so they can visit their home one day and their invited to someone's birthday, whatever the festivities or whatever the change in each individual, they become more friends, become much like a family. Or make it into a bigger group maybe an outing you know. (Participant 5)

One Caribbean relative commented that living in a care home allowed their relative to socialize with others, and also socialize with other service user from the Caribbean which helped discuss life within the Caribbean Islands.

Well as I said their accustomed to being with each other because I mean had they not been in a home and they were out they would be going around but being in a home they congregate and right now they stayed in an earlier compartment like this like a lounge and they sit and talk and they watch their television etc. I mean some of them are from different islands in the Caribbean so they talk. (Participant 2).

6.5.12. **Staff characteristics**

Care home staff attributes

Attributes of staff were raised by both South Asian and African-Caribbean participants. Discussions centered on personality attributes, staff competency and staff demographical groups.

Almost all South Asian Hindu relatives discussed that staff qualities were included in defining service quality, which included staff treating them well and staff who do not quarrel.

T: Everybody said that staff is very good with them. Everybody is good
T: They been treated well
T: Everyone's the same, everyone's' got the same mentality you know. They don't quarrel .
T: But they don't quarrel, they don't fight. That's what's very clear, they don't fight.

A few south Asian Hindu service users commented staff varied in terms of communication with service users.

T: They don't speak to you if you don't want to.
T: Sometimes they don't speak to you
T: It's your choice whether you want to speak to them or not
T: It depends. Everyone's different that's what's she is saying. Some people will like to speak to her
T: There are 28 people, their not all the same.

However, a few south Asian Muslim service users commented some staff were good, some of them were not.

Service users-Oh yes very good. ...Manageress is very respectful
Service users- Some staff are good, some are not.....
T: But some there just for money their not for the quality of service. Some are like that

One African-Caribbean relative commented it was important for staff to be attentive and observant to service users needs.

Because the manageress of this place. She doesn't go around with her eyes closed (Relative 1).

Furthermore, one African-Caribbean relative implied a need for genuine staff.

The carers, the staff. I couldn't expect better. I mean they don't put on when they see us come to visit. Because if they know that your coming they can make things look good (Relative 1)

Both south Asian and African Caribbean participants commented on staff competencies in defining service quality, including well trained staff. Most African-Caribbean relatives commented, it was important for their relative to receive support from well trained staff with a prompt response to any complaints:

Well the staff, well trained is like that. Because I came to see my cousin and everything coz if anything he mentioned to me, I go down there and I let them know and it sort it out. It might be the same time but they make a note of it and sort it out. The staff who listen to you when you make a complaint and they follow it up. They don't just there and don't bother themselves (Relative 2).

Similarly, a few South Asian relatives commented on staff competency:

Another important aspect which can't be overstated I think, is well trained, motivated, Staff. Ok. Because, you know, there's nothing worse than if their under paid, overworked, overstretched (Participant 1)

Some south Asian relatives commented on need for specialist care home services for south Asian older people to implement 'positive discrimination' in order to support and care for south Asian older people.

So, in this context, it would be proper for positive discrimination (Participant 1)

Another South Asian relative implied a need for staff from comparable ethnicity groups to facilitate comfort.

But if I mean if you're looking we're all in Leicester we're all comfortable round here we're all Asians we talk about Asian things and all that (Participant 4)

One African-Caribbean relative implied staff needed to be 'accustomed' to looking after, which for this relative, appeared to indicate care from African-Caribbean staff members.

Oh yes, it is important because I mean the carers who are here, they know how to care for these people. I'm not saying that the others don't, but I mean in every aspect of life you find that people become accustomed to who their looking after and the people who their looking after them. If possibly they were in another home, possibly

he would be feeling better but being amongst his own kind of people is important (Relative 1)

Communication needs

As Table 6.4 shows, communication needs were discussed by south Asians only.

Almost all South Asian relatives discussed communication need as a lack of communication was associated with isolation and a failure to meet the service users medical and food needs:

You know the person who is brought up by a Polish person. Russian, whatever they are. When they go into a care home, if they can't communicate with the staff then that could be a problem in itself, because it could isolate the person it could prevent them from getting the medical attention they need, the food they need, any other needs that they may have. So communication I think is an important provision of care (Participant 1)

For some relatives, it was important for care home to include staff that could speak languages spoken by the service users. Some relatives discussed need for home to have 'positive discrimination' which in this context refers to actively recruiting staff with bi-lingual capabilities in order to address the communication needs of South Asian older people.

But if you had English staff, mind you everything else is done brilliantly, but if the communication was lacking, then that could also have an effect on the provision of the services for the person. So in this context, it would be proper for positive discrimination to come into play because you've got to play to the needs (Participant 1).

Other relatives also discussed the need for professionals with 'multi linguistic' skills in order to communicate with South Asian older people. Furthermore, almost all South Asian relatives discussed need for professionals to speak dialects spoken by South Asian communities including Gujarati and Hindi rather than English.

Even on a medical ground, you need a doctor who is a multi linguist, you know possibly a Gujarati speaking (Participant 3).

One relative commented possessing multilingual skills was associated with family networks.

Somebody like speaking Gujarati and come and talk to them in Gujarati, Hindi or whatever the language and they feel like you know family, their families there and their part of the family and that feeling is different (Participant 2).

Furthermore, one relative discussed possessing literacy skills reduced the chances of becoming a burden to their relatives.

We are prepared but they haven't been prepared you see that's the thing. Like myself I know for a fact that I wouldn't be dependent on my children because obviously we can read and write and we already know that we're coming to a stage where in the circumstances we do become a burden to them we don't, we don't want to be a burden to them. But because we're educated we can communicate on a different level (Participant 5)

Half of the Hindu service users discussed the presence of written language written languages other than English used in order to communicate with service users as the quotations below illustrate:

T. There's instruction in Gujarati as well. in their rooms.
T: There are fire instructions in Gujarati in all the languages.
Service users
T: So once their explained properly, then they understands.
T. I think its Gujarati mainly. It's in Punjabi as well.

One relative commented some older peoples are illiterate therefore will not understand languages other than their native language

T: She said only the old people can't read so that's why they put it in a different language.
T Yeah, Yeah, it's very important, otherwise they won't understand
T. It's an issue and in order to remedy it is the transmission. In nice clear writing that you can read as well. So it's quite clear you know.

6.6. **Conclusion**

In summary, this chapter explores focus group findings from South Asian and African-Caribbean service user and relatives. This chapter presents qualitative findings on culture, needs, service quality and experiences of care homes, including experiences of specialist and mainstream care homes for older people.

7. Chapter Seven. Sensitivity to cultural needs

This chapter presents observational evidence of sensitivity to cultural needs across three parts. First, preliminary observations of layout, staff characteristics and décor of specialist care homes for observant Jews collected from the MOPSU study and specialist care homes for South Asian and African Caribbean older people collected from focus groups. Second, description of language capabilities and religious orientation of learning disability and older people service users collected from MOPSU study. Finally, MOPSU study findings on sensitivity to cultural needs.

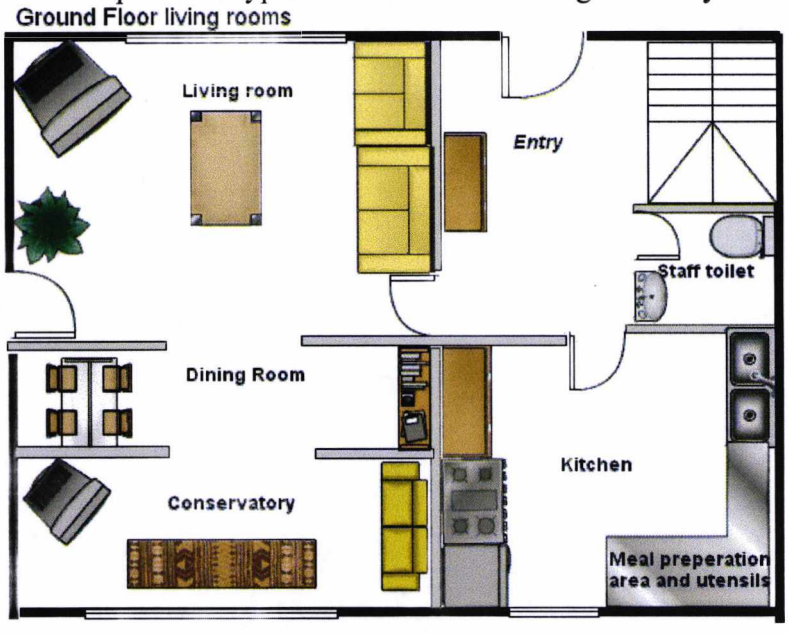
7.1. Initial observations

An unexpected benefit from MOPSU and focus groups data collection enabled insights into how care home staff within specialist and mainstream care homes supported minority ethnic service users. This section compares environmental observations from a typical mainstream care home for adults with learning disabilities with initial environmental observations of specialist care homes for Jewish, South Asian and African Caribbean service users respectively.

7.1.1. Mainstream care home for adults with learning disabilities

Figure 7.1 presents a ground floor plan of main living areas of a typical learning disability care home. This care home contained soft furnishings including sofas, tables, fish tanks, plants along with televisions and sensory lights. This care home was decorated with pictures of flowers, photos of service users and service user art. All foods were kept within one kitchen and stored in singular cupboards and fridges. Most direct care staff was female with the exception of two male care staff. With the exception of two non-white minority ethnic direct care staff, all other staff were from white ethnic groups. Activities include painting, singing nursery rhymes and singing from musical soundtracks, reading books and watching television, predominately children's British Broadcasting Channel (BBC), CBeebies and Eastenders.

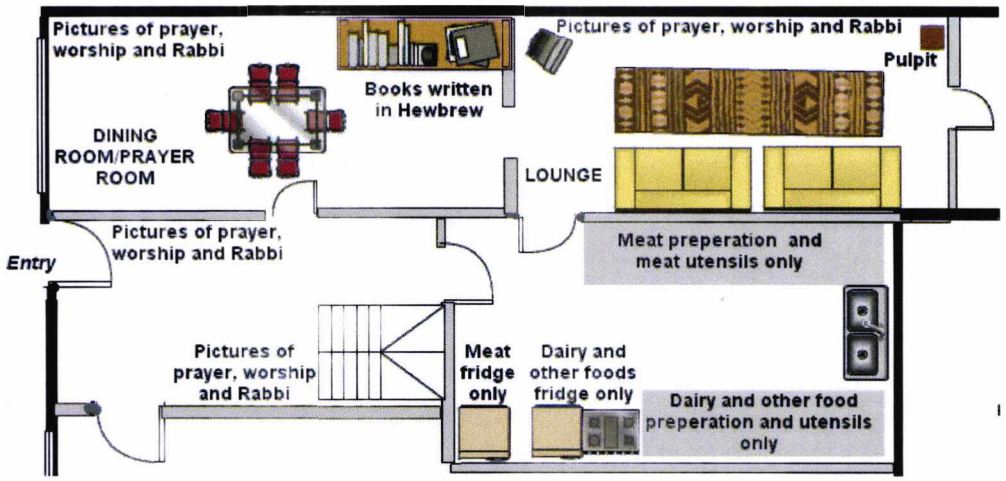
Figure 7.1- Partial floor plan of a typical mainstream learning disability care home



7.1.2. Specialist care home for observant Jewish adults with learning disabilities

Figure 7.2 depicts a partial ground floor plan of main living areas of a specialist learning disability care home for observant male orthodox Jews. This care home contained sofas, tables, plants and chairs. Unlike the typical mainstream learning disability care home displayed in Figure 7.1, the specialist care home was decorated with photos reflective of Judaism including pictures of Rabbis, synagogues and pictures of Israel. All foods were contained within one kitchen, but the kitchen was divided. One side of the kitchen was dedicated to diary products and the other side dedicated to all other food products. This care home contained two fridges, one for diary products and the other for meat products. Separate utensils were used for diary products and meat products. As these care homes catered for male service users only, all staff were male, with some wearing clothing reflective of Jewish sects. All men wore kippahs. Most activities seemed to reflect Judaism with some service users reading the Torah with a Rabbi for the majority of the fieldwork visit. Jewish music was played throughout observations, along with television programmes and films that were preliminary approved by a Rabbi. This care home frequently celebrated Jewish festivals and Jewish events. For example, during Friday observations, Jewish service users assisted staff in Sabbath preparations. Furthermore, all meals and bread were cooked on the Friday to enable staff and service users to completely observe the Sabbath on Saturday.

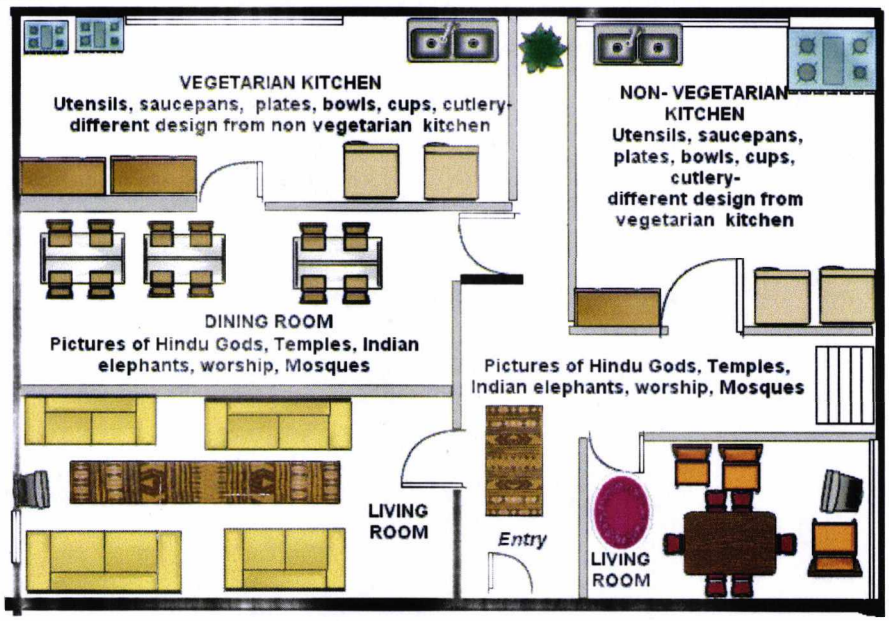
Figure 7.2- Partial ground floor plan of a specialist care home for adults with learning disabilities practicing Judaism



7.1.3. Specialist care home for south Asian older people

Figure 7.3 depicts ground floor plan of main living areas of a specialist care home for older people from south Asian backgrounds. This care home contained soft furnishings of sofas, tables, plants and chairs. Unlike the typical mainstream learning disability care home, this specialist care home was decorated with photos reflective of south Asian countries including pictures of India as well as religious temples, mosques, Hindu Gods and elephants. This care home contained two kitchens. One kitchen stored vegetarian foods only with a strict no meat policy within the vegetarian kitchen. Conversely, the non vegetarian kitchen was utilized by meat eaters and stored meat products along with other foods. In order to ensure clear separation of food products, Plates, crockery, and cutlery from the vegetarian kitchen were visually different from plates, crockery and cutlery from the non vegetarian kitchen. Of the staff observed, all staff were female. English was rarely spoken amongst service users and staff. Staff and very few service users spoke English in the presence of English speakers. Most activities seemed to reflect South Asian culture with some service users watching Asian television programmes and films throughout the day. This care home operated in accordance with non Christian faiths including Hinduism, Islam and Sikhism. Eid and Diwali reflected major celebrations within this care home.

Figure 7.3- Partial ground floor plan of a specialist care home for older people of South Asian descent



7.1.4. Specialist care home for older people from black ethnic groups

The specialist care home for black ethnic groups was similar in layout to mainstream care home depicted in Figure 7.1. This care home contained chairs, tables, plants and televisions. This care home contained many pictures and photos showing the Caribbean Islands. Large pictures and photos of key influential black historical figures including Martin Luther King. Furthermore, Jamaican flags were presented throughout. All staff were from black ethnic groups with combination of both male and female staff. No activities were observed within this home. Only English was spoken in this home, but both service users and direct care staff utilized strong Caribbean accents and Caribbean colloquialisms throughout.

7.2. Service user characteristics- Language and religion

7.2.1. Language

Twelve per cent or eleven learning disability care homes collected from MOPSU study contained service users for whom English was not their main language. Most south Asian learning disability service users main language was English (33.3%) or Hindi (33.3%) with the remainder being Urdu (11.1%), other languages (11.1%) and sign language (11.1%). English was the main language spoken by 85 % of learning disability service users from black ethnic groups with the remainder being sign language (10%) and other languages (5%). Conversely, the most frequent main language spoken by learning disability service users from other ethnic group was English, Bengali and other languages reflecting 40%, 20% and 20% respectively with the remainder being Arabic (10%) and sign language (10%). Language capabilities were also collected from nine service users from other European countries or other white ethnic groups. English was the main language spoken by 56% of other ethnic groups with the remainder of main languages being Greek (22%), Spanish (11%) and other languages (11%).

Nine older people care homes from the MOPSU study contained service users for whom English was not their main language. The main language spoken by south Asian older

peoples was either English (50%) or Punjabi (50%). English was the main language spoken by all older people from black ethnic groups. In contrast to older people from south Asian and black ethnic groups, English was not the main language spoken by any of the older people from other ethnic groups. Most older people from other ethnic groups spoke either other languages (50%) with the remainder being Cantonese (25%) or Arabic (25%). In terms of older people from other white ethnic groups, English was the main language for over 70% older people from other white ethnic groups with the remainder 30% of other white ethnic groups main language depicted Greek, Italian, Polish, Russian and other languages.

7.2.2. Religion

In terms of care home service users from learning disability homes, the two most frequent religions practiced by learning disability service users was Christianity and Islam which reflected with 49% and 24% respectively. These religion findings were comparable to the 2001 census figures of religion practiced for adults aged between 16-64 (ONS, 2005c). The remainder of learning disability service users were Jewish (14.6%), Hindu (4.9%), from other religions (4.9%) and Sikh (2.4%).

Most of south Asian service users were Muslims (50%), the remainder being Hindus (25%), Sikh (12.5%) or Christian (12.5%). Over 84% of learning disability service users from black ethnic groups practiced Christianity with the remainder practicing Islam (8%) and other religions (8%). Most of learning disability service users from other ethnic groups were Muslim (71.4%) with the remainder practicing Christianity (28.6%). Religion was also reported from a small sample of learning disability service users from white ethnic group, with 92% of service users practicing Christianity (46%) of Judaism (46%) with the remainder practicing other religions. For older people service users, Christianity and other religions reflected the two most frequent religious with 83% and 10% respectively with the remainder being older people service users practiced Buddhism (3.4%) and Sikhism (3.4%). Similarly, Christianity was the most frequent religion practiced by older peoples over 65 with 98% reported from the 2001 census. South Asian older peoples practiced either Christianity (50%) or Sikhism (50%). All older people service users from black ethnic groups and white ethnic groups practiced Christianity. Finally, older people from other ethnic groups practiced Christianity (33.3%), Buddhism (33.3%) and other religions (33.3%).

As the MOPSU study contained small proportions of service users from religions other than Christianity, the current study explored care home sensitivity to religious needs for care home service users from the four most frequent minority religions outlined from census figures, namely, Muslim, Hindu, Sikh and Jewish faiths (ONS, 2005c). Religious participation was noted from the MCNQ which included questions on frequency of religious participation.

7.3. Sensitivity to minority ethnic language needs

Following from data collected from the MCNQ, eleven learning disability care homes and seven older people care homes contained at least one service user for whom English was not their first language. As shown from Table 7.1 over 57% of both learning disability and older people care homes did not contain any multilingual staff. One care home out of eleven learning disability care homes contained multilingual staff with no multilingual staff in the older people care home containing non English speakers. All learning disability care homes that contained at least one non English speaker contained no information published in

languages other than English an five out of the 7 older people care homes contained information published in English.

Table 7.1. Sensitivity to language needs- Cultural index

Service level: Cultural Index and communication needs for service users for whom English was not their first language (CCHOT)	**Adults with learning disability homes with service users for whom English was not their first language N=11**	**Older people homes with service users for whom English was not their first language N=7**
1. Staff always used different languages to communicate with service users for whom English was not their first language	*(n=7)*	(n=7)
All cultural needs met	1 (14%)	0 (0%)
Some cultural needs met	2 (29%)	3 (43%)
No cultural needs met	**4 (57%)**	**4 (57%)**
2. Staff were immediately available with bilingual skills to communicate with residents	*(n=6)*	(n=7)
All cultural needs met	1 (17%)	0 (0%)
Some cultural needs met	1 (17%)	3 (43%)
No cultural needs met	**4 (67%)**	**4 (57%)**
3. Care home contained accessible written information published in other languages besides English	*(n=7)*	(n=7)
All cultural needs met	0 (0%)	1 (14%)
Some cultural needs met	0 (0%)	1 (14%)
No cultural needs met	**7 (100%)**	**5 (71%)**

All cultural needs met= staff always available with bilingual skills; extensive coverage of written material presented in different languages. No cultural needs met= no language support.

7.4. Sensitivity to religious worship

Table 7.2 shows religious symbols were observed for the two care homes that contained at least one Jewish service user and the one care home that contained at least one Sikh service user. Over 87% of care homes with at least one Muslim service user contained no observed religious symbols. Accessible prayer locations were found with all learning disability care homes with at least one Jewish service user, whereas over 87% of care homes with at least one Muslim service user contained no accessible prayer locations. The remaining care homes did not contain any accessible prayer locations. Finally, religious festivals other than Christianity were celebrated in all care homes for adults with learning disabilities with Hindu, Jewish and Sikh service users. However, 75% of care homes with at least one Muslim service user and the older people care home that contained at least one Sikh service user did not celebrate religions other than Christianity.

Table 7.2 - Sensitivity to religious needs- cultural index

Service level: Cultural Index and religious needs for care homes that contained service users from religiously diverse faiths (CCHOT)	**LD home with Muslims N=8**	**LD home with Hindus N=2**	**LD home with Sikhs N=1**	**LD specialist home for Jews N=2**	**OP home with Sikhs N=1**
Religious needs					
1. Observed religious symbols					
All cultural needs met	0 (0%)	0 (0%)	0 (0%)	2 (100%)	1 (100%)
Some cultural needs met	1 (13%)	2 (100%)	0 (0%)	0 (0%)	0 (0%)
No cultural needs met	7 (88%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)
2. Accessible prayer locations					
All cultural needs met	1 (13%)	0 (0%)	0 (0%)	2 (100%)	0 (0%)
Some cultural needs met	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
No cultural needs met	7 (88%)	2 (100%)	1 (100%)	0 (0%)	1 (100%)
3. Celebration of religiously diverse festivals					
All cultural needs met	2 (25.%)	1 (100%)	1 (100%)	2 (100%)	0 (0%)
Some cultural needs met	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
No cultural needs met	6 (75%)	0 (0%)	0 (0%)	0 (0%)	1 (100%)

Note= All cultural needs= maximum score- i.e. accessible prayer locations, frequent religious celebrations. No cultural needs met= no evidence of sensitivity to religious worship. LD= Learning Disability. OP= Older People

7.5. Sensitivity to cultural and religious needs

From MCNQ data, thirteen care homes with adults with learning disabilities contained service users from religiously diverse faiths, whereas only one older people care home contained at least one service user from a religious background. Of the thirteen care homes for adults with learning disabilities that contained at least one service user from a religiously diverse background, the majority of care homes contained Muslim service users (61.5%) with the remainder from being 2 care homes with at least one Hindu service user (15.4%), 2 care homes with at least one Jewish service user (15.4%) and 1 care home containing at least one Sikh service user. One older people care home was identified as containing at least one Sikh service user.

7.5.1. Accommodation cleanliness

Table 7.3 presents findings of accommodation cleanliness for each learning disability and older people care home containing religiously observant service users. With the exception of one learning disability care home and older people care home containing Sikh service users, all other homes contained no noticeable signs of urine or faeces. No evidence of other odours were present within learning disability care home containing Hindu service users and over 85% of the eight care homes containing Muslim service users contained no noticeable odours. Odours were prevalent in the learning disability care home containing Sikh service users and one of the two care homes for Jewish service users contained prevalent odours. Almost all care homes containing religiously observant service users lived within clean accommodation with the exception of the older people care home containing Sikh service users which was considered dirty by fieldworkers.

Table 7.3 Accommodation cleanliness- cultural index

Service level: Cultural Index and personal care needs for care homes that contained service users from religiously diverse faiths- NHQ	**LD home with Muslims N=8**	**LD home with Hindus N=2**	**LD home with Sikhs N=1**	**OP home with Sikhs N= 1**	**LD home with Orthodox Jews N=2**
Noticeable odours of urine or faeces within the care home					
All cultural needs met	4 (57%)	2 (100%)	0 (0%)	0 (0%)	2 (100%)
Some cultural needs met	3 (43%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
No cultural needs met	0 (0%)	0 (0%)	1 (100%)	1 (100%)	0 (0%)
Other odours present within the care home					
All cultural needs met	6 (86%)	2 (100%)	0 (0%)	0 (0%)	1 (50%)
Some cultural needs met	1 (14%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
No cultural needs met	0 (0%)	0 (0%)	1 (100%)	1 (100%)	1 (50%)
Clean service users rooms, hallways and common rooms					
All cultural needs met	4 (57%)	2 (100%)	0 (0%)	0 (0%)	0 (0%)
Some cultural needs met	3 (43%)	0 (0%)	1 (100%)	0 (0%)	2 (100%)
No cultural needs met	0 (0%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)

Note= All cultural needs= maximum score- i.e. no odours. No cultural needs met= Pervasive odours. LD= Learning Disability. OP= Older People

7.5.2. Meals and nutrition

Table 7.4 shows percentages from the cultural index for religious needs and dietary needs for care homes with learning disabilities and care homes for older people containing at least one religiously diverse care home service user.

Table 7.4- Meals and nutrition- cultural index

Service level: Cultural Index and religious needs for care homes that contained service users from religiously diverse faiths (CCHOT)	**LD home with Muslims N=8**	**LD home with Hindus N=2**	**LD home with Sikhs N=1**	**LD specialist home for Jews N=2**	**OP home with Sikhs N=1**
Dietary needs					
1. Specially prepared foods- i.e. *halal, kosher, jhatka*					
All cultural needs met	3 (38%)	-	0 (0%)	2 (100%)	0 (0%)
Some cultural needs met	0 (0%)	-	0 (0%)	0 (0%)	0 (0%)
No cultural needs met	5 (63%)	-	1 (100%)	0 (0%)	1 (100%)
2. Separate food utensils for separate food groups					
All cultural needs met	2 (25%)	-	0 (0%)	2 (100%)	0 (0%)
Some cultural needs met	0 (0%)	-	0 (0%)	0 (0%)	0 (0%)
No cultural needs met	6 (75%)	-	1 (100%)	0 (0%)	1 (100%)
3. Culturally appropriate foods consumed					
All cultural needs met	4 (50%)	-	0 (0%)	2 (100%)	0 (0%)
Some cultural needs met	0 (0%)	-	0 (0%)	0 (0%)	0 (0%)
No cultural needs met	4 (50%)	-	1 (100%)	0 (0%)	1 (100%)

Note= All cultural needs= maximum score- i.e. clear separation of foods and consumption of religiously appropriate foods. No cultural needs met= lowest possible score= i.e. no separation of food groups for religiously observant service users and consumption of culturally inappropriate foods. LD= Learning Disability. OP= Older People

As shown from Table 7.4, over 62% of care homes with learning disabilities with at least one Muslim service user did not show any evidence of specially prepared foods such as halal meats. However, all care homes with at least one Jewish service user consumed kosher foods. No specially prepared foods were found in the two remaining homes at least one Sikh resident. Similarly, over 75% of care homes for adults with learning disabilities that contained at least one Muslim resident did not show any evidence of separate food utensils used for separate food groups, whereas all the care homes with at least one Jewish resident contained separate food utensils for separate food groups. None of the care homes for Sikh service users contained any evidence of separate food utensils. Finally, in terms of foods consumed, half of care homes for adults with learning disabilities with at least one Muslim service user were observed eating foods deemed as culturally inappropriate, such as eating pork products, whereas all of the care home homes containing Jewish service users were observed eating kosher foods. All care homes for Sikh service users were observed eating foods that diverged away from Sikh dietary practices.

7.5.3. Personal care

7.5.3.1. Hair and skin care needs

Black ethnic groups

From twenty four care homes for adults with learning disability with at least one service user from a black ethnic group, 13 (57%) of key workers stated that focal service users from black ethnic groups had particular skin and hair products. Furthermore, out of the seven older people care homes with at least one service user from a black ethnicity group, four (57%) staff reported service users used particular skin and hair products. From observations, Table 7.5 explores whether care homes containing service users with at least one black service user had access to oils and moisturizer, well groomed hair and specialized hair care products for Afro hair. Table 7.5 shows the majority of service users from black ethnic groups did not have access to skin moisturizers and hair care products in order to maintain healthy skin and hair care requirements for people from black ethnic groups. Although the majority of service users within care homes with at least one black ethnic service user were observed to have well groomed hair.

Table 7.5—Sensitivity to hair and skin care needs- black ethnic service users

Service level: Cultural Index and appropriate skin and hair care needs for care homes that contained service users from Black groups- (CCHOT)	**Learning disability home with service users from Black groups N=17**	**Older people home with service users from Black groups N=8**
1. Access special skin care products such as oils and moisture risers	*N= 17*	n=7
All cultural needs met	8 (47.%)	2 (29%)
Some cultural needs met	1 (6%)	1 (14%)
No cultural needs met	8 (47%)	4 (57%)
2. Service users with well groomed hair	*N= 17*	n=6
All cultural needs met	14 (82%)	5 (83%)
Some cultural needs met	3 (18%)	1 (17%)
No cultural needs met	0 (0%)	0 (0%)
3. Service users were able to access special hair care products such as wide toothcombs and oil for black hair	*N= 16*	n=7
All cultural needs met	2 (13%)	4 (57%)
Some cultural needs met	0 (0%)	0 (0%)
No cultural needs met	14 (88%)	3 (43%)

Note= All cultural needs= maximum score- i.e. hair and skin products for black skin and hair. No cultural needs met= no evidence of hair and skin products for black hair and skin.

Hair- religious groups

Table 7.6 presents hair items for care homes containing religiously observant service users. With the exception of one care home for learning disabilities containing Muslim service users, all other care homes contained service users with very well to well groomed hair. Almost all staff consulted with service users regarding hair cuts.

Table 7.6. Sensitivity to hair care- religious groups- cultural index

Service level: Cultural Index and personal care needs for care homes that contained service users from religiously diverse faiths- CCHOT	**LD home with Muslims N=8**	**LD home with Hindus N=2**	**LD home with Sikhs N=1**	**OP home with Sikhs N=**	**LD home with Orthodox Jews N=2**
Service users with well groomed hair					
All cultural needs met	5 (83%)	2 (100%)	0 (0%)	1 (100%)	1 (50%)
Some cultural needs met	0 (0%)	0 (0%)	1 (100%)	0 (0%)	1 (50%)
No cultural needs met	1 (17%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Service users- consulted with hair cuts					
All cultural needs met	1 (50%)	1 (100%)	-	-	1 (100%)
Some cultural needs met	1 (50%)	0 (0%)	-	-	0 (0%)
No cultural needs met	0 (0%)	0 (0%)	-	-	0 (0%)

Note= All cultural needs= maximum score- i.e. all service users well groomed. No cultural needs met= ungroomed hair. Hair cut without permission. LD= Learning Disability. OP= Older People

7.5.3.2. Personal cleanliness

Table 7.7 contains personal cleanliness items from the NHQ. Table 7.7 shows only 29% of care homes with at least one Muslim service user were regularly toileted which contrasts to 50% of Jewish homes. Furthermore, almost or all incontinent residents changed quickly. Personal care was conducted in away which preserved peoples dignity for most care homes with at least one Muslim, Hindu and Sikh resident. The majority of homes contained no noticeable odours of urine or faeces for care homes with at least one Muslim, Hindu or Jewish resident, however, care homes for Sikh service users both contained extensive amount of noticeable odours or urine or faeces. Furthermore, strong unpleasant smells were found in Sikh homes and 50% of Jewish homes, although these contrasts to care homes for Muslim and Hindu service users whereby a high percentage proportion were free from unpleasant smells. Most care homes containing Muslim and Hindu service users were observed to be clean or somewhat clean.

Table 7.7- Personal care needs- NHQ measure- Cultural Index

Service level: Cultural Index and personal care needs for care homes that contained service users from religiously diverse faiths- NHQ	**LD home with Muslims N=8**	**LD home with Hindus N=2**	**LD home with Sikhs N=1**	**OP home with Sikhs N= 1**	**LD home with Orthodox Jews N=2**
Dressed and clean service users					
All cultural needs met	3 (38%)	1 (50%)	0 (0%)	0 (0 %)	0 (0%)
Some cultural needs met	5 (63%)	1 (50%)	0 (0%)	1 (100%)	2 (100%)
No cultural needs met	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)
Well groomed service users					
All cultural needs met	5 (71%)	1 (50%)	(0%)	0 (0%)	1 (50%)
Some cultural needs met	2 (29%)	1 (50%)	0 (0%)	1 (100%)	1 (50%)
No cultural needs met	0 (0%)	0 (0%)	1 (100%)	0 (0%)	0 (0%)
Service users who were regularly toileted					
All cultural needs met	2 (29%)	0 (0%)	0 (0%)	0 (0%)	1 (50%)
Some cultural needs met	2 (29%)	1 (100%)	1 (100%)	1 (100%)	0 (0%)
No cultural needs met	3 (43%)	0 (0%)	0 (0%)	0 (0%)	1 (50%)
Incontinent service users who were changed quickly			*N=0*	*N=0*	
All cultural needs met	0 (0%)	0 (0%)	-	-	1 (100%)
Some cultural needs met	1 (100%)	1 (100%)	-	-	0 (0%)
No cultural needs met	0 (0%)	0 (0%)	-	-	0 (0%)
Personal care was conducted in a way which preserved peoples dignity					
All cultural needs met	5 (71%)	1 (50%)	1 (100%)	0 (0%)	0 (0%)
Some cultural needs met	0 (0%)	1 (50%)	0 (0%)	0 (0%)	2 (100%)
No cultural needs met	2 (29%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)

Note= All cultural needs= maximum score- i.e. all service users well groomed and clean. No cultural needs met= lowest possible score= i.e. very dirty. No dignity for service users. LD= Learning disability; OP= Older people

CCHOT items

Table 7.8 lists CCHOT items in line with the cultural index scores. Table 7.8 shows a high percentage of homes did not contain bidets, taps and jugs for service users use. Furthermore, most or all homes allowed service users to lock doors during personal care, most staff screen service users during personal care, most personal care was conducted with same-sex carers. Moreover, most service users had access to personal cleaning products in order to maintain high levels of personal hygiene. Additionally, most care homes contained service users that had well groomed hair . Finally, most staff within care homes consulted with service users about hair care.

Table 7.8—Personal care needs- CCHOT- Cultural Index

Service level: Cultural Index and personal care needs for care homes that contained service users from religiously diverse faiths- CCHOT	**LD home with Muslims N=8**	**LD home with Hindus N=2**	**LD home with Sikhs N=1**	**OP home with Sikhs N=**	**LD home with Orthodox Jews N=2**
Presence of bidets, taps and jugs for use after using the lavatory					
All cultural needs met	3 (38%)	0 (0%)	0 (0 %)	0 (0%)	1 (50%)
No cultural needs met	5 (63%)	2 (100%)	1 (100%)	1 (100%)	1 (50%)
Service users able to lock doors during personal care					
All cultural needs met	5 (83%)	1 (100%)	1 (100%)	-	1 (50%)
Some cultural needs met	1 (17%)	0 (0%)	0 (0%)	-	1 (50%)
No cultural needs met	0 (0%)	0 (0%)	0 (0%)	-	0 (0%)
Staff ensure all doors were closed or screened during personal care					
All cultural needs met	4 (80%)	1 (100%)	0 (0%)	-	2 (100%)
Some cultural needs met	1 (20%)	0 (0%)	0 (0%)	-	0 (0%)
No cultural needs met	0 (0%)	0 (0 %)	1 (100%)	-	0 (0%)
Care home ensured that examinations and practical care were performed by same sex carers					
All cultural needs met	1 (25%)	1 (100%)	0 (0%)	-	2 (100%)
Some cultural needs met	3 (75%)	0 (0%)	0 (0%)	-	0 (0%)
No cultural needs met	0 (0%)	0 (0%)	1 (100%)	-	0 (0%)
Service users had unrestricted access to personal cleanliness products to maintain personal hygiene					
All cultural needs met	3 (50%)	2 (100%)	1 (100%)	0 (0%)	2 (100%)
Some cultural needs met	3 (50%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
No cultural needs met	0 (0%)	0 (0%)	0 (0%)	1 (100%)	0 (0%)
Service users with well groomed hair					
All cultural needs met	5 (83%)	2 (100%)	0 (0%)	1 (100%)	1 (50%)
Some cultural needs met	0 (0%)	0 (0%)	1 (100%)	0 (0%)	1 (50%)
No cultural needs met	1 (17%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Service users- consulted with hair cuts					
All cultural needs met	1 (50%)	1 (100%)	-	-	1 (100%)
Some cultural needs met	1 (50%)	0 (0%)	-	-	0 (0%)
No cultural needs met	0 (0%)	0 (0%)	-	-	0 (0%)

Note= All cultural needs= maximum score- i.e., all service users well groomed, all same sex care; No cultural needs met= lowest possible score= i.e. completely disregard for personal choice. LD= Learning Disability. OP= Older People

7.5.3.3. Dress code

Females

Given the number of clothing items, this section will summaries the main findings from female clothing items only.

Specific clothing items

Of the three Muslim females, two service users (66%) wore bright attention worthy clothes, and none of the Muslim females wore clothes that exceeded the ankles were comparable to the opposite sex, wore night clothes for the majority of the day, or wore clothes dyed in saffron. None of the female Muslim females wore headwear. Of upper body clothing items, two Muslim females wore t-shirts and one wore a Salwar Kameez. Of lower body clothing items, one female wore trousers, one female wore jeans and one female wore a Salwar Kameez. All Muslim females wore shoes. Of the two Hindu female service users, the following items of clothing were worn: one wore a hat, one wore a blouse and one wore a jumper. Both Hindu females wore trousers and shoes. The one female Sikh service user wore saffron coloured clothing, wore a Haijab, traditional dress and wore shoes. Finally, all three Jewish female service users wore t-shirts, skirts and shoes.

Clothing and anatomical exposure

All female service users from Muslim, Hindu, Sikh and Jewish backgrounds wore very loose or loose clothing on the upper body and wore obscure clothing. Furthermore, female residents from Muslim, Hindu, Sikh and Jewish faiths were observed to have the following anatomical parts covered: shoulders, upper arms and chest. Excluding Hindu females with missing data, elbows and waist were also covered for females from Muslim, Sikh and Jewish faiths. In terms of the lower body, all females from Muslim, Hindu, Sikh and Jewish backgrounds wore loose or very loose and obscure clothing. All female service users from Muslim, Hindu, Sikh and Jewish faiths had the following anatomical parts covered: thighs or upper legs and knees.

Dress condition

None of the Muslim, Hindu, Sikh or Jewish women were observed wearing clothes that needed repair. All Hindu and Sikh females were observed wearing clean clothes although one Muslim female (33%) and one Jewish female (50%) were observed wearing dirty, soiled or marked clothing.

Males

Specific clothing items

Attention worthy clothes was worn by one Muslim and one Jewish male. All Jewish males and one Muslim male wore some form of headwear. Two Jewish males wore kippaha's, whereas hats were worn by one Muslim and one Jewish male. Most men wore Jumpers (50% Muslim, 67% Jewish) and shirts (50% Muslim, 100% Sikh and 33% Jewish). One Jewish male was observed wearing nightwear and another Jewish male was observed wearing a prayer shawl. All Sikh and Jewish males wore trousers and one Muslim male wore Jeans. All Muslim, Sikh and Jewish males wore shoes. Loose clothing on the upper body was worn by

a small proportion of Muslim male service users (33.3%), the only Sikh male and the majority of Jewish males (66.7%). All Muslim and Jewish males wore completely obscure clothing.

Clothing and anatomical exposure

All Muslim, Sikh and Jewish males wore items of clothing that concealed shoulders, upper arms, hands, chest and waist, upper leg, lower leg and knees. The Sikh male and most of the Jewish males (66.7%) wore loosely fitted clothing on the lower body as well as completely obscure clothing on the lower body.

Dress condition

All Muslim males wore clean clothes without needing repair although one Jewish male was observed wearing dirty, soiled or marked clothing.

7.6. Conclusion

This chapter explored whether care homes were sensitive to language, religious and minority ethnic needs for care home service users living in learning disability and older people homes. This chapter explored mixture of findings, which suggest some degree of sensitivity to cultural needs as well as evidence to suggest that care homes were sometimes failing to meet needs for culturally diverse care home service users.

Evidence of sensitivity to cultural needs

This study found some evidence of sensitivity to cultural needs. Firstly, within some care homes there appeared to exhibit some sensitivity to religious practice. Secondly, within some care homes contained evidence of culturally appropriate dietary preparations, including halal meats and kosher foods according to service users religious preferences. Finally, service users from religiously diverse groups appeared to be dressed appropriately, in terms of loose fitting, obscure clothing, clothes that covered anatomical parts and the majority of service users from religiously diverse groups wore clean clothes.

Evidence of lack of sensitivity to cultural needs

However, there appeared to be some evidence of a lack of sensitivity to cultural needs. For both learning disability and older adult homes, for service users for whom English was not their first language, there appeared to be very few care homes that contained members of multi- lingual staff and accessible information published in other languages besides the English language. Moreover, in terms of religiously diverse service users, a higher degree of sensitivity to cultural needs was observed from the two specialist learning disability home for orthodox Jewish service users, rather than the majority of non specialist care homes. Similarly, with dietary requirements, although there was some evidence of culturally appropriate foods for Muslim service users such as halal meats, these foods were only available from a small sample of homes. Furthermore, excluding two specialist care homes, the majority of homes did not provide service users from religiously diverse groups with appropriately prepared foods and clear separation of food products. In terms of vulnerable adults from black ethnic groups, only a small number of care homes contained appropriate skin and hair care requirements for care home service users from black ethnic groups.

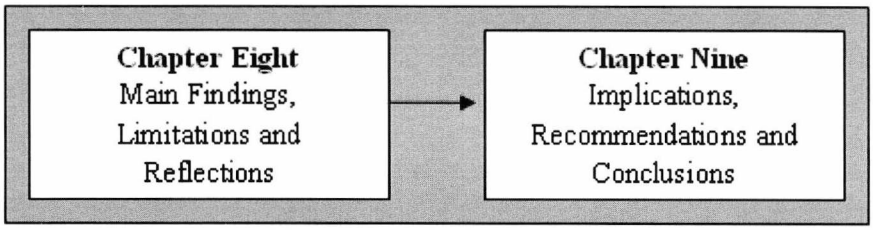
In general, although this study found evidence of sensitivity to the needs for minority groups such as service users from religiously diverse groups, black groups and for service users for whom English was not their main language, in terms of non specialist care homes, in general, the current findings suggest that many non specialist care homes collected from the MOPSU study are failing to adequately meet the cultural needs of minority groups. These findings appear to support views expressed by south Asian service users and relatives as outlined in chapter 6 and previous researchers comments of culturally inappropriate care as outlined in chapter 3. However, whilst these findings may reflect unmet needs in terms of cultural needs, whilst every attempt was made to consider individual preferences in assessing sensitivity to cultural needs, it is important to recognize that individual preferences may still have played a large role in findings, particularly with regards to service users from religiously diverse groups.

PART C

DISCUSSION

Part C discusses main findings, study limitations, implications, recommendations, conclusions and researcher reflections. In Chapter eight, notable findings from literature reviews in Part A were compared with empirical research findings presented in Part B of this thesis, followed by an overview of study limitations and reflections on whether personal characteristics influenced the research process. Chapter nine summarizes implications, recommendations, general conclusions and reflections on the PhD process.

PART C-
Discussion



8. Chapter Eight. Summary findings, Study Limitations and Reflections

8.1. Main findings

This exploratory study primarily fills a dearth in community care knowledge by exploring needs, characteristics and experiences for service users from minority ethnic communities living in learning disability and older people in UK care homes. This thesis reports on findings from the MOPSU study and additional focus groups. Specifically, MOPSU study data collection enabled investigation of characteristics for service users, care homes and care home staff as well as quantitative observations of sensitivity to cultural needs. Defining cultural needs and qualitative experiences of specialist and mainstream care homes were also collected from focus groups with older people care home service users and their relatives associated with two specialist care homes for south Asians and specialist care home for African-Caribbeans. This section firstly summarizes characteristics findings for care homes, care staff and service users followed by findings depicting definitions of cultural needs and sensitivity to cultural needs.

Each characteristic section firstly depicts initial supplementary and preliminary analyses of comparing learning disability with older people findings followed by ethnicity comparisons.

8.1.1. Characteristics of care homes, care home staff and service users

Care home

Sample size and percentage proportion of 90 (53%) care home with learning disabilities and 83 (48%) for care homes for older people from MOPSU study reflects larger care homes samples than other care home studies including Mansell, Ashman, Macdonald & Beadle-Brown (2002).

Conversely to care homes for older people, there were more learning disability care homes classified as residential care homes, located within London and South East and with higher CQC lifestyles standards met. These findings are unsurprising given deinstitutionalization extent for learning disability homes, prevalence of smaller learning disability care homes, higher population prevalence within the London and South East and presumably more active lifestyle learning disability populations than older people populations.

Characteristics for learning disability care homes containing at least one non white minority ethnic service user were comparable with care homes containing only white ethnic service users. Conversely, with older people care homes, care homes with at least one minority ethnic service user contained statistically higher percentages of nursing homes than care homes with only white ethnic service users which implies care homes containing at least one minority ethnic service user were more likely to require nursing care and presumably characterized with more impairments to necessitate nursing care.

Findings of more nursing homes amongst care homes with at least one minority ethnic service users perhaps suggests tendencies for some minority ethnic families to admit minority ethnic older people into care homes as a final resort thus leading to highly impaired minority ethnic older population within care homes. Furthermore, perhaps some non-white minority ethnic older populations are characterized by considerable levels of impairments in comparison with white ethnic populations, thus requiring nursing care. Numerous studies

suggest non-white minority ethnic older people (Patel 1999) encounter significantly more health problems than white ethnic older people and this finding of higher proportion of nursing homes amongst care homes with at least one non white minority ethnic service user may reflect this difference. Moreover, given extent of oppression, discrimination experienced by some non white minority ethnic older people, perhaps considerable level of impairments and subsequent admissions into nursing homes reflects the long term physiological consequences following resisting societal oppressions? Alternatively, perhaps non-white minority ethnic families were less likely to be able or be willing to assist with nursing care with their older relative in comparison with white ethnic communities.

Care home staff

Percentage proportions of 38% from non white minority ethnic staff from learning disability care homes and 28% non white minority ethnic staff from older people care homes reflects considerably more prevalent minority ethnic populations than reported in other care home studies (Mansell et al, 2002) and national NMDS-SC (Hussein, 2009) workforce statistics and UK census 2011 (ONS, 2011a). Findings of non white ethnic minority staff may challenge previous researchers assertions noting a general lack of ethnic diversity in learning disability services (Azmi et al. 1996), although given minority ethnic staff reflect minority groups in some UK care homes, findings suggest continued limited ethnic diversity with staff amongst some care homes. Findings of prevalent female staff reported in learning disability care homes is consistent with other UK empirical research into learning disability care homes studies (Hatton et al. 1995; Hatton, Rivers et al. 1999; Rose, 2001) and researcher conclusions on learning disability services (McCarthy, 1996).

In contrast with older people care homes, learning disability care homes contained significantly more male staff, more full time workers, and staff were predominately occupied with non-personal care. More male staff in learning disability care homes in comparison with male staff in older people care homes may reflect social attitudes whereby potentially less nursing care maybe more socially acceptable for males in contrast to working within female dominated nursing environments within older people care homes. Furthermore, with prevalent challenging behaviours, managers may prefer staff with traditional male dominated characteristics of strength, dominance and assertiveness, and may therefore recruit more male staff. Alternatively, care homes for older people contained substantially higher females staff similarly depicted elsewhere (Daker-White et al, 2002). Nevertheless, higher percentages of female staff working in older people homes than learning disability care homes, echoes findings of secondary analysis of NMDS-SC datasets, whereby in comparison with care workers supporting other populations, dementia care workers were more likely to be female (Hussein & Manthorpe, 2012). More prevalent full time staff and participation in non personal care work may suggest differences in shift patterns between learning disability and older people care homes as well as differences in service user characteristics with potentially lower personal care with learning disability populations than older people populations. Staff working in older people care homes participated in more nursing hours and more hours devoted to personal than staff working in learning disability care homes, which is unsurprising given degree of morbidity amongst older people populations in care homes. Findings depicting higher percentages of hours devoted to other tasks may imply different tasks carried out by staff working within older people care homes which presumably vary in comparison with staff working within smaller learning disability care homes.

In contrast to learning disability care homes containing only white ethnic service users, within learning disability care homes containing at least one minority ethnic service user, there were higher percentages of Asian staff, lower percentage of staff aged 55-64 and a higher percentage of full time staff. These findings may indicate geographical differences and population prevalence of particular demographical groups, considering that learning disability care homes were more prevalent within London and South East regions which typically contain more minority ethnic populations. Findings that learning disability care homes with at least one South Asian service user had higher percentages of Asian staff than care homes with no South Asian service users perhaps suggests managerial tendencies to recruit more Asian staff to meet the cultural needs of Asian service users. Such findings may suggest improvements with person centered planning by equipping a more qualified workforce skilled in meeting the needs of minority ethnic populations (Shah, 2005, 2006) if it is assumed that minority ethnic staff reflect useful contributions towards supporting minority ethnic communities. Equally, if Asian applicants knew care homes contained Asian service users, this may have increased motivations to work within care homes containing Asian service users than if care homes contained no Asian service users. These findings also suggest some evidence of Asian staff working within care homes which enables insights into Asian staff working within care homes which was outlined as an important predictor for care home admissions (Hatton et al. 2004).

In contrast to care homes for older people containing only white ethnic service users, care homes for older people containing at least one minority ethnic service users contained higher percentages of staff from minority ethnic groups and staff from black ethnic groups. These findings may suggest recruitment biases amongst managerial staff in assuming that minority ethnic staff posses more knowledge about cultural needs therefore selectively recruiting minority ethnic staff. Alternatively, given low pay status of direct social care work and wider social inequalities, perhaps higher percentages of minority ethnic staff working within older people care homes containing at least one minority ethnic service user reflect: minority ethnic people struggles in finding higher paid jobs; increasing migration populations searching for unskilled social care professions in order to stay within the UK and unwillingness and apathy amongst native Britons to work within occupations with considerable high levels of personal care for little money. Furthermore, findings that older people care homes with at least one minority ethnic service user contained higher percentages of qualified nursing hours and more personal care may reveal insights into considerable impairments amongst service user populations within care homes.

Service users

Focal minority ethnic percentage proportion of 13 % and 3% for learning disability and older people respectively reflects higher percentage proportion to other studies with adults with learning disabilities that reported around 5% of samples were from learning disability minority ethnic groups (Mansell, Elliot et al, 2002; Mansell, Ashman et al. 2002; Mansell et al 2003). Although Beadle-Brown, Mansell, Whelton et al. (2006b) reported 23% of participants were from minority ethnic groups from a sample size of 30 adults with learning disabilities. Furthermore, as shown in chapter five, the figure of 13% of adults from minority ethnic groups is similar to census ethnicity findings (ONS, 2011a). Similarly, for other care home studies with older people the 3% of older people from minority ethnic groups is larger than the 1.2% minority ethnic groups reported from Bebbington et al (2001).

In contrast to older people service users, learning disability service users were more likely to be male, possess problem behaviors, difficulties in communicating with others, cognitive performance impairments and more confusion. These findings are unsurprising given characteristics of learning disability populations and more prevalent female populations within older people care homes given higher survival rates amongst older females. Findings that old people were older and encountered more memory problems than adults with learning disabilities is unsurprising considering older age increased memory deterioration tends to characterize older populations.

Non-white minority ethnic adults with learning disabilities were also statistically older than white adults with learning disabilities which may suggest differences in family carers supporting learning disability populations. As family carers become older, they may no longer be able to cope with caring for their relative which may explain why non-white minority ethnic adults with learning disabilities maybe older than their white ethnic peers. This finding may also reflect potential family motivations in admitting family relatives with disabilities. Non-white minority ethnic people with learning disabilities may have reached an age where they have failed to fulfill traditional social roles such as marriage or producing children. Care home admissions may thus reflect disappointment amongst families in not having a family member partaking in traditional social roles thus motivating families to move people out of immediate surroundings. Furthermore, non disabled siblings and parents may have reached developmental, social and economical live stages where they are unable to continue supporting minority ethnic adults with learning disabilities thus seeking community care support and potentially explaining older non-white minority ethnic learning disabled service users. Findings of older minority ethnic learning disabled service users also perhaps highlights an increasingly older learning disability population which may require further attention and support within community care.

South Asian adults with learning disabilities were shown to exhibit more signs of depression than adults with learning disabilities from black ethnic and other ethnic groups. Accentuated signs of depression for south Asian service users could be explained by awareness of stigmatizing attitudes regarding care homes within south Asian communities; considerable isolation for south Asians considering low numbers of south Asians within services and potential unmet communication needs leading to isolation within mainstream care homes. Nevertheless caution is necessary whilst interpreting these depression findings, as a singular 'signs of depression' question does not reflect diagnoses from mental health professionals and relies on judgements of depressive symptoms amongst unqualified staff. Furthermore, diagnostic inadequacies in diagnosing psychopathology, particularly depression amongst minority ethnic populations highlight difficulties with depression diagnoses.

Non-white minority ethnic older service users displayed significantly more impairments with communicating with others, higher cognitive impairments, higher rates of impairment and more short term memory than white older people which suggests non-white minority ethnic older people may reflect more impaired and dependent populations. This finding perhaps suggest family inabilities to cope with increasing morbidity older minority ethnic older populations. Thus minority ethnic populations may constitute considerably more impairment groups in comparison with white ethnic older people who may have differing family dynamics and maybe admitted into care with significantly less morbidity.

8.1.2. Conceptualizing culture

Before presenting findings on definitions of cultural needs and sensitivity to cultural needs, other relevant themes were discussed from focus groups which may impact cultural need definitions and care home experiences.

Culture

A first initial finding across focus groups with service users and their relatives concerned strong affiliations with their cultural, ethnic and religious identity. Similarly to Bowes & Darr (2000), focus group participants constructed themselves as culturally distinct, emphasizing their ethnic identity including the importance of language and religion. This distinction was particularly prevalent within the south Asian focus groups whilst discussing people from different religious faiths. South Asian participants referred to 'Asian things' when drawing comparisons with other ethnic groups, particularly when comparing comparisons with 'English people'. Comments including 'we all come under umbrella of Asian things' suggests homogeneity, yet clear group distinctions were made between Muslim participants and Hindu participants within the south Asian focus groups particularly in depicting themes associated with foods and religion. Likewise, 'Caribbean way of life' was depicted by African Caribbean relatives which suggests group distinctiveness from other ethnic and cultural groups.

These findings appear to be consistent with other research (Bunning & Steel, 2006) whereby older service users appear to have strong affinities and associations with their cultural and religious identities. Furthermore on one level, focus group participants tended to utilize homogenous group categorizations when drawing comparisons with other groups, for example distinguishing between 'Asian' in contrast to 'English' people. These finding also supports other studies that found an affiliation with cultural identity for older people (Patel, 1999).

Community care admissions

As with other studies (Azmi et al. 1996), admissions into care homes were primarily motivated for health reasons of their relative and preserving the dignity of their relative. Associating dignity with admissions perhaps suggests favourable attitudes towards older people. However, from South Asian relatives focus group, some family members appeared to reflect 'sandwiched generations', whereby relatives felt trapped between wanting to ensure that their needs are being met, but given economic commitments with jobs and the health needs of their older relatives, they had no other choice but to admit their older relative into care, but justified care as they 'best place for them'. Similar conflicts within relatives feeling trapped with demands of relatives and economic reasons are comparable with other research (Hatton et al. 2004). Comments from some of the South Asian relatives that specialist care homes 'should be put on the map' perhaps highlights particular satisfaction expressed by relatives and seems to contradict overall negative findings regarding care homes expressed by other studies (Hatton et al, 2004). Findings may indicate desires for knowledge transmission, but also indicative of limited knowledge about types of community care service support service available. This finding of isolated care home is consistent with Goodman , Baron, Machen, Stevenson, Evans, Davies & Iliffe (2011:475) conclusions that 'care homes are isolated communities of care'. However, given clear distinction made between specialist and

mainstream care homes particularly by south Asian relatives, staff working within mainstream care homes may be more isolated that staff working within specialist care homes.

Whilst this finding of limited availability of care home services for relatives is consistent with other studies similarly depicting limited knowledge gaps with community care support (Azmi et al. 1996), discussions surrounding types of community care support focused on awareness of specialist care home services only, although this may reflect the characteristics and preferences of the group given that focus groups were exclusively conducted in specialist care homes. This may have also been a finding for south Asian groups given that such desires and preferences for specialist care did not seem to be heavily emphasized in the African Caribbean groups. Preferences for specialist care homes amongst south Asian communities is consistent with findings from Askham et al. (1995) as well as findings from mailed self reports with older people from Korean American backgrounds similarly requesting specialist care services (Jang, Kim, Chiriboga & Cho, 2008).

Nevertheless, lack of information regarding specialist care homes seemed to be a particular issue amongst South Asian communities which seemed to be particularly confounded by language capabilities of the south Asian communities. Lack of information on care home support is found within other studies (Daker-White et al. 2002), but focus groups findings suggest the knowledge gap maybe particularly pertinent amongst some minority ethnic communities. Interestingly, possessing knowledge about community care support from local mainstream care home services had limited impact on the South Asian relatives. Available knowledge regarding for mainstream service provision was met with considerable repugnance in light of beliefs that mainstream services would be culturally inappropriate. Relatives therefore seemed to focus their efforts on searching for knowledge regarding community care support focused primarily on specialist care home support for south Asian older people, rather than mainstream care home support.

Motivations for searching for specialist care homes for south Asians for older people could be due to strong social stigmas regarding care homes which for the south Asian relatives seemed to be particularly prevalent. Conversely to African Caribbean focus groups, admissions into specialist care homes appeared to be a particularly emotive topic for most south Asian relatives that followed on from discussing needs and experiences of services responses to cultural needs, admission. From south Asian relatives focus groups, care homes were generally associated with 'Ashrams' meaning orphanages and elicited feelings of shame, guilt were expressed by some of the south Asian relatives in admitting their relative into a care home for older people which were associated with peer pressures and social stigmas from the wider south Asian community. Peer pressure findings seemed to play a significant role in care giving behaviors from neighbours and relatives were similarly noted with Chinese relatives of Chinese older people (Zhan & Montgomery, 2003; Zhan, Feng & Luo, 2008). Nevertheless, peer pressure findings may reflect geographical variations and availability of varied community support models (Zhan et al, 2008). Thus, these findings of peer pressure amongst south Asian communities may reflect opinions of people of a specific city within the UK which maybe unrepresentative of other regions.

However, despite apparent social stigmas associated with care homes, unexpected favourable impressions into care home admissions were also identified by some of the south Asian relatives. Favorable experiences and expressing a desire to enter a care home for older people within the future was an unexpected finding given the apparent social stigma associated with care homes within the wider south Asian community discussed from the focus groups (Hatton

et al. 2004) literature on low utilization of care homes for minority ethnic groups and previous findings illuminating a preference for mainstream rather than specialist care (Hatton et al. 2004; Nadirshaw, 1997). This finding suggests that there is some evidence of positivity associated with care homes which contrast to some of the more gloomy attitudes of care homes as a last resort, although, it is unclear whether this finding is reflective of the good CQC rating, rather than a generalized comment on experiences of care homes.

Within the south Asian focus groups, being in a financial position to afford care, residing in an overly subscribed care home with long waiting lists and living within care home that successfully catered for their cultural needs, admission into a care home for their older relative seemed to be associated with privilege, especially as some of the south Asian relatives aspired to live at the care home within the future. These findings may operate from cognitive dissonance whereby individual cognitions including beliefs, attitudes, and behaviors are at odds (Festinger, 1954, 1957) and a comforting coping device by emphasizing the benefits of specialist care homes in light of the considerable adverse social stigma seemingly present within the wider Asian community. Conversely, in comparison with south Asian relatives, African-Caribbean relatives generally appeared less enthusiastic about care homes, which may suggest that experiences of specialist care homes for South Asian and African-Caribbean groups reflect differences in service quality of the two homes rather than cultural differences. Nevertheless, similar shifts from stigma to privilege have been found within studies with Chinese older people whereby being able to afford for care implied a sense of wealth by wider communities (Zhan, Feng, Chen & Feng , 2011). Similarly, Cheng , Rosenberg, Wang, Yang & Li (2011) concluded, perhaps shift from stigma to privilege indicates attitudinal changes towards community care more generally and general reduction in stigma surrounding community care.

8.1.3. Defining cultural needs

This section firstly summarizes focus group findings on cultural needs which were comparable to social care outcomes, followed by cultural needs that differ from explicit mentions to needs and social care outcomes yet defined as cultural needs and important for quality conceptualization.

Cultural needs and social care outcomes

This section firstly presents cultural needs that were identified by both south Asian and African Caribbean participants, followed by cultural needs that were discussed by south Asian or African Caribbean people only.

Similar themes discussed across cultural groups

Some social care outcomes including accommodation cleanliness, control, activity engagement, meals and nutrition, personal care, religion, safety and social participation were identified by all minority ethnic older people and their families which suggest some universal appeal with particular definitions of needs.

Nevertheless, successfully implementing care in relation to needs and outcomes surrounding meals, activities, social engagement and personal care required sensitivity to cultural and religious beliefs surrounding each of these domains. For example, older service users practicing Islam and Hinduism both agreed on the importance of staff recognizing the

significance of foods and personal care, but it was discussed that staff needs to be aware of the differences in food requirements for people belonging to different faiths. Similarly, south Asian focus group participants discussed consuming Asian foods and watching Asian TV programmes which is similarly comparable to other findings (Moon et al. 1998) demonstrating that certain needs should take into consideration divergent cultural beliefs, for minority ethnic older people. Living within environments that were reflective of their well known socio-cultural environment is comparable to qualitative findings reported by older people living in community care settings from Finland (Heikkilä et al. 2003).

Dissimilar themes

Communication was frequently discussed amongst south Asian focus groups as the English language was rarely spoken by south Asian older people similarly found elsewhere (Shah, 1999). Communication was not mentioned by the African Caribbean focus groups, although this is unsurprising given that English was the first language spoken by all African Caribbean participants.

Unlike African Caribbean focus groups, south Asian service users discussed dress codes in terms of wearing culturally specific clothes, jewellery and forehead markings, although dress codes were elicited by prompting from focus group facilitators. These findings perhaps illuminate differences in cultural norms associated with dress codes within the Asian communities which differ from African Caribbean communities.

Other cultural needs

Other needs were also identified by some of the minority ethnic groups which perhaps differ for people from indigenous white British backgrounds. For example, communication issues and the need for competency for staff to speak languages other than English were frequently mentioned by both south Asian service users and their relatives. Religion seemed to be particularly important aspect of their lives for most of the south Asian and African Caribbean focus groups. Other studies similarly identified the significance of sensitivity to communication in terms of providing multilingual staff (Kang, Domanski & Moon, 2009) and religion (Lawrence, Banerjee, Bhugra, Sangha, Turner & Murray, 2006; Hwang, 2008) whilst supporting minority ethnic service users.

Relatives of south Asian older people reported numerous factors which impacted need conceptualizations for south Asian populations including: increased comprehension of understand, writing and speaking English for later generations, increase in secularism, development of technological and electronic skills in living within a technological age. Consequently, south Asian populations may have different psychological needs based on differing levels of acculturation, historical, educational and life experiences. This finding is consistent with differing psychological needs based on their acculturation, historical, and life experiences outlined for older people from Japanese decent (Machizawa & Lau, 2010). Change in culture for future generations as a result of acculturation were also consistent with qualitative findings from Latino family members of older people with Alzheimer's disease (Mahoney, Cloutterbuck, Neary & Zhan, 2005). Collectively, exploring findings on needs and experiences for both south Asian and African groups findings support other findings that minority ethnic people reflect internally diverse and heterogeneous groups (Liu, 2003), particularly if participants were from divergent religious faiths and in consideration of differences with immigration history, cultural background and socio-economic position.

8.1.4. Sensitivity to cultural needs- focus groups

Given differences in findings and data collection, this section distinguishes sensitivity to cultural needs identified from focus groups separately from observational findings.

Need focused

Both south Asian and African Caribbean focus group participants generally discussed implementing care in relation to their cultural and religious preferences. South Asian relatives frequently reported that for services to be truly accessible, services must be culturally sensitive to the needs of south Asian people. African-Caribbean relatives similarly made this point, but this seemed to be considerably less emphasized in comparison with south Asian groups. This finding is consistent with recommendations noted for older people from Korean- American backgrounds in providing culturally sensitive care (Moon et al. 1998; Min, 2005). Emphasis on meeting cultural needs of individuals also has relevance to social constructionist and universalism theories.

Mainstream and specialist care service provision

Awareness of specialist and mainstream services and differences in sensitivity to cultural needs were outlined across all focus groups. Similarly to Daker-White et al. (2002) preference inconsistency on specialist and mainstream service provision for minority ethnic older people themselves were found.

African-Caribbean focus group participants expressed preferences for specialist care, yet were willing to accept mainstream care support. Preferences for specialist care homes for African-Caribbean people are consistent with Lewis (1996). Conversely, focus group south Asian participants appeared vehemently against mainstream care in favour of specialist care support for South Asian populations. Preferences for specialist care amongst south Asians thus mirror findings of Patel (1999), but conflict with other studies (Hatton et al. 2002) demonstrating preferences for mainstream care amongst south Asian participants.

Reasons for reluctance to utilize mainstream services amongst the African Caribbean relatives were primarily due to wanting their older relatives to socially engage with people from similar backgrounds , or as some relatives commented, to live within lifestyles that they are 'accustomed to'. Conversely, reasons for reluctance to utilize mainstream services for south Asians included insensitivity to cultural needs, particularly, dietary requirements, fears of social isolation, fears that everyone will look at them and worries about isolation and not being able to communicate with anyone.

Preference differences in service type within African Caribbean and South Asian participants potentially illuminates heterogeneity amongst minority ethnic populations, yet, preference differences may reflect differences in religious beliefs, gender differences and the quality of care within each specialist care home. For example, the African-Caribbean participants all identified themselves as practicing Christian. Similarly all south Asian focus groups identified themselves as practicing Muslims, Hindus and Sikhs. Given differences in how religions operate in terms of dietary needs and worship, individuals belonging to religions with more stricter dietary and worship requirements, this may affect motivational and willingness to use different types of service provisions. Equally, whilst all focus group participants were actively religious observant, if individuals were particularly devout,

presumably they would be more motivated to utilize services which claim to actively meet their religious needs and therefore less willing to utilize mainstream care support.

Differences in preferences could reflect differences in cultural and religious beliefs between religions in setting particular restrictions on lifestyles as well as existing secularization and differences in adherence to religious beliefs and how important their religion was to them. There could also be a social explanation for these differences in preferences findings. Given the smaller prevalence of south Asian populations utilizing care in contrast to African Caribbean populations which are considerably larger, south Asian populations may wish to reside in environments which yield more social advantages. For example, opportunities for communication and familiarity, consequently leading to preferences for specialist care homes and therefore, less willing to utilize mainstream care homes.

8.1.5. Sensitivity to cultural needs- Observational findings

Unless otherwise stated, this sensitivity to cultural needs section focuses on care homes collected from the MOPSU study only including two 'specialist' care home for adults with learning disabilities practicing orthodox Judaism and various mainstream care homes for both adults with learning disabilities and older people containing varying frequencies of Muslim, Hindu, Sikh and black ethnic service users.

The previous section presented focus group findings on sensitivity to cultural needs investigated from specialist care homes for south Asian and African Caribbean older people conducted separately from MOPSU study.

Mainstream versus specialist care

A first initial and unsurprising finding concerned considerable differences in meeting cultural needs between service users living in specialist care homes versus mainstream care homes.

Specially, conversely to mainstream care homes, staff within specialist care homes were more likely to successfully administer sensitive culturally appropriate care with the following. First, *accommodation cleanness* depicting limited odours and general clean accommodation. Second, *meals and nutrition* such as specially prepared kosher foods, separate food utensils for different food groups. Third, *personal care* differences including swift staff action in light of incontinence and increased tendency to close doors and access to personal hygiene products. Fourth, *religious sensitivity* in terms of overt presence of religious symbols, prayer locations, celebration of religious festivals reflective of service users religions. Such findings are consistent with Valins (2002) comments that specialist care homes were more likely to meet the needs of culturally diverse populations in contrast to mainstream care.

Nevertheless, initial differences between specialist and mainstream care homes may reflect variations in service quality, differing organizational ethos and priorities concerning emphasis on meeting religious needs for orthodox populations and varying service user characteristics within care homes. Yet, these findings also indicate that in ascertaining sensitivity to cultural needs, further research may need to separate specialist care from mainstream care.

All cultural needs met

'Met needs' in relation to cultural needs were ascertained from percentages within 'all cultural needs met' category obtainable from post-hoc cultural indexes. Despite general unmet cultural needs within care homes noted elsewhere (Daker-White et al, 2002) there was some evidence of sensitivity to cultural needs.

Accommodation cleanliness

All cultural needs met and no odours of urine or faeces were found with learning disability care homes containing Hindus and learning disability care homes containing Orthodox Jews. Whilst these findings may suggest that other care homes containing religiously diverse populations were more likely to encounter odours, these findings could be relate to differences in service user characteristics with these homes containing more continent service users.

Meals and nutrition

The specialist care home only contained 'all cultural needs met' for meals and nutrition whereby all foods were specially prepared and complied with Kosher requirements, all staff utilized separate food utensils and all service users were observed consuming foods that complied with Jewish dietary requirements. This finding potentially suggests unmet need for meals and nutrition within mainstream care homes, although this is an unsurprising finding given that these homes catered for orthodox Jewish service users.

Personal care

Learning disability care homes containing Hindus and older people care homes containing Sikhs were all observed to have well groomed hair which complied with 'all cultural needs met'. Only specialist care homes for Jewish service users quickly changed incontinent service users. Staff closed ensured doors were closed during all personal care sessions was evident from or learning disability care home containing Hindus and specialist care homes only. Learning disability care homes containing Hindus and the Jewish specialist care homes ensures same gender care staff to service user during personal care. Finally, unrestricted access to personal hygiene products were noted with learning disability care homes containing Hindus, learning disability care home containing Sikhs and specialist learning disability care home for Jews. Whilst this highlights some sensitivity to personal care amongst some culturally diverse populations, the above findings could reflect varying staff characteristics in terms of staff numbers, varying staff demographics and differing service user characteristics.

Religion

Religious symbols correctly identifying Judaism and Sikhism were noted in specialist learning disability care home for Jewish service users and older people care home for Sikh service users. Learning disability care homes containing Hindus, Sikhs and Jews all celebrated religions other than Christianity. Evidence of religious participation within specialist care is unsurprising given religiously observant orthodox service users, although acknowledgement of other religions other than Christianity and in line with service users religious beliefs may suggest sensitivity to religious diversity or secularization.

Collectively, findings on all cultural needs met concerning accommodation cleanliness, meals, personal care and religion suggest may challenge rather homogenous sweeping statements that care homes fail to meet the cultural needs of service users. These findings support the findings of Bunning et al (2006) of the significance of religion within community care and provide some insightful observational evidence on the lived experience for Orthodox Jewish adults with learning disabilities and that some adults with learning disabilities actively construct their lived experiences in accordance with their religious faith.

Unmet needs

'Unmet need' in relation to cultural needs were ascertained by percentages within 'no needs met' and 'some needs met' from post-hoc cultural indexes. Observational findings depicted considerable unmet need within some mainstream care homes in five main need clusters: accommodation cleanliness in terms of pervasive smells, inappropriate meals for Muslims, inappropriate personal care for black ethnic service users and inadequacies with religion and language.

Accommodation cleanliness

Both learning disability care homes containing Hindus and the older people care home containing Sikhs contained extensive noticeable odours of urine or faeces. Furthermore, evidences of other odours were found in a specialist care home, both learning disability care homes containing Hindus, the learning disability care home containing Sikhs and the older people care home containing Sikhs. Most learning disability care homes containing Muslims contained no noticeable smells of urine or faeces.

Presence of pervasive urine and faeces odours in care homes are likely to be unpleasant and distressing for all individuals concerned, but perhaps more unpleasant for religiously observant individuals that prioritize purity and cleanliness. Within particularly regimented care homes, presumably not being able to make choices in leaving care homes, enter gardens or open windows, living within prevalent smelly environments is potentially uncomfortable and unpleasant, although human noses may adapt to prevalent unpleasant smells over time, so unpleasant smells may not be noticeable to some. Findings of odours regarding urine and faeces may also highlight incontinence amongst some service users or immediately following personal care . Overall smells observations between the learning disability and older people care homes may reflect differences in size of accommodation, with larger care homes being more susceptible to odours and due to chemical diffusion within the air of larger properties, smells may linger in larger properties in comparison with smaller properties which may heighten unpleasantness.

One of the learning disability care home containing Hindus contained some unclean service user rooms, hallways and common rooms, whereas the older people care home containing Sikh service users contained largely unclean rooms, hallways and common rooms. Whilst these findings only reflect two care homes, therefore the findings are very limited, the question of cleanliness relies on judging accommodation cleanliness on combination of three different types of rooms which may differ substantially in cleanliness. Nevertheless, having dirty living quarters could be more distressing if service users spent most of their time in their bedrooms and for people who insist on cleanliness and perhaps more so if service users lack control and ability to clean if staff are otherwise apathetic over cleaning. Nevertheless, given

purity and cleanliness value within Hinduism and Sikhism, overt dirt evidence could elicit distress.

Meals and Nutrition

Given the majority of learning disability care homes containing Muslims (63%) contained no specially prepared meals such as halal meats and one Muslim male was observed consuming pork sausages, suggests insensitivity to Islamic dietary requirements, although findings were based on only eight care homes with learning disabilities containing Muslim service users which highlights small sampling. Neither learning disability care home containing Sikhs nor the older people care home containing Sikhs contained specially prepared meals, although this may reflect vegetarianism amongst Sikh service users, but suggests that adhering to Jhatka meats is most likely not performed in these care homes containing Sikh service users.

Such observations thus support findings of culturally inappropriate meals found from (Hatton et al, 1998). None of the learning disability care homes containing Hindus and the older people care home containing Sikhs utilized separate food utensils for separate food groups and 75 percent of learning disability care homes containing Muslims failed to utilize separate food utensils for food groups. Whilst caution is necessary with these findings given small samples, such findings suggest there is high potential for staff using same utensils for different food groups and potentially using same utensils for meats and vegetables, which for religiously observant Muslims, Hindus and Sikhs could reflect contamination, impurity and religious insensitivity. Unmet cultural dietary needs could be explained by micro and meso factors.

First, concerns issues surrounding individual service users themselves. As shown by Muslim service users focus groups, participants may believe 'God forgives' if someone eats something that doesn't comply with dietary requirements, thereby justifying consuming religiously inappropriate foods. Service users may have preferences on particular types of foods and may follow more relaxed attitudes surrounding specific dietary requirements. Equally, relatives may have explicitly stated that service users may consume particular types of foods, thereby staff may simply be following relatives dietary guidelines on consuming particular types of foods.

Second, dietary rules within services and care home may influence menus. Within strictly regimented care homes, management and staff decide on particular food options whilst overriding service user choice. Similarly, service users may have set evening bath-time routines to coincide with evening medication. Staff may therefore feel pressured to complete meal preparations within shorter times which may therefore involve utilizing limited utensils, limited crockery or using the quickest food option such as microwave meals or frozen vegetables. Care home kitchens may contain limited foods on specific food times or nearing a 'house shop', thus consuming meals for specific days may be prepared and cooked by staff in order to avoid food wastage which may override service user religious beliefs. Within some geographical regions, retail outlets may not sufficiently supply food items which cater for religiously diverse populations. If staff regimentally follows daily menu plans, staff may chose the food items which are available in stock and return to care home as soon as possible. To search for items that are prepared in accordance with religious preparations in multiple retail outlets for a small number of service users could drain both staff time, petrol and transport resources, which could be particularly important with limited staffing and budgetary factors.

Service providers may also have rules regarding washing utensils within dishwashers which may have considerable timeframes. Using one form of utensils, crockery and cutlery may reflect availability of utensils if other utensils are being washed. Furthermore, service rules and regulations regarding certain utensils used for cooking as opposed to others. For example, for checking for food temperatures, a care home may have access to one food temperature control thermometer to check for meat temperatures. To have two food temperature control thermoses involves extra money, resources and training in being able to utilize two different thermoses which maybe too much information for care homes to process. Food weekly rotas and menu plans maybe constricted by management with little appreciation or thought that menus may conflict with religious events, for example, serving meats on menus for Good Friday which could be religiously insensitive to practicing Christians.

Insensitivity to meals could also be attributable to staff beliefs and training. Care home senior staff may not possess adequate training on importance of specific requirements such as keeping utensils separate, thus there maybe sufficient knowledge gaps with service staff surrounding food issues. Staff may feel given state of specific impairments, a need to have meat protein for health reasons may override religious concerns. Furthermore, staff maybe particularly unfamiliar with religious requirements, whereby whilst staff maybe familiar with more well-known dietary requirements such as halal meat, staff maybe unfamiliar with less well known dietary practices such as Jhatka meat for Sikhs. Selection of cutlery, crockery and food items maybe largely controlled and governed by staff choices who themselves are from particular cultural backgrounds. White British staff may therefore purchase items such as cutlery and specific items that they are most familiar with. Conversely, more junior Chinese staff and Japanese staff may feel motivated to purchase chopsticks rather than cutlery, but purchase cutlery given decisions made by senior staff. In order to comply with senior staff, avoid compromising group dynamics and desire to portray themselves as team players, if staff follow religiously inappropriate practices, more junior and less senior staff who otherwise have more experience with religious requirements may therefore not question the meal decisions made by staff. Service users may therefore constantly consume religiously inappropriate foods if no staff initiates checks on types of foods.

Food consumption may also be attributable to service characteristics and extent of challenging behaviours within care homes. Care homes may contain considerable numbers of service users with challenging behaviours and in light of limited staffing; staff may feel pressured to finish meals as soon as possible. To separate utensils for separate food groups could be too much information for staff to manage. Moreover, using one utensil for separate food groups maybe considered as most time effective option in cooking foods. Furthermore, if staff are required to cook different meals for different service users, staff may feel considerably pressured to prepare meals by set times. To comply with additional religious requirements in addition to meal preparations could be particularly challenging. Food insensitivity could also be related to budgetary constraints. Service providers may also have limited budgets for certain kitchen items. To purchase additional items maybe place considerable demands on already stretched budgets. Given limited care home budgets during care home shops, staff feels pressurized to may feel motivated to purchase cheaper food options. Searching for specially prepared foods such as Halal foods may reflect the more expensive option. In order to reduce budgets and reduce potential reprisal from staff in purchasing more expensive items, given that senior staff may check food receipts; staff may feel pressurized to purchase cheaper food items which are not specially prepared.

Personal care

With the exception of one care home with learning disabilities containing Hindu service users containing all clean and dressed service users, findings generally suggest *some* service users living in learning disability care homes containing Hindus, learning disability care homes for orthodox Jews and older people care home containing Sikhs were clean and dressed.

Emphasis on *some* suggests some service users within each of these homes were considered unclean or undressed during some or all of the observations. The finding that none of the service users in the learning disability care home containing Sikhs were clean and dressed is a surprising one, but reflective of only one care home. Nevertheless, being unclean and undressed could be distressing for care home service users, particularly for religious observant individuals. One notable finding concerned the one older people care home containing Sikhs whereby observers noted that none of the service users received personal care which was conducted in a way which preserved people's dignity. Whilst this finding was only from one care home and may reflect a care home with a poor CQC quality rating, such findings could be distressing for all service users involved, not just the Sikh service users. A further notable finding involved whether care home staff ensured that care home staff from the same gender as the service user support the service user. Within the learning disability care home containing Sikh service users, findings suggest a mismatch in gender between service user and staff for care home service users in this home. Whilst this finding may reflect service user preferences and staff resources, gender disparities whilst conducting personal care maybe particularly distressing for some service users.

Whilst these findings may suggest care home staff were potential insensitive to personal cleanliness, there are some general points which may explain some of these findings surrounding personal care. First, there are issues surrounding time of data collection. Observations relating to personal care were collected throughout the two days of data collection, therefore, findings relating to personal cleanliness could be shortly after personal care, and depending on eating behaviours, and one would except that service users may have evidence of food coverage after meals. Equally, whether service users were 'undressed' could be associated with bathing times, although there is also some variability on being undressed, that is whether service users were completely naked wondering living areas, or undressed in the sense of not wearing a jacket for example.

Second, concerns service user characteristics surrounding personal care. Some service users possess cognitive awareness of being unclean, untidy and undressed, so some service users may not experience distress following from being unclean or undressed. Although, this is obviously tied in with dignity and respect and infection control with service users in ensuring that service users are dressed and clean, at least in terms of westernized ideals of personal cleanliness. Service users may also feel particularly attached to unkempt and stained or tattered clothing and whilst such individuals may well be personally clean following extensive bathing, others may perceive such service users to be unclean due to state of clothing. To support service users to change unkempt clothing could be deeply distressing for some service users.

Furthermore, service users may exhibit particular challenging behaviours surrounding personal care which poses specific problems in supporting service users towards personal care. If service users exhibit challenging behaviours surrounding personal care, to

continually change service users in light of any dirty clothing could elicit distress amongst service users. Eliciting staff response in changing service users could require additional staffing and training with challenging behaviour, therefore staff maybe reluctant to support changing service users in light of slight soiled clothing. Moreover, services may contain regimented timetables regarding bath times or service users assume time regimentation with bath times. Service users may have become institutionalized and conditioned into thinking they have to wait their turn before having a bath, thus remaining unclean until staff prompt service users to partake in personal care.

Third, numerous issues exist at service level surrounding personal care. Staff may install regimented lifestyles for service users, whereby service users lives are fitted in with accordance to waiting for taxi drivers or appointments within communities. Given time taken to support service users and desires to meet regimented timetables, staff maybe reluctant to support service users to change items of clothing. Moreover, trying to maintain personal cleanliness and keeping service users dressed may also be particularly challenging for staff, especially if service users are messy eaters or engage in challenging behaviours such as pica or consuming non food materials. Findings of unclean status could reflect observations of small events in time prior to staff supporting service users to change clothes. Furthermore, service providers may also have set rules on temperature control for items of clothing in presence of heavily soiled clothing. Staff may well be reluctant to support service users to change clothes if washing machines take several hours to wash soiled clothing at high temperatures. Furthermore, in light of challenging behaviours, protection of staff, health and safety issues and emergencies, staff may actively discourage closing and locking doors during personal care.

Hair and skin care needs for black ethnic groups

Almost half (47%) of learning disability care homes containing service users from black ethnic groups and just over half (57%) of older people care home containing service users from black ethnic groups did not have immediate access to special skin care products such as oils and moisturizers for black skin. Nevertheless the other major half (47%) of care homes with learning disabilities containing black ethnic service users had immediate access to skin care products for black skin, which although is considerably more than 29% availability of skin products in care homes in older people containing black ethnic service users, suggests that for some care homes containing black people, service users do sometimes have access to skin products to help preserve the quality of black skin. Furthermore, 88% of care homes for adults with learning disabilities containing black ethnic service users and nearly half (43%) of older people care homes containing black ethnic clients had not have access to hair care products for black afro hair. Although over half (57%) of care homes for older people containing black ethnic service users were able to access hair products for black afro hair, which although is considerably more than the 13% figure for care homes with learning disabilities containing black ethnic service users accessing hair products, suggest that older people maybe more likely to have healthier hair than adults with learning disabilities from black ethnic groups.

Variability in health and skin care procedures for care homes with black ethnic service users is surprising and indicates that older people from black ethnic groups maybe more susceptible to poorer skin health than black adults with learning disabilities. Whereas, adults with learning disabilities from black ethnic groups maybe more susceptible to poorer hair health than older people from black ethnic groups. These finding potentially suggest service users

from black ethnic groups living within learning disability and older people care homes were prone to general poor skin and hair health and may provide insights into the visual presentation of black ethnic service users.

However, these finding may also reflect service user preferences or staff practices in discreetly keeping hair and skin care products within bathroom or bedroom cupboards out of sight. In the presence of any challenging behaviour or significant confusion, staff may primarily store personal care products away from service users which although may be due to health and safety reasons for both service user, other service users and staff, if staff actively remove such products from service users vicinity may limit choices for service users and increase reliance and dependency on staff in having to ask staff were certain products were located. Such actions may also highlight staff desires in preserving the modesty of service users by not having personal care products on display, but by keeping products out of sight may also indicate beliefs that such products are insignificant and unimportant for service user health. Furthermore, with occasions of black ethnic service users with challenging behaviours, expressing reluctance to get cleaned and washed for the day during morning and evening personal care sessions or otherwise pace bedrooms and bathrooms, immediate unavailability of such products presumably reduces the likelihood of staff using such products which may further compromise skin and hair health of black ethnic service users. Keeping personal care objects within cabinets may also presumably limit likelihood of such objects being thrown at community care staff and other service users during challenging behaviour outbursts which may necessitate staff motivations in keeping products locked away.

These findings may also indicate service user characteristics in terms of physical impairments, mobility and community access. More mobile and active service users may have more opportunities for engaging in outside activities which may increase usage of products protecting skin and hair. Less mobile service users and less active maybe more confined to their rooms and maybe less likely to use health and skin care products. Lack of immediate availability of products may therefore reflect disengagement with outside communities. Furthermore, these findings may allow insights into service user awareness, motivation for beautification and healthy skin and hair care, where service users maybe less interested in looking after their skin and hair and less interested in their appearance, which may indicate institutionalized practices or perhaps lack of awareness of social cues in presenting oneself in an attractive favorable light, which seems to be important amongst British culture on physical attractiveness.

Language

The vast majority of mainstream care homes for both learning disability and older people care homes containing at least one service user for whom English was not their first language were not supported by multi lingual staff, or had immediate access to bilingual speakers and very limited information presented in languages other than English which suggests considerable unmet language needs. Furthermore, there seemed to be more unmet language needs for learning disability care homes containing at least one service user for whom English was not their first language in comparison to older people care homes containing at least one service user for whom English was not their first language. Collectively, these findings suggest a heavy reliance on the English language utilized within care homes sampled from the MOPSU study, which suggests that service users without the capacity to speak English potentially are at risk for considerable isolation without the availability of translators

and bilingual staff. Less translators in learning disability care homes may indicate more competency with English language than older people from minority ethnic groups. Not being able to read or see material presented in familiar languages may also be particularly isolating.

Whilst these findings of English language usage in mainstream care homes are perhaps unsurprising given that this study reports on findings from UK care homes, these finding of comprehensive usage of the English language, strikingly contrast with focus group experiences whereby staff within UK specialist care homes for South Asian service users. Focus groups conducted in specialist care homes for South Asian older people revealed that English was only really spoken in presence of English speaking visitors, given that the majority of older service users in the specialist care homes for south Asian older people rarely spoke English. A native English speaker would require extensive translator support living within a specialist care home for South Asian people, yet there seems to be considerable unavailability of multi-language facilities within mainstream care homes.

Several explanations with individual service users may exist with language findings in mainstream care homes. Service users may well have been sufficiently fluent in English to not warrant translator support. Service users may have preferred to speak English rather than native languages. Furthermore, care homes may have contained service users with considerable visual impairments of service users prevent reading written information published in English. Motivations to integrate multilingual material in such care homes may have been particularly limiting. Services may have also contained service users with considerable prevalent severe disability and reliance on non verbal rather than verbal communication. Not being able to speak English may not have motivated staff to recruit and integrate multilingual community care staff.

Religion

Findings of no prayer locations were located within learning disability care homes containing Muslim, Hindu and Sikh service users or within an older people care home containing Sikh service users may suggest secularization and religious insensitivity in not providing dedicated prayer locations. However, these finding may also indicate differences in layout, space availability and resources within each care home, service user preferences for private worship in their own bedrooms and perhaps apathy in prayer participation. Service users may also feel uncomfortable or fear segregation from others if staff within care homes provides isolated areas for prayer for small numbers of religious diverse service users. If service users possess uncomfortable associations or memories with religions from their family experiences, service users may wish to refrain from participating in public worship or having the option of not praying may provide some service users with more freedom and participate in secular activities.

Sensitivity to cultural needs- Learning disability and older people

Collecting data on sensitivity to cultural needs from both learning disability and older people care homes allowed some unique opportunities to compare differences in findings between sensitivity in meeting cultural needs, which to the best of our knowledge, reflects new contributions to knowledge as no other study has compared sensitivity to cultural needs between learning disability and older people care homes. Several similarities and differences were found in sensitivity to cultural needs between learning disability and older people from minority ethnic groups.

Similarities

There were some important similarities in sensitivity to cultural needs between care homes containing adults with learning disabilities containing religiously diverse service users and older people care homes containing religiously diverse service users which suggests some comparable care home experiences with regard to sensitivity to cultural needs. Both learning disability and older people similarly experienced no prayer locations, no specially prepared foods for Sikh service users, minimal availability of staff using different languages with service users for whom English language was not their first language; to be clean and dressed amongst Jewish service users and older Sikhs, were toileted some of the time for learning disabled Sikhs, Hindus and older Sikhs and learning disabled Sikhs, learning disabled Hindus and older Sikhs did not have access to bidets, taps or jugs for usage after the toilet. Nevertheless, there were some more positive findings with regards to sensitive to cultural and religious needs whereby both Sikhs from learning disability and older people care homes consumed culturally and religiously appropriate foods; and service users had well groomed hair in learning disability care homes containing Hindu service users and a care home for older people containing Sikh service users.

Differences

There were also a few notable differences between learning disability and older people care homes with regards to implementing culturally sensitive services.

For people for whom English was not their first language , people living in older people care homes were more likely to have access to literature published in other languages than people living within learning disability care homes. Learning disability service users from culturally and religiously diverse backgrounds were more likely to receive support from bilingual staff, have immediate access to hair, skin and oil products and unrestricted access to personal cleaning products and celebrate religions other than Christianity. However, the learning disability care homes containing Sikh service users were less likely to be well groomed in comparison with the care home for older people containing Sikh service users. Conversely, older people from religiously diverse groups were more likely to encounter odours of urine and faeces, encounter other odours, live within dirty environments, and receive less dignified care than adults with learning disabilities from religiously diverse backgrounds. Furthermore, older people from black ethnic groups were more likely to have access to skin and hair products for black hair and be better groomed in comparison with learning disability service users from black ethnic groups.

Collectively findings of initial similarities and differences in sensitivity to cultural needs highlights: unexplored and new contributions to community care literature; illustrates experiences in terms of sensitivity to cultural needs may differ for learning disability and older people and a need to consider that sensitivity to cultural needs may differ between learning disability and older people care homes.

8.1.6. Sensitivity to cultural needs- focus groups and observations

Collecting sensitivity to cultural needs from both focus groups and observations allowed some initial testing to explore whether comments made by focus groups regarding experiences and thoughts of mainstream care homes were actually observed within

mainstream care homes. Nevertheless, caution is necessary whilst considering these comparisons given that observations from mainstream care homes were from a very small sample and focus group participants reflected participants external to the MOPSU study. As shown from focus group findings, south Asian service users emphasized that within mainstream care homes there would be considerable unmet need with language, meal preparations in terms of separating foods and providing adequate foods and limited prayer facilities. Drawing from observations of sensitivity to cultural needs from the MOPSU study, there were some support for the comments made by focus group participants as mainstream care homes in general demonstrated considerable unmet needs with language capabilities, food separation, and evidence of culturally and religiously inappropriate foods consumed and a lack of other religions celebrated.

However, despite skeptism from some of the focus groups, there was some evidence to suggest sensitivity to cultural needs within mainstream care homes, although generally, evidence of sensitivity to cultural and religious needs were generally minimal within mainstream care homes. For example, some learning disability care homes containing Muslim service users provided service users with halal meat, there were some evidence of bi-lingual translators available for service users. Observational findings therefore seem to contradict some of the focus group discussions that 'in an English care home it wouldn't be happening' , whereby in some mainstream or 'English' care homes, there is some sensitivity to cultural needs, although rather limited. Furthermore, findings from this study suggest that within specialist care homes for orthodox Jewish service users, food was clearly separated, staff used separate utensils and the care home contained prayer facilities for private and group worship.

8.2. Social care outcomes and PhD chapters

Table 8.1 summarizes and compares findings on social care outcomes reported from previous research depicted in chapter 2 and 3 and findings relating to defining cultural needs and sensitivity to cultural needs depicted in chapter 6 and chapter 7 respectively.

Table 8.1 - Social care outcomes (Netten et al 2012) and key PhD chapter summaries

	PhD Chapters		
Chapter Two Needs, quality and outcomes (Netten et al, 2012)	**Chapter Three** Needs, culture and quality- Literature Review	**Chapter Six** Needs, cultural needs and quality- Qualitative findings (Summary)	**Chapter Seven** Cultural sensitivity- observations of mainstream and specialist care homes
Accommodation cleanliness, comfort	a) Varies between cultures; b) cleanliness religious value	a) cleanliness has religious significance	Unmet needs (MC & SC) - some evidence of dirty environments
Control over daily life	a) reflects Westernized individualism bias; b) language competency; c) emphasis on focus on spiritual, weather & planetary control rather than individual control	a) choice with foods reflective of cultural & religious group, b) choice in participating in activities; c) choice when to pray; d) choice in talking to others	
Employment and occupation	a) meaningful differs cross culturally; b) value of religious stoicism rather than active lives; c) engagement in activities reflective of westernized cultures; d) type of activity- inappropriate	a) types of activity- reflective of cultural group (Asian TV); b) activities fit operate with language abilities c) visits to native countries d) visits to temples	a) Reflective of cultural group. SC- Jewish books, TV programmes and films etc approved by Rabbi,
Meals and nutrition	a) meals religious significance; b) Cultural and religious differences with type of food, etiquette, timing , food preparations	a) meals has religious significance b) Cultural differences with types of food, cooking and preparation style, food preparations and etiquette	a) SC- met needs in types of food and food preparations b) MC- general unmet need, but some sensitivity to specially prepared foods for some service users
Personal cleanliness and comfort.	a) ascertaining personal cleanliness varies between cultures; b) cleanliness- religious significance; c) bedtimes vary in religious events d) acknowledgement of skin and hair needs for black ethnic groups	a) important before prayer b) same sex carer; c) dress codes for Hindu women d) principles of modesty; e) differences in colour clothing items	a) evidence of poor personal cleanliness in MC; b) MC- unmet needs for sensitivity to skin and hair requirements for black ethnic groups; c) some undignified care in MC; d) some evidence of no same sex carers in MC e) general met needs in SC; f) met need with dress codes in MC & SC
Safety	a) abuse definition differs between cultures; b) racism	Fears of electricity (south Asian groups)	
Social participation and involvement	a) very important within collectivist cultures; b) socialization with people from similar cultural and religious groups	a) Socially engage with similar cultural groups and backgrounds; b) engage with people who can speak same languages	
	Religion- very important	Religion very important	MC- general unmet need; SC- met
	Sensitivity to communication needs	Important for non English speakers	High unmet need in mainstream care; SC- all native English speakers

MC= Mainstream Care; SC= Specialist care for orthodox Jewish adults with learning disabilities

8.3. Limitations

Before exploring implications, recommendations and conclusions discussed in the next chapter, the next section explores study limitations. First, whilst this study was exploratory in nature, the most important limitation lies in small samples from MOPSU focal service user characteristics of 45 and 13 minority ethnic service users from learning disability and older people care homes respectively. Whilst sample sizes for minority ethnic groups for minority ethnic learning disabilities are considerably larger than other post-deinstitutionalization studies (Mansell et al, 2002), caution must be applied in interpreting findings from the MOPSU focal samples as the findings might not be transferable to understanding needs, characteristics and experiences of minority ethnic care home service users. Furthermore, emphasizing south Asian and African Caribbean populations although allows important insights considering that research into African Caribbean populations specifically are relatively under researched in community care research, yet, focusing on these two groups in the focus groups contributes to neglect of failing to address qualitative cultural needs and experiences of other minority ethnic groups including Chinese populations.

Second, focus groups were conducted separately from the MOPSU study which highlights disconnected findings from MOPSU findings to focus groups findings. However, given considerable small numbers of minority ethnic service users within each of the MOPSU care homes, specialist care homes for minority ethnic groups were sought to enable more enriched information on cultural needs, experiences of care homes, specifically sensitivity to cultural needs. Unexpectedly, collecting qualitative information from care home service users living in specialist care homes allowed detailed exploration of mainstream and specialist care homes for both adults with learning disabilities and older people which are generally unexplored within community care research. Nevertheless, this study reports on findings from a small sample of two specialist care homes for orthodox Jewish adults with learning disabilities, one specialist care home for older African Caribbean and two specialist care homes for south Asian older people, which is a limited sample considering numbers of specialist care homes found from the specialist care home review conducted for this study and limits study conclusions.

Third, the current study conducted focus groups with older people only, which considering thesis emphasis on both learning disability and older people populations reflects an acknowledged flaw with the study design. Selection of older people and their relatives for focus groups was implemented to reduce acculturation effects with younger populations and unlock qualitative potential in exploring views from people with considerable life histories and experiences. However, focusing on older people and their relatives with the focus groups fails to acknowledge the benefits of focus groups with adults with learning disabilities outlined by Cambridge & McCarthy (2001). Relatives focus groups were also unexpectedly, all male, which may have elicited gender confounding which may limit qualitative findings as views may not reflect female relatives perspectives. Furthermore, unlike quantitative positivism approaches, obtaining representative samples is not prioritized by qualitative researchers. Given that south Asian focus groups were conducted in the East Midlands and African-Caribbean groups were conducted in the West Midlands, findings may not be representative of qualitative views of minority ethnic individuals in different parts of the UK, therefore caution needs to be applied in generalizing findings. For example, 45% of minority ethnic people live in London in contrast to 13% of minority ethnic groups in the West Midlands and 6% in the East Midlands (ONS, 2005c).

Fourth, this study failed to account for socio-economic factors within the focus group samples and from the backgrounds of participants recruited from the MOPSU study. Families in more advantageous socio-economic positions such as with high income, good employment and housing may have more positive family experiences in comparison with individuals from poorer socio-economic positions. In the context of findings from the specialist care homes for south Asian populations, one relative commented one of the reasons for moving was the purposes of moving his relative into a specialist care home. It follows therefore that findings from the focus groups with south Asian relatives may reflect a group in a more advantageous socio-economic position which may not be generalize to other minority ethnic groups in less advantageous socio-economic positions. It could be argued that having access to the financial resources and being in a good social economic position allows a greater level of freedom and selection of care homes in comparison with minority ethnic groups from a less advantageous socio-economic position.

8.4. Researcher reflections

Given reflections merits discussed in section 1.2, this section explores researcher reflections on whether researcher characteristics, namely, socialization, female, mixed ethnicity, mid twenties at time of data collection impacted research processes.

8.4.1. Researcher background

Similarly to Carter (2004), interests in diversity broadly stems from social exclusion and difference interests ascertained from experiences with power dynamics impacting social group dynamics.

Socialization

Exploring difference potentially originates from childhood and adolescent socialization primarily within the particularly multicultural south London Borough of Croydon, South East England between the mid 1980s and 2000s. For example, the Strategic Partnership Croydon (2009) showed Croydon contained one of the highest minority ethnic prevalent regions conversely to other London boroughs. Furthermore, Croydon contained 56% people from minority ethnic backgrounds, conversely to 44% white British people living in Croydon. These findings mirror Manthorpe, Moriaty et al. (2010) conclusions whereby people from white ethnic groups sometimes reflect minority ethnic populations within some UK regions. Living within prevalent multiethnic communities enabled frequent interaction with people from diverse ethnicities, cultures, religions and linguistic backgrounds including Africans, African Caribbean, Indians, Pakistanis, Bangladeshis, and Chinese, Middle Eastern as well as people from other parts of Europe including Poles, Spanish, Turks and Greeks. Generally, recognizing heterogeneity and successfully meeting diverse needs by implementing culturally sensitive respective and flexible practices, reflects crucial requirements for living within multicultural south London.

Moving from Croydon to the historical semi-rural city of Canterbury in Kent, South East England for PhD study resulted in numerous changes, particularly, interactions with more prevalent white ethnic populations as shown in recent ethnicity profiles (Canterbury District Profile, 2012). This environmental transition elicited questions as to whether communities without prevalent culturally diverse communities adequately responded to culturally diverse needs. Focusing on minority ethnic populations within this thesis may reflect personal

socialization experiences with people from varying ethnic and cultural backgrounds which potentially influenced and biased preliminary research stages. Furthermore, at a social psychological level, predominately focusing on minority ethnic populations may provide researchers with prominent primary multicultural socialization with some degree of familiarity, similarity and comfort whilst living within considerably less diverse environments. Focusing on minority ethnic groups during this PhD process may reflect ways of coping within isolated environments and ethnic dissimilarity between minority ethnic researchers living amongst prominent white ethnic communities.

Training

Emphasizing population heterogeneity predominately originates from experiences and extensive psychological training accumulated within universities, NHS and private settings, primarily in London and South East England. This training included an explorative study into cross cultural differences in male physical attractiveness between Greek and native British females (Swami, Smith, Tsiokris, Georgiades, Sangareau, Tovée, & Furnham, 2007) which enabled preliminary insights and confidence in conducting research with multicultural populations. Such training may contribute to psychological orientated biased thesis and reflect academic biases and influences within South East England.

Demographical characteristics

Age

Erikson (1950) outlined young adulthood in mid-to-late twenties is generally characterized by striving towards intimacy to other people. However, others challenge Erikson's model by stating 'stages is not unidirectional and that there is not an epigenetic unfolding of developmental issues' (Whitbourne, Zuschlag, Elliot & Waterman, 1992:270). Others illuminate weaknesses of the theory and nature of the model development (Wastell 1996). Nevertheless, characteristics of young adulthood particularly striving towards intimacy may have assisted in developing rapports and understanding with participants from differing age groups. However, young adult status may have elicited communication barriers with older participants, particularly if older participants and staff question the creditability, professionalism and expertise of younger professionals and prefer contact, expertise and experience from older professionals as shown from preference studies with health care practitioners (Buller & Buller 1987). Nevertheless, some evidence suggests preferences for younger health care professionals amongst young populations (Balfe, Brugha, O'Donovan, O'Connell & Vaughan, 2010). Integrating fieldworkers of varying ages or considering preferences on fieldworker age may alleviate age confounding.

Gender

Interacting with other females from different backgrounds enabled insights into marital status changes and issues surrounding parenthood, particularly amongst older females. Focus group discussions surrounding marriage and parenthood seemed to reflect traditional gender roles advocated by some supporters of functionalism (Talcott, 1951) and Marxism (Engels, 1884) which emphasize functional traditional gender roles of women as the mother and child bearer.

As a childless and unmarried female, this drive towards marriage and parenthood potentially illuminated implicit social pressures of conforming to traditional gender roles (Sharp &

Ganong, 2011) and introduced initial barriers in building rapports with individuals with children and different marital status. Furthermore, childless and unmarried status also elicited personal identity questions of sometimes being placed in an alternative seemingly minority position relative to married females with children which potentially enabled insights into minority group membership. However, if gender roles are constructed in terms of marriage and parenthood, where does this leave the majority of unmarried females without children living in learning disability care homes as well as older unmarried females living in care homes without any children? Are unmarried females without children living in community care somehow unfulfilled or 'less female' by failing to meet female societal landmarks of marriage and parenthood?

Ethnicity

As a native British citizen from mixed white British and Indo-Caribbean ethnicity, enabled recurrent intimate insights into how differing cultural beliefs impact everyday living. Furthermore, prioritization of certain cultural beliefs over others during the socialization process revealed insights into difference between social groups and subsequent isolation, marginalization and exclusion following from unmet needs and limited socialization other cultural beliefs. Experiences of conflicting divergent cultural beliefs provided intimate insights into how needs, characteristics and experiences occasionally differ between cultures which elicited confidence in conducting research on culturally diverse populations. Perhaps this thesis emphasis on recognizing minority ethnic groups within care homes enabled unique unconscious opportunities to explore cultural beliefs reflective of part Indo-Caribbean background which was largely absent during childhood socialization. Similarly, whilst it was fully intended to be sympathetic and open minded to varying cultures, there may have been barriers to fully understand and appreciate differing cultural norms and beliefs perhaps due to unconscious affinity and identification as a native British citizen.

Mixed ethnic background also revealed social psychological dynamics of frequent societal attempts to ascribe assumed ethnicity classifications during initial introductions. An assumed incorrect ethnicity classification from others typically ignites personal self evaluations. Additionally, receiving an incorrect ethnicity group typically results in denial of incorrect ascribed ethnicity labels, but also illuminates the powerlessness of labels, whereby others automatically allocate social categorizations and labels. Furthermore, mixed white British and Indo-Caribbean ethnicity is seldom mentioned within ethnicity classifications (other than mixed ethnicity group) although researchers explored older people form Indo-Caribbean backgrounds (Rao, Desphande, Jamoona & Reid, 2008). This unique mixed ethnicity background enabled insights into confusion and isolation due to failing to meet an initial ethnicity classification. Failing to fit into specific ethnicity categories along with multiple conflicting cultural beliefs potentially illuminates this thesis emphasis on recognizing heterogeneity amongst people. Such experiences may also mirror experiences of service users struggling to fit into predefined categories and diagnoses.

Personal mixed ethnic background may have also impacted integration and rapport building with participants and staff from particular ethnicity groups. Indeed, the first few questions asked by south Asian focus group participants concerned ethnicity background of focus group facilitators. Such questioning may reflect group dynamics and social comparisons, specifically viewing minority ethnic researchers which may yield commonality between researcher and participant. However, minority ethnic researchers may have also initiated barriers with participants and staff within care home services, particularly within

environments transmitting prejudicial or stereotypical attitudes against certain minority ethnic groups. Findings from this thesis, especially in relation to qualitative findings, may reflect participant responses to a researcher from seemingly similar minority ethnic groups, although this is unsubstantiated and speculative without a focus group facilitator from a white ethnic background for comparative purposes.

Failing to speak, read and understand languages other than English depicted significant challenges whilst conducting fieldwork with service users with multilingual skills. During focus groups, whilst translators were utilized to obtain south Asian perspectives and translate project material into different languages, limited language skills undoubtedly influenced interactions with participants and potentially created a dissimilarity barrier between researcher and participant. Furthermore, conducting fieldwork within non-English speaking environments resulted in uncomfortable and unfamiliar 'outsider' positions. These 'outsider' social attributions and self categorizations resulted in surprising utilization of submissive behavioural responses and shifts in power dynamics with English speakers seemingly placed in a different, submissive, inferior and minority position to those with multi-lingual skills. As a native English speaker, 'outsider' self categorizations resulted in feelings of isolation, frustrations, alienation and segregation whilst trying to interact with people who utilized different languages which may mirror experiences of people living in England with little to no understanding of English.

8.4.2. Researcher role and research process

Population groups

Service user characteristics occasionally infiltrated the research process. For example, during focal participants introductions, some care staff integrated diagnoses or particular cognitive impairments and existing challenging behavior. Aside from formal introductions and checking participant consent, fixation on certain characteristics may reflect social psychological concepts of impression formulation, social categorization, in-group or out-group dynamics or perhaps even medical model orientated biases within community care services. Nevertheless, there was some attempt to incorporate lived experiences of people with considerable impairments through observational approaches which arguably reduce subjectivity and group dynamics with interviews and questionnaire methods. However, this same reflective point on focusing on specific characteristics could be applied with emphasis on cultural diversity which may potentially obscure other characteristics central to effective service provision.

Data Collection

Collecting fieldwork across the UK led to further seemingly 'outsider' positions from people native to particular geographical UK regions which led to uncomfortable feelings of being away and 'out of area' away from friends, family and colleagues. Temporal separation from familiar university surroundings could be comparable to feelings of separation anxiety, loss and grief by service users placed 'out of area' or placed in considerable distances away from friends and family, particularly for service users deriving from close knit communities. Given 'out of area' prevalence for adults with learning disabilities (Beadle-Brown, Mansell, Whelton & Hutchinson, 2009; Beadle-Brown, Mansell, Whelton, Hutchinson & Skidmore, 2005, 2006a 2006b), negative emotions associated with 'out of area' and temporal separation

from others could be important antecedents for detrimental psychological wellbeing experienced by community care service users.

8.5. Conclusion

This chapter summarized main findings from this study, compares thesis findings with other studies, summarizes findings from this study in relation to social care outcomes, discusses study limitations and outlines researcher reflections. Whilst the small samples of minority ethnic service users within this study reflect important limitations, this study could be viewed as an explorative starting point given coverage of needs, characteristics and experiences of care homes with specific reference to minority ethnic populations.

9. Chapter Nine. Implications, Recommendations and Conclusions

9.1. Introduction

This final chapter explores general implications, recommendations, conclusions, contributions to knowledge and closing reflections.

9.2. General implications

As the UK becomes increasingly diverse, sensitivity to diverse populations will become more prevalent. This thesis aimed to explore the multifaceted influences ethnicity and culture on service users lived experiences within care homes. Findings illuminating ethnic and cultural differences within micro, meso and macro levels suggest ethnic and cultural factors may have far reaching effects on the lifestyles of surrounding community care service users.

Theoretical frameworks

Investigating diverse populations challenges various theoretical frameworks. First, researchers typically consider Goffman (1961, 1962) findings of block community care treatment of service users, social distancing between staff and service users, depersonalization and regimentation and lack of choice within community care. In light of general unmet cultural needs with language and religious sensitivity in some mainstream care homes, minority ethnic and diverse groups maybe more susceptible to institutional practices namely, depersonalization, block treatment in comparison with native white British groups if care home staff neglect diverse needs. However, positive environments for some minority ethnic people living in specialist care homes, including increased opportunities for morale building, social opportunities and frequent engagement with individuals sharing similar backgrounds challenge inevitability of total institutions and depersonalization as Goffman depicts.

Second, generally, theoretical frameworks portray gloomy conclusions regarding community care experiences including tendencies to victimize community care service users as passive recipients of care. Nevertheless, study findings show some older minority ethnic service users actively embraced their cultural and religious identity by continually engaging within spiritually based activities, selecting culturally distinctive clothing and actively vocalizing their concerns to care staff, families and professionals. Despite onsets of aging and disengagement principles, findings suggest some older minority ethnic people implemented proactive strategies in order to embrace their identity including continuing with prayer whilst sitting down and slightly modifying dress codes to accommodate physical impairments .

Third, conversely to absolutist assumptions, findings support Berry et al (1997) universalism assumptions, whereby culture impacts development and display of basic human characteristics. Study findings highlight that characteristics including: food, dress and communication reflect universal qualities as all humans eat, wear some form of clothing and communicate with others in some form, yet how we display, cook, prepare and consume foods with differing eating etiquette, wear clothing and communicate with others differs between cultures. Focus groups findings illuminate denial of opportunities for service users to embrace their cultural and religious identity could be sufficiently detrimental to psychological wellbeing and quality of life. Perhaps universalism and absolutist perspectives explain variations in service sensitivity to cultural needs. Failing to implement

any sensitivity to cultural needs may adhere to absolutist perspectives, whereas care staff adopting more universalist perspectives may reflect more culturally responsive services and operate services in accordance with sensitivity meeting varying cultural needs.

Fourth, rather than rigid race biological conceptualizations, study findings illuminate implications and support for social theories surrounding ethnicity and culture. Multiculturalism supporters argue minority ethnic populations should not change to allow integration, but rather should remain distinctive and separate. Policy emphasis on acknowledging cultural needs and implementing services in accordance with cultural needs (DH, 2001a) implies multiculturalism. Specialist care services and preferences for specialist care may reflect multiculturalism in its most extreme form, as such services allow for unique and specialized opportunities to maintain cultural beliefs distinctive and separate from other cultural influences. Findings of successfully and sensitively responding to minority ethnic needs within care homes perhaps highlight supporters of multiculturalism within community care.

Conversely, unmet cultural needs findings within some mainstream care homes may indicate integration and assimilation perspectives, whereby, in order to achieve harmony, people from diverse cultures need to adapt and change in order to successfully integrate within society. Mainstream care homes by definition generally support this assimilation perspectives by highlighting diverse groups need to adapt and change their lifestyles in order to 'fit in' within British culture, thus justifying why services fail to meet needs of diverse populations. Findings relating to sensitivity to cultural needs highlight conflicts between multiculturalism supporters contrary to those who advocate assimilation who believe in integration for harmonious societies. Some South Asian relatives commented on acculturation and changing cultures within the future may reflect macro influences of dominant societal assimilation perspectives consequently explaining significant unmet need for minority ethnic populations. Effectively improving the lifestyles of minority ethnic groups may therefore require more macro efforts in promoting multiculturalism perspectives and illuminating potential dangers of absolutism.

Fifth, social constructivism highlighting complexity of real life learning, whereby people learn as they work to understand their experiences, may have relevance to study findings. Historically, limited travel opportunities potentially denied interaction with minority ethnic and culturally diverse populations and subsequent learning. Considering projected increases in minority ethnic populations, parts of the UK maybe operating within transitional learning phase discovering how to support and improve lifestyles for minority ethnic community care service users. Findings of unmet needs for minority ethnic populations within less multicultural regions may illuminate infancy in understanding diverse populations and limited opportunities to engage with culturally diverse populations in order to learn and adapt to different experiences. Conversely, more prevalent minority cultural communities may provide frequent opportunities for learning thus motivating community care staff to adapt services accordingly. Furthermore, social constructivism may explain differing discriminatory attitudes towards people with disabilities and older people. Increased opportunities for learning by engaging with presumed oppressed populations may help provide opportunities for learning and adapting behavioural responses to oppressed populations. More positive attitudes towards others may reflect people with more varied experience and learning opportunities to challenge oppressive attitudes, consequently yielding behavioural change.

Finally, implications for person centered planning and equality. Findings highlight considerable unmet need within some domains such as meals and personal care amongst some minority ethnic groups, which raises questions on the adequacy and effectiveness of services utilizing person centered approaches, but also attainment of equality amongst service users. Findings of unmet need amongst minority ethnic communities could be viewed as evidence of continued inequalities which is contrary to numerous social policy agendas including *Valuing People* (DH, 2001a) in illuminating importance of race, ethnicity and culture as important factors in developing and improving services for minority ethnic communities. If minority ethnic communities still experience inequalities, within care homes, even eleven years after *Valuing People* (DH, 2001a) , has there been any progress in installing race, ethnicity and culture as important for developing and improving services? Findings from this study highlight whilst some services successfully meet minority ethnic needs, there is considerable scope for service improvement in striving towards equality for minority ethnic service users. Considerable met needs within specialist care homes in comparison with mainstream care homes suggests mainstream service may diffuse responsibility of providing support for minority ethnic communities in light of specialist service provision which warrants further investigation.

Normalization- cultural and quality considerations

Normalization, familiarity and well-known environments encapsulates study findings. Study findings reveal at the micro level that older service users and relatives emphasized familiarity and well-known environments particularly for purposes of with social engagement, participation in activities and consuming particular foods. Nevertheless, meso-level findings within some mainstream care homes depicted religions are not celebrated for religiously observant individuals and there seems to be considerable unmet language needs for people whose first language is not English. Workforce care home characteristics also generally support a preponderance of white ethnic staff in care homes, although this study also reports on findings suggesting significantly more minority ethnic staff in care homes with at least one minority ethnic service user. Furthermore, in general and in contrast to the two specialist care homes for Jewish adults with learning disabilities, there appeared to be a real lack of sensitivity to cultural, linguistic and religious needs for minority ethnic people in learning disability and older people within mainstream care homes If minority ethnic populations consider integrating with minority ethnic people and environments which cater for south Asian people for example as a 'normal' 'familiar' and 'well-known' environment, relocating to mainstream care homes which cater primarily for native white British people could reflect abnormal, unfamiliar and unknown environments.

Illumination of cultural factors highlights three further implications for normalization. First, highlighting cultural significance of normalization, familiarity and well-known environments highlights challenges in measuring and monitoring concepts surrounding normalization and subsequent inferences on service quality and quality of life. An overall finding from this study illuminates, how one describes something as 'normal' and 'familiar' could be considered as completely 'abnormal' and 'unfamiliar' by others. Given this degree of subjectivity, how is it possible to accurately explore normalization? How are we defining normality? Normality could be defined along with norms held within some 'majority' culture. Alternatively, normality could be defined by people of powerful influence which reflect specific and unique agendas unrelated to individual definitions of normality. Furthermore, are inferences on normality as defined by norms within a seemingly majority group? Or

inferences on normality as viewed by norms within seemingly minority groups? Such inferences depict conflicts in identifying normality.

Findings from this study generally suggest normalization is socially constructed as how we define something as 'normal' is dependent on cultural values and norms. Perhaps the best approach for policy, service provision and political context involves implementing person centered approaches and recognizing both heterogeneity and uniqueness of each individual before ascertaining normality. Recognizing aspects of individuality illuminates individualized micro level theories including social constructivism and universalism. Nevertheless, given Manthorpe & Moriaty et al (2010) conclusions of potential 'super diversity' with no real minority group within some UK regions, highlights difficulties in identifying normality given varying complexity and attributions of normality. Super diversity highlights further challenges for service provision and illuminates postmodernist ideologies. Numerous policies and researchers call for consideration of person centered approaches. Findings from this study, particularly, sensitivity to cultural, religious and linguistic needs highlight considerable work still needs to be undertaken in meeting needs of minority ethnic groups in order to achieve equality and good quality culturally acceptable services.

Second, striving to produce environments considered normal and familiar could have important implications for psychological wellbeing. Presumably, long term uncomfortable psychological states maybe associated with continued exposure to unfamiliar surroundings. Similarly, given evidence of normalization and sensitivity to cultural needs could be related to Manthorpe et al (2010) findings depicting how social care practitioners support minority ethnic peoples mental wellbeing. Similarly, how does normalization relate to psychological adjustment and adaption to different situations? Given complexity and heterogeneity amongst human societies, excluding isolated sect communities, adapting within varying heterogeneous societies and being able to cope with different situations is seen by some psychologists as an important part of happiness and tends to be a key occupational requirement, particularly working within stressful, emotive and demanding occupations such as working within emergency services. If care homes continually implement environments which service users find deeply abnormal, unfamiliar and unknown, particularly for service users newly relocated to care homes, could services be exacerbating and increasing the likelihood of challenging behaviours and psychopathological depression and anxiety? Implementing normalized environments which match service users definition of normality reveal important psychological benefits for service users themselves, but also important for both service user and relatives wellbeing.

Drawing from interpretivism and Weber's *Verstehen* concept of imagining stepping into another individuals reality in order to understand behaviour (Weber, 1947; Tucker, 1965) may improve sensitive service provision. Furthermore, upholding the' Golden Rule' of treating others as one would like to be treated as depicted in Matthew 7:12 may assist in supporting service users. For example, similarly to normalization case scenarios in chapter three, presumably white British observant Christian females would expect respect sensitivity and preferences in celebrating Easter, just as practicing Muslims would expect others to respect sensitivity whilst observing Ramadan.

9.3. Additional specific implications

Findings allude to additional specific implications for academics, policy makers, regulatory organizations, service providers, service users and relatives and researchers. Although additional specific limitations discussed in this section are applicable to all audiences.

9.3.1. Academics

Study findings highlight social care outcomes may have particular significance, preference weighting and value for some socio-cultural groups. For example, meals and activity engagement whilst identified as important for some service users, findings highlight religious and cultural significance for some diverse populations. To assume domains reflect universal and relevancy for all, potentially implements eurocentric and absolutist biases, subsequently marginalizing and oppressing diverse populations. Increasing research attention on minority diverse groups allows opportunities to challenge, develop and enrich quality and social care outcomes. Illuminating perspectives of minority ethnic groups also calls into question the representativeness and demographical sampling disposition of participants in community care research. Whilst white ethnic groups may continually constitute modal ethnicity demographics within community care research, needs, experiences and preferences of minority ethnic groups maybe neglected if the perspectives of minority ethnic communities are unintentionally neglected.

9.3.2. Policy makers

Policy makers need to implement and integrate initial and continual qualitative scoping projects by involving minority ethnic communities. For example, whilst policy makers emphasize sensitivity to cultural needs, equality and promoting mainstream care as opposed to specialist care, failing to consult with service users, families and direct care staff, may lead to missing valuable insights into the practicality, usefulness, viability and validity of relevant policies. Consultation may also shed light on important preferences and wishes amongst minority ethnic communities which may reflect important antecedents for service uptake. Consultation with service users, direct care staff and facilities may open new discussions for opportunities for improving service awareness and developing strategies to improve cultural appropriateness of community care services. Integrating viewpoints and perspectives from service users themselves, families and direct care staff may also help improve communication across different populations, ignite more motivation and interest in care staff if policy makers integrate the perspectives of those working at grass roots level. Such movements may provide various individuals with a sense of pride, accomplishment and value if senior policy makers continually acknowledge other viewpoints at the micro level.

Networking with organizations specializing in protecting the interests of minority ethnic populations and developing full support and assistance with such organizations allowed unique insights and access to minority ethnic communities which may not have been possible through conventional cold calling techniques. Consulting with minority ethnic communities, relevant minority ethnic organizations and obtaining full support from such organizations represented a useful starting point in bypassing initial gate keeping barriers. Being aware of initial language and communication barriers is also an important issue for policy makers. Findings from this study revealed minority ethnic older people may have never put pen to paper or be able to read their language in printed form. Discussing with minority ethnic

communities regarding the best medium for dissemination may reflect important issues with appropriate dissemination of policy material.

9.3.3. CQC and commissioners

Regulatory organizations such as the CQC need to be informed of increasingly prevalent minority ethnic populations potentially utilizing community care services. This increase will result increased challenges and adaptations by direct care staff which commissioners need to be aware of. Audit investigations and routine collection of information on numbers of minority ethnic people utilizing CQC services could provide CQC with valuable insights into service utilization and findings on mainstream versus specialist care uptake. Development of post hoc cultural indices which aim to ascertain sensitivity to cultural needs presented within this thesis alerts questions on CQC inspection process. Given potential adherence to either absolutist or universalist perspectives amongst inspectors as well as inspectors own experience and backgrounds, questions remain whether CQC inspectors prioritize sensitively to cultural needs within inspection processes. Findings from this study reveal sensitivity to cultural needs constitutes important ingredients for defining quality and essential for wellbeing. But the question remains whether inspectors infiltrate sensitivity to cultural needs during inspection process. Whilst sensitivity to cultural needs constitutes part of the inspection process, subjectivity amongst inspectors as well as focusing particular requirements may diminish priorities in checking for sensitivity.

There may also be limited guidance material and understanding concerning how to assess cultural sensitivity. The CCHOT and cultural indices presented in this thesis may assist inspectors with indicators to determine whether care home staff were implementing culturally sensitive services. Procedures including research audit and consultancy work on sensitivity to cultural needs within the CQC inspection process could explore these issues. Focus group with inspectors from various backgrounds to explore views on prioritization of sensitivity to cultural needs within inspections.

In order to reduce subjectivity and inspector variability, CQC may need to implement standardized procedures to ensure that all inspectors prioritize sensitivity to cultural needs within the inspection process. Securing agreement and commitment from CQC in illuminating the needs of minority ethnic populations as well as ensuring sensitivity to cultural needs reflects an important step in improving the lived experiences of service users. Support, emphasize and dedication to these issues by senior level regulators may increase motivations for direct care staff to pay attention to unmet needs amongst minority ethnic communities utilizing services and therefore indirectly improving the lives of minority ethnic people associated with community care.

9.3.4. Service providers, care staff, practice and service development

Practitioners need to recognize the impact of stigma and cultural expectations which can influence willingness of minority ethnic people and families to access community care services. Following from personal reflections outlined in chapter eight, implementing reflective practices and being aware of personal prejudices could help staff with 'bracketing off' their own ideas of acceptability and normality which could improve sensitivity services. Staff may therefore require considerable training on sensitivity to cultural needs and acknowledgement of individual heterogeneity.

Increasing opportunities for communication between staff working within different care homes could also help services. Nevertheless, isolation of care staff between care homes may reflect confidentially contracts signed by new members of staff to prevent any discussion, publication or transmission of information ascertained from other care homes. Whilst isolation may also reflect competition, and potential group dynamics of keeping 'others' distinct from 'in-groups', facilitating communication between care home staff may help to share examples of good practice and discuss case examples which may assist in service development and accurate favourable outcomes for service users and their relatives. Particularly, communication between care home staff working within specialist care homes and care home staff working within mainstream care homes. Similarly, delivery of services to minority ethnic older people could be enhanced through greater collaboration between specialist ethnic specific service and mainstream service providers. Researchers and inspectors encounter unique opportunities to experience how different care home staff operate in meeting the needs of service users from differing backgrounds. Care home staff may similarly accumulate useful knowledge from visiting other care homes to observe staff practices, particularly within care homes implementing specialist provision.

9.3.5. Service users and relatives

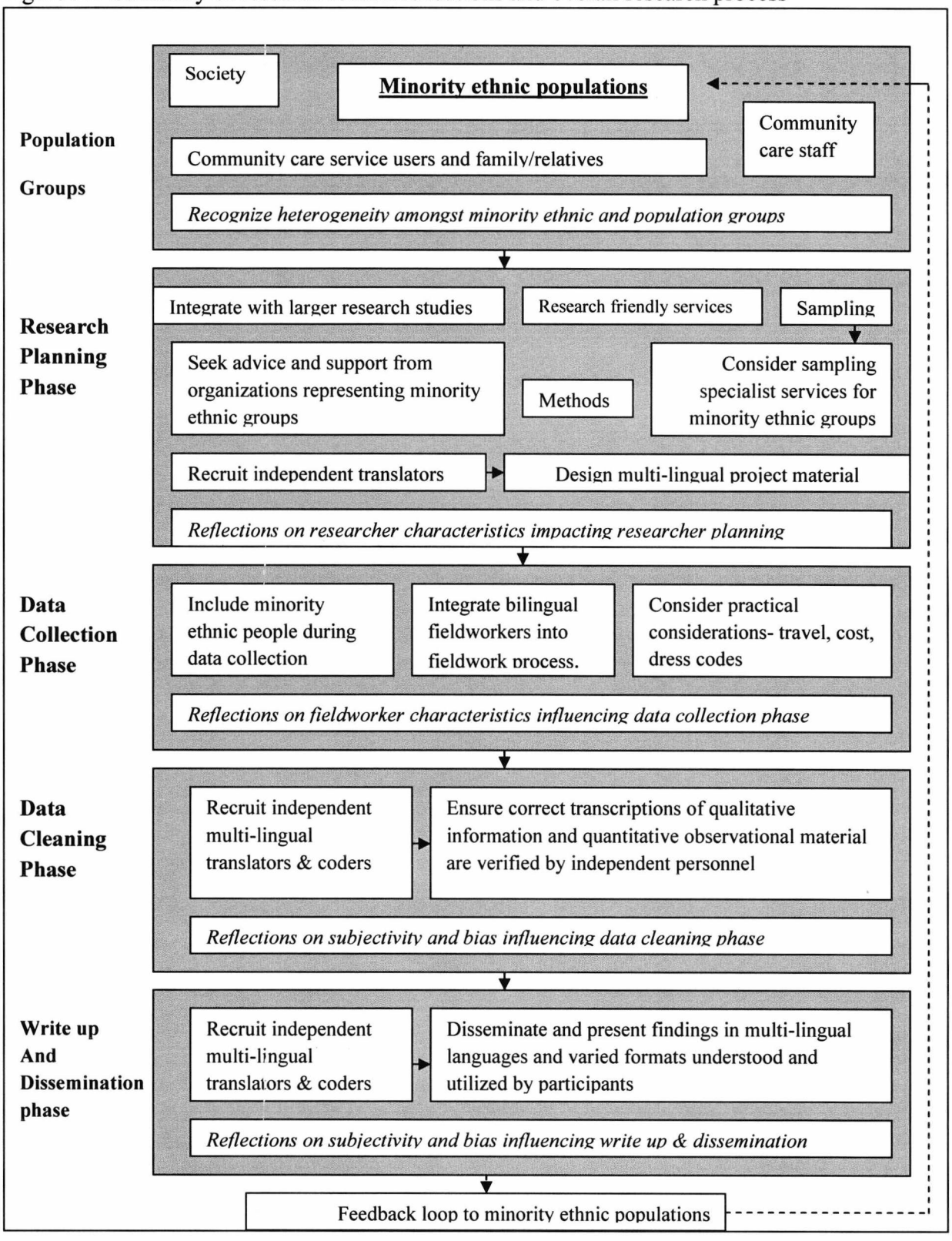
Qualitative findings reveal paucity knowledge gaps in the existence of community care support. South Asian relatives particularly requested knowledge on specialist care homes. Regardless of preferences on mainstream and specialist care, service users and relatives need support and availability of community care options in order to make appropriate informed choices which are essential for decisions surrounding admissions into community care services . Nevertheless, communication abilities with South Asian older people and literacy and writing skills suggests service users and their families may need additional support in accessing knowledge through alternative communication mediums. For example, accessing information on services through discussion groups, meeting groups and visits from religious leaders reflect additional ways of transmitting information. Appropriate information should facilitate informed choice and help families plan future care. Availability of care support information may reassure service users and families that they have access to support adaptable to their unique circumstances. Conversely, insensitive and inappropriate communication options may oppress, accentuate inequalities, people without English language competency and implement biases of only providing English speakers with wider choices and knowledge on service availability. Findings on social stigmas surrounding care place some minority ethnic families within difficult positions. Wider educational interventions within communities depicting facilities, resources, activities and celebrations within some services as well as encouraging visits to community care facilities may encourage disintegration of care stigmas. Speaking with families and service users themselves may also assist in reducing social stigmas.

9.3.6. Researchers

Low utilization of community care services for some minority ethnic groups and difficulties recruiting some minority ethnic populations pose significant dilemmas with investigating minority ethnic experiences of community care settings. Researchers therefore require research strategies to successfully recruit minority ethnic groups. Figure 9.1 summarizes strategies used within this thesis to collect minority ethnic populations as well as strategies that in hindsight, could increase sampling proportions of minority ethnic groups and help future research into minority ethnic groups in community care settings. Strategies over five

research stages include: population groups, research and planning stages, data collection, data cleaning and dissemination stages. Recognizing heterogeneity amongst minority ethnic populations and continually reflecting on potential impact of specific behaviours impacting others is necessary at each research stage.

Figure 9.1-Summary of research recommendations and overall research process



Population stage

This stage involved ascertaining populations targeted minority ethnic populations for research exploration including service users, community care stuff, wider society and relatives.

Research planning phase

Three general strategies were utilized within research planning phases to increase minority ethnic samples. First, linking with larger studies with considerable funding support from CQC and ONS provided opportunities to increase study creditability during participant recruitment stages and accessing larger care home samples and presumably more minority ethnic populations. Second, through networking with organizations specifically supporting minority ethnic population and specialist care homes for minority ethnic groups provide access to concentrated minority ethnic populations which allow scope for detailed discussions on ethnicity and cultural factors within community care. Although minority ethnic people associated with specialist care may have different views and preferences in contrast to minority ethnic people outside of specialist care, particularly in terms of affiliation, adherence and integration of more orthodox religious beliefs. However, given low numbers of specialist care homes, recruiting specialist services only may also saturate service with research requests which may increase reluctance to participate in research, so consideration of sampling strategies outside of specialist care homes maybe necessary. Third, recruiting services which contain 'research friendly' attitudes amongst care home staff and understanding of research challenges (Goodman et al 2011) may accentuate research samples. However it is important not to saturate 'research friendly' staff with research requests . Furthermore, consenting care home staff reflect arguably higher quality than care homes with lower quality who maybe more reluctant to participate in research.

Furthermore, consulting and associating with widely known organizations linked within numerous minority ethnic communities could help access facilities and participants, but also improve investigators creditability in accessing populations. Recruiting and identifying in advance independent translators to assist in designing multi-lingual project material, assist during any qualitative interviews. However, it is important to obtain independent translators to prevent biases with interpretation and translations. Translators limitations including inaccuracies in translation due to screening out socially undesirable comments made by participants and summarizing content may require additional independent translators to check the viability, validity and reliability of specific translations. Translators need to posses multilingual skills which match participants languages as well as translators that can speak, write and understand languages spoken by participants. Nevertheless, considering findings that some south Asian older people could not read or write their native language and never use pens or pencils (Shah, 1999), it is worth looking at other mediums in gaining consent and discussing project material. Drawing assumptions that people could read, write and use writing materials could potentially result in questionable ethical dilemmas as to whether participants possess full understanding for consent.

Combination of mixed methods reflects complies with recommendations from influential academic figures in quality of life including Schalock. However, amongst collectivist cultures, group based data collection may reflect important preferred mediums of data collection as opposed to individualistic one on one interviews with people which denies

collectivist group dynamics. Combining methods may reduce chances of implementing individualistic bias during data collection.

Data collection phase

Research reflections in chapter eight showed integrating minority ethnic fieldworkers may accentuate rapports with minority ethnic participants and facilitate deeper exploration of minority ethnic issues, particularly if minority ethnic service users prefer not to disclose issues with white ethnic fieldworkers. However, minority ethnic participants may similarly withhold information considering fear repercussions if participants believe minority ethnic fieldworkers from similar backgrounds would break confidentiality and disclose sensitive material to their local communities. Subsequently, it might be worthwhile recruiting fieldworkers from varied backgrounds. This study highlighted the importance of utilising native speakers to minority ethnic groups whilst conducting research among specific minority ethnic communities. Limited language abilities was a significant barrier but could be worked round by recruiting objective independent translators or objective multilingual fieldworkers within the research process.

An unexpected finding concerned fieldworkers characteristics potentially influencing data collection. For example, staff within some specialist care homes only recruited male care staff whilst supporting a care home exclusively for male populations. The presence of female fieldworkers thus may have elicited uncomfortable feelings for service users living within an all-male household. Sending male fieldworkers may have limited uncomfortable feelings amongst male service users.

Female oriented specialist care homes supporting orthodox Jewish women included specific dress codes for female staff including long sleeves, long skirts and overall wearing modest clothing. Participants within particularly orthodox religiously orientated homes may prefer to consult with fieldworkers in similar clothing. However, 'power dressing' by wearing smart business suits may accentuate impressions of superiority and power dynamics which may stunt data collection and accentuate observational problems of Hawthorne effects. Participants and services may prefer to consult with researchers wearing more informal clothing. Sensitivity to dress codes and positively discriminating on gender amongst fieldworkers may therefore improve data collection. Furthermore, discussion of particularly sensitive matters such as personal care may have been particularly uncomfortable for female participants to discuss with male researchers.

Data cleaning phase

In order to check the validity and reliability of translators during the data collection stage, it maybe necessary to recruit independent translators to check the validity of translations given that some translators may have summarized or omitted important information which may otherwise compromise valid qualitative research.

Dissemination phase

Disseminating material is important for concluding research processes. Failing to feedback information to participation populations could accentuate frustrations and skepticism amongst research participants if researchers fail to feedback project material if participants wished to see final reports. Figure 9.1 therefore integrates a feedback loop from dissemination to the

first population stage to facilitate project feedback. Nevertheless, given language capabilities, it is important to disseminate material in primary languages understood by research participants. Utilizing alterative mediums such as verbal feedback in dissemination group could be utilize in light of any difficulties in reading written text or preferences for verbal feedback as opposed to written feedback.

9.4. Suggestions for future research

Combining observations emerged from discussion in chapter eight with implications described in this chapter, poses multiple interesting directions for future research.

This study is limited by cross sectional design in not being able to explore the long term psychological consequences of unmet cultural needs on psychological quality of life and wellbeing. Presumably, services which actively embrace and are successful at meeting diverse cultural needs install more enhanced quality of life and wellbeing than peers from similar backgrounds living in environments which promote unfamiliarity, abnormality and unmet cultural needs. Further longitudinal work needs to be done to establish whether there are any long term psychological consequences with outcomes on community care service users lifestyles. Whilst chapter two reviewed various longitudinal studies depicting outcomes following deinstitutionalization (Cambridge et al 1994) it would be interesting to explore the long term effects of quality of life outcomes for minority ethnic people in comparison with white ethnic people and explore which predictors accentuated or impeded well-being. Exploring matched samples for participants within specialist care homes with participants within mainstream care homes would enable insights into whether specialist services impacts the psychological well-being of services.

More information on micro-meso-macro factors surrounding ethnicity and culture with larger sample minority ethnic samples and a more detailed range of minority ethnicity groups would help researchers to establish a greater degree of accuracy on these matters. Anchoring qualitative focus groups with a white British comparison group which was not included in this thesis due to practical constraints could also help understanding into defining cultural needs and exploring service experiences.

9.5. Final conclusions and contributions to knowledge

Emphasizing ethnic and cultural factors may impact characteristics, beliefs, experiences and preferences for minority ethnic community care service users could help improve community care practice by incorporating these variables. This would ultimately improve care for service users by illuminating continual heterogeneity amongst minority ethnic populations. With increasing prevalent minority ethnic populations, appreciation and sensitivity to minority ethnic populations will become increasingly important community care issue.

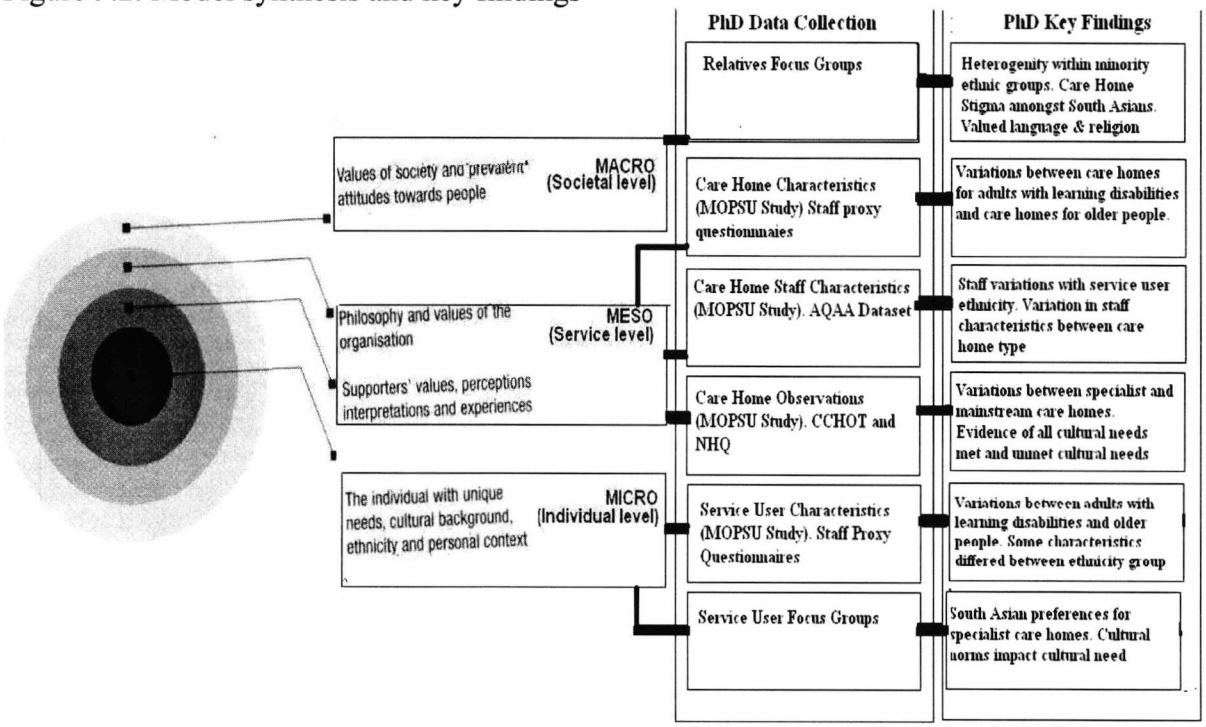
However, research investigating needs and experiences of minority ethnic adults with learning disabilities and minority ethnic older people living in care homes is currently relatively unexplored which the current thesis attempted to readdress. Drawing from data collected across England, an explorative mixed methods study was conducted to primarily explore the needs of minority ethnic adults with learning disabilities and minority older people living in care homes and whether care home staff implemented culturally appropriate care for minority ethnic care home service users. Differences in needs and characteristics between minority ethnic care home service users and white ethnic group service users were

also explored as were differences in staff characteristics for care homes containing at least one minority ethnic service user with care homes containing only white ethnic service users.

9.5.1. Model synthesis and key findings

Figure 9.2 combines earlier Figures 3.1 and 3.2 with key findings reported in chapter six and seven. Figure 9.2 shows this thesis explores ethnic, religious and cultural factors as collected from micro, meso and macro levels. Presenting needs and experiences of care homes for minority ethnic people from micro- meso and macro levels illuminates study uniqueness as other community care studies investigate minority ethnic needs and experiences of care at the micro or meso or macro level rather than combination of findings reflecting three different levels. As Figure 9.2 summarises, at the micro level, this study reports on service user characteristics, definitions of cultural needs and experiences of sensitivity to cultural needs. At the meso level, this study highlights whether staff working within care homes implemented sensitive care provision for minority ethnic and culturally diverse populations and also presents data on staff and care home characteristics. Views from family relatives of care home service users were ascertained on definitions of cultural needs and experiences of sensitivity to cultural needs within community care service provision which could allow insights into macro societal level perceptions.

Figure 9.2. Model synthesis and key findings



9.5.2. Most relevant conclusions

In conclusion, whilst this study was limited by small sample sizes, this study highlights ethnicity and cultural factors could be ascertained from micro, meso and macro levels. Second, minority ethnic populations reflect heterogeneous and varied populations and services, researchers and policy makers need to recognize significance of linguistic and religious needs whilst considering social care outcomes. Third, variations in needs and experiences were noted across learning disability and older people populations which highlights further acknowledgement and research attention. Collectively, findings on unmet needs for minority ethnic groups suggests that despite policies acknowledging the

experiences of minority ethnic groups and sensitivity to minority ethnic needs, considerable work needs to be integrated into community care services recognizing minority ethnic groups, particularly given increasingly prevalent projected increases of minority ethnic populations in the UK

In a final attempt to condense findings whilst referring to the main proposition of cultural considerations within community care research and research questions, key findings are summarized in Table 9.1a for characteristics findings of service users, care homes and staff and Table 9.1b summarizes key findings on defining cultural needs and sensitivity to cultural needs.

Table 9.1a- Key findings- characteristics of service users, care staff and care homes

	Research questions	Empirical support
1. Characteristics of care homes, staff and care home service users		
RQ 1	Were there any variations in service user characteristics for non-white minority ethnic service users in comparison with white ethnic care home service users?	• Non-white learning disability older than white learning disability service users • Non white minority ethnic older people depicted more impairments with communication, cognitive impairments and short term memory problems
	Were there any variations in service user characteristics for service users from differing minority ethnic groups?	• South Asian adults with learning disabilities displayed significantly more signs of depression than black ethnic and other ethnic groups
RQ 2	Were there any variations staff characteristics in care homes containing at least one non-white minority ethnic service users in comparison with care homes containing only white ethnic service users?	• Learning disability care homes with at least one minority ethnic service user contained more Asian staff, lower percentages of staff aged 55-64 and higher percentages of full time staff. • Older people care homes with at least one minority ethnic service user contained staff implementing more qualified nursing hours, more personal care hours and higher percentages of minority ethnic staff
	Were there any variations in staff ethnicity in relation to service user ethnicity?	• Learning disability care homes with at least one Asian service user contained higher percentages of Asian staff • Older people care homes with at least one minority ethnic service user had higher percentages of staff from black ethnic groups
SupR Q	Were there any variations in characteristics for care homes, care home staff and service users between learning disability and older people services?	***Care home characteristics*** • Learning disability services contained more residential care homes, higher proportions located within London and South East and higher percentages of lifestyle standards met
		Care home staff characteristics • Learning disability staff- more males, more full time hours, more non-personal care hours • Older people staff- more qualified nursing hours, more personal care and more other staff hours
		Service user characteristics • Learning disability- more men, more independent, more challenging, more problem behaviours • Older people- older and more memory problems

Table 9.1b- Key findings - cultural needs and sensitivity to cultural needs

	Research Questions	Empirical support
Cultural needs and sensitivity to cultural needs		
RQ3	How did older minority ethnic care home service users and their relatives define 'cultural needs' and experience care homes?	Cultural needs • Activities- reflective of cultural groups • Visiting countries of origin • Foods types, preparations, restrictions- important for south Asians. Differences between religions and cultural group • Personal care- same sex carer, cleanliness important for religion • Dress codes- important to wear traditional south Asian clothing. Some South Asians wear jewellery and light colour clothes. • Religion- very important • Socialization- similar cultural group • Language needs- very important for older south Asian groups with limited language skills • Cultural needs will change following acculturation and generation changes
		Experiences • South Asians- strong preference for specialist care homes • Stigma of care homes within south Asian communities
RQ4	Did staff working within care homes respond to the cultural, religious and linguistic needs of minority ethnic care home service users?	• Limited bilingual staff, availability of non English information in care homes containing non English speakers • Limited prayer and worship facilities in mainstream care homes • Majority of mainstream homes did not celebrate non Christian religions • Evidence of dirt and odours within mainstream care homes containing religiously observant service users • Majority of mainstream care homes fail to implement sensitive dietary practices for religiously observant service users. Specialist services carefully considered dietary practices • Some evidence of insensitivity to hair and skin care requirements for black service users in learning disability and older people care homes • Very limited evidence of bidets, jugs and bidets in bathrooms for service user use

9.5.3. Contributions to knowledge

The main original contribution emphasizes exploration of cultural considerations within community care research by exploring needs, characteristics, experiences and views of people from minority ethnic communities living within care homes for adults with learning disabilities and care homes for older people. Such insights and voices have been largely absent from community care literature to date. This thesis presents four major contributions to community care knowledge. First, study design features. Second, innovative empirical findings. Third, new measurement tools. Fourth, strategies for future research, service awareness and development.

Study design features

First, given community care studies tend to use mono-methods, this study contributes to community care knowledge by adding to mixed methods studies and integrates recommendations in completing mixed methods to explore the needs and experiences of minority ethnic groups. Most researchers tend to explore needs and experiences via questionnaires and/or interviews rather than other measures such as observational measures. This study adds to community care literature by focusing on needs and experiences of minority ethnic care home service users by reporting findings from questionnaires, focus groups and observational measures.

Second, most studies collect findings from singular geographical regions including the North West, South West, South East England and London often within areas of presumed high prevalence of minority ethnic populations or within close proximity to researchers work base. This study is unique as it draws from findings from geographically dispersed UK regions across London, South East, West Midlands and the North West. It is hoped by including data from a variety of different regions adheres to Manthorpe & Moriaty et al. (2010) conclusions of increasing the likelihood of tapping into minority ethnic populations residing in geographical regions outside of regions known for prevent cultural diversity.

Third, this study is unique in that explores data from both learning disability and older people populations and explores similarities and differences in needs and experiences across two population groups. Furthermore, unlike other community care studies, this study explores needs and experiences findings from different perspectives and populations including: focus groups with older people care home service users, focus groups with family members of older people living in care homes; observations of care home service users and proxy perspectives of care home service users obtained by questionnaires completed by key worker staff.

Fourth, most researchers comment on differing mainstream and specialist care homes for minority ethnic groups through policy papers , interviews with service users and relatives providers and community care staff. This study contributes to community care research by reporting findings on needs and experiences collected from both mainstream and specialist care homes for minority ethnic service users through observational and focus group methods.

Empirical findings

Given acute shortage of national data on minority ethnic needs, characteristics and experiences of care home services, this sample of minority ethnic populations provided a rare opportunity to collect findings on needs, characteristics and experiences of care homes

experienced by minority ethnic adults with learning disabilities and older minority ethnic people. This study produced important findings related to minority ethnic people utilizing care homes support.

Micro level findings

Numerous researchers and policy reports outline considerable neglect of community care research focusing on minority ethnic populations. This thesis presents content analyses conducted on peer reviewed learning disability and gerontology journals published in 2006-2009 and contributes to knowledge by highlighting lack of research into minority ethnic needs and experiences. Exclusively focusing on minority ethnic groups contributes to knowledge by addressing this neglect within learning disability and gerontology research and complies with policies and research recommendations in conducting future research into minority ethnic populations.

This thesis presents frequencies, physical, social, cognitive needs and characteristics of minority ethnic people living in care homes and also compares needs and characteristics with care home service users from white ethnic groups as a comparison group. Prevalence of minority ethnic backgrounds of service users living within community care services has been ascertained from providers research audits and census material. This study contributes by depicting a detailed ethnicity profile of care home service users living within 83 care homes for older people and 90 care homes for adults with learning disabilities. This sample size of 173 care homes therefore draws findings from a relatively large pool of care homes.

Given findings from content analyses reported in this thesis that most studies tend to present only percentage of white ethnic participants, this study contributes by highlighting the actual percentage prevalence of minority ethnic groups living in care homes which shows that there are some minority ethnic populations living in care homes across England. Furthermore, depicting information about minority ethnic populations may assist service providers in developing accurate and ongoing information regarding minority ethnic communities living within care homes.

Most research studies focus on singular minority ethnic groups, fail to explore needs and characteristics of minority ethnic groups and fail to explore characteristics in relation to a comparative group such as people from white ethnic groups. This study adds to the evidence base by exploring needs and characteristics for non-white minority ethnic groups in comparison with white ethnic groups, but also adds to community care knowledge by accounting for service user heterogeneity and exploring needs and characteristics for people from different non-white minority ethnic groups. This study also reports and compares findings of both adults with learning disabilities and older people. Most studies focus on learning disability and older people separately.

Focus group findings for South Asian and African Caribbeans along with their relatives enabled detailed explorations of cultural need definitions, definitions of quality, outcomes and experiences of care homes. Most researchers define 'cultural needs' by consulting with service professionals and providers, so findings from this study add to the evidence base of collecting views from service users and relatives and therefore complies with recommendations on the importance of including perspectives from service users themselves and their relatives. Furthermore, some authors comment on the neglect of research focusing on African Caribbean populations, so this study fills an important gap. Most studies seem to

report on findings from either service users or relatives, yet, few studies collect perspectives of both service users and relatives which this study incorporates.

This study also placed considerable attention in integrating sensitivity to heterogeneity within minority ethnic groups by splitting focus group by religious belief and conducting separate focus groups for Muslims, Hindus, Sikhs and African Caribbeans. This separation of groups allowed for detailed discussions on cultural needs that maybe unique for people within specific religious groups whilst diminishing any potentials for animosity and rivalry between different social groupings.

This thesis also emphasizes experiences of minority ethnic groups in order to highlight potential oppressive practices and following Plummer's accounts, provides seemingly silenced minority populations a voice through explorative research.

Meso level findings

Numerous authors comment on neglect of insight into characteristics of social care workforce. Describing the characteristics of care home staff therefore adds to studies depicting profiles of social care staff. Most studies report increasing minority ethnic staff could improve uptake of services, but fail to describe actual profile of care home staff supporting minority ethnic service users. Findings presented in this thesis add to the literature by highlighting ethnicity characteristics of care home staff in relation to ethnicity characteristics of care home service users living in both learning disability and older people care homes.

Numerous policy reports and researchers comment on integrating culturally sensitive service provision within community care settings such as care homes. However, most of this research into whether community care services are sensitive to cultural, linguistic and religious needs of care home service users is conducted via interviews with service users, service users and relatives or discussions with service providers and professionals. Other studies explore practices operated within services in order to meet cultural, linguistic and religious needs from postal questionnaires with service providers and commissioners, interviews with staff, questionnaires, and interviews with family members. However, no study has utilized structured observational approach to assess whether staff working within care homes responds to the cultural, linguistic and religious needs of minority ethnic populations. This study therefore contributes to knowledge by introducing observational findings to literature surrounding sensitivity to cultural needs for minority ethnic people living in learning disability care homes and care homes for older people.

Strategies for future research, service awareness and development

Unlike most other community care studies focusing on minority ethnic service users, this study introduces several techniques that could be used for further research into the under-researched area of experiences of community services from diverse groups.

First, this study contributes to community care knowledge by presenting directories of UK specialist care homes for adults with learning disabilities and older people populations. These directories include details of UK specialist care homes from various diverse groups including minority ethnic groups, religious specialism as well as service users from membership with various societies and organizations including the Freemasons, ex-military and farming

societies. These directories could interest researchers, service provisions, service users and relatives, particularly as some of the south Asian relatives disclosed a need for knowledge and information of specialist care homes. Given findings from the USA that African Americans were much more likely to use service directories of community health and human services once they received in comparison with white older people (Cherry, 2002) may indicate the potential benefits for directories for minority ethnic groups. This study also includes numerous strategies and techniques which could be utilized to increase minority ethnic samples which could be used for further research into needs, characteristics and experiences of minority ethnic groups utilizing care home support.

New measurement tools

This study also includes three new tools for defining cultural needs via a staff proxy questionnaire (Minority Cultural Questionnaire= MCNQ), sensitivity to cultural needs through an quantitative observational tool (Cultural Care Home Observational Toolkit-CCHOT) and a post hoc cultural index which provides quantitative depictions on how findings could be converted into numerical scores to ascertain competency in cultural diversity sensitivity. Collectively, these new tools illuminate further research and practical applications.

9.6. **Closing note and reflections on PhD process**

To close, increasingly prevalent ethnically and culturally diverse UK populations calls for increased acknowledgement and sensitivity to ethnically and culturally diverse populations within community care research and services. It is hoped this thesis emphasis on needs, characteristics and experiences for minority ethnic adults with learning disabilities and minority ethnic older people living in care highlighted the importance of cultural competency at mico, meso and maco levels.

Reflections

Obtaining a PhD requires 'quality of originality, to contribute new and significant ideas, make a positive contribution to knowledge and creativity in their respective disciplines... subsequently assuming the role of independent scholars and research workers at the highest level, capable of planning and carrying to completion a well-conceived plan of research' (Pole, 2000:96). Furthermore, obtaining a PhD theoretically enhances initial membership into academic communities (Lee, 2008).

The original aspiration of this PhD involved contributing to community care knowledge by researching lived experiences of minority ethnic care home service users from adults with learning disability and older people. This original aspiration was later confirmed. Nevertheless, challenges impacted research processes including varied time frames, financial constraints, time and energy involved with travelling across England for data collection. Difficulties in locating minority ethnic populations within care homes required flexible, dedicated and problem solving approaches in tackling PhD research questions. Such experiences enabled insights into problematic and challenging nature of community care research, particularly with participants from varying backgrounds, characteristics and requirements. An additional challenge involved handling and managing politics amongst some care home staff by either working with either accommodating and helpful care staff or reluctant, fearful, hesitant and suspicious care staff.

The above PhD reflections emphasize personal skills developed from PhD study, rather than expertise developed as part of PhD study, which is consistent with Pole (2000) findings in how PhD candidates reflect retrospectively from PhD study. Perhaps this illustrates socially desirability and social conditioning within certain paradigms, namely, discussing skills learnt rather than declaring certain community care expertise. Alternatively, reluctance to fully acknowledge community care expertise may reflect personal personality attributes in actively refraining from potentially arrogant and overly confident behaviours. Nevertheless, considering researcher subjectivity, existing unpublished research, variable access to relevant literature and inevitable limitations with all research, perhaps it is best to urge on the side of caution and implement tentative and modest conclusions, rather than declaring expertise with particular community care knowledge fields.

This thesis also emphasized considerable marginalization, isolation and disparity between people from minority communities whilst living within environments with seemingly majority communities. Whilst this thesis focused predominately on minority ethnic and culturally diverse populations, to some extent, PhD candidates also comprise two noteworthy minority populations. First, frequencies of PhD candidates are characteristically minuscule in comparison with prevalent undergraduates. Furthermore, minority ethnic PhD candidates may depict even smaller frequencies, conversely to white ethnic PhD candidates. Second, completing a PhD depicts the first stages of an academic career. Consequently, PhD candidates are placed within a minority group, conversely to colleagues with completed PhDs and supervisors with completed doctoral qualifications and years of impressive expertise.

Research into minority populations may reflect unconscious attempts to actively strive against potentially unconscious barriers created by members of a seemingly majority in-group against individuals within minority out-groups. Moreover, if researchers define themselves as belonging to multiple minority groups, researchers may feel compelled and motivated to research minority experiences. Research into minority experiences may elicit personal psychological solutions in being able to cope, adapt and survive whilst living within seemingly minority groups. Furthermore, by identifying that others belong to comparable minority groups may diminish feelings of isolation, disparity and marginalization and elicit self protective functions. Belonging to seemingly minority groups may therefore bias initial research processes in focusing on the experiences of minority populations. Inferences on majority versus minority populations also illuminate flexibility and fluidity of group membership. For example, presenters at academic conferences typically include individuals with completed doctoral qualifications, consequently placing those without doctoral qualifications within a minority group. Similarly, an older person from a white ethnic group visiting a specialist care home for south Asian older people would place a white ethnic service user within a minority group.

In closing, the above reflections call for cautionary considerations in interpreting thesis findings. Yet, reflections on minority group membership illustrate personal subjectivity and social constructions. For example, some individuals struggle to cope with seemingly out-group membership, yet others thrive in belonging to seemingly minority out-groups. Furthermore, inferences on powerful seemingly in-group majority groups ascribing powerful control over minority groups assumes people from minority groups typically omit powerless and passive behavioural responses. However, detailed research attention into highlighting needs, characteristics and experiences of minority ethnic and culturally diverse populations reported in this thesis reflects noteworthy and assertive contributions in highlighting inequalities. This thesis attempted to address a community care research gap surrounding

minority ethnic and culturally diverse groups within community care settings. It is hoped findings from this PhD will illuminate experiences of minority populations, encourage further research and acknowledgement of cultural considerations within community care research.

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11. Appendices

11.1. Appendix 1- Definitions of Impairment and Disability (WHO, 1980, 1999, 2001a)

	ICIDH (WHO, 1980)	ICIDH-2 (WHO, 1999)	ICF (WHO, 2001a)
Impairment	'a disturbance affecting functions that are essentially mental (memory, consciousness) or sensory, internal organs (heart, kidney), the head, the trunk or the limbs' (WHO, 1980)	Impairment is a loss or abnormality in body structure or of a physiological or psychological function.	Impairments "represent a deviation from certain generally accepted population standards" of functioning (WHO, 2001a, p. 12).
Disability	a restriction or inability to perform an activity in the manner or within the range considered normal for a human being, mostly resulting from impairment'. (WHO, 1980)		disability refers to any impairments, activity limitations, or participation restrictions or to "the outcome or result of a complex relationship between an individual's health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives" (WHO, 2001a, p. 17)

ICIDH= International Classification of Impairments, Disabilities and Handicaps;
ICIDH-2=International Classification of Impairments, Disabilities and Handicaps- beta draft 2;
ICF=International Classification of Functioning Disability and Health; WHO= World Health Organisation

11.2. Appendix 2- Timeline- Changes in learning disability terminology

(Atherton, 2005; Keely, 1944; Race, 2002)

	Terminology	Legalisation and reports
1300s	Idiots and lunatics	De praerogativa regis
1339	Idiots and 'natural fools	Statue de Prerogativa Regis
1400s	Lunatics	Treatment- chaining and whipping in hospitals
1542	Insane	Borde recommends treatment for the 'insane'
1774	Distinctions between lunatics, vagrants and paupers	Idle and Disorderly Persons Act
1853	Idiots and 'lunatics'	Lunatic Asylum Regulation Act-.
1867	Mentally handicapped	Metropolitan Poor Bill
1886	Idiots	The Idiots Act
1890	Mentally ill and mentally retarded	The Lunacy Act
1867	Mentally handicapped	building of Poor Law Infirmaries and asylums
1904	Feeble minded	Royal Commission
1913	Idiot, Imbecile, feeble minded and moral defectives	Mental Deficiency Bill
1929	Mental deficiency	Wood committee/report
1930s-1940s	Extermination of undesirables	Nazi Germany
1959	Mental illness and mental sub-normality	Mental Health Act.
1971	Mentally handicapped	Better Services for the Mentally Handicapped
1971		Campaigning for the Mentally handicapped
1980		An Ordinary life (Kings Fund, 1980, 1984)
1988		Griffiths Report
1990	Learning disabilities	NHS and Community Care Act
1992		Health Services for adults with learning disabilities (Department of Health, 1992a)
1992		Mansell report
2001		Valuing People (DH, 2001a)
2009		Valuing People now (DH, 2009)

11.3. Appendix 3 -Learning disability- definitions and subcategories

	DSM-IV-TR (APA, 2000)	ICD-10 (WHO, 1993)	*Valuing People* (DH, 2001a)
Term	Mental Retardation	Mental Retardation	Learning disability
Definition	(a) Significantly sub-average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test. (b) Concurrent deficits or impairments in present adaptive functioning (i.e. the person's effectiveness in meeting the standards expected for his or her age by his or her group) in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. (c) The onset is before age 18 years.	… a condition of arrested or incomplete development of the mind, which is especially characterized by impairment of skills manifested during the developmental period, which contribute to the overall level of intelligence, i.e. cognitive, language, motor and social abilities. … Adaptive behaviour	Learning disability includes the presence of: a) a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with b) a reduced ability to cope independently (impaired social functioning) c)which started before adulthood, with a lasting effect on developmental.

11.4. Appendix 4- Learning disability- subcategories (ICD-10 and DSM-IV-TR)

	ICD-10 (WHO, 1993)	DSM- IV- TR (APA, 2000)
Term	Mental Retardation	Mental Retardation
Mild	'IQ range 50 to 69. Understanding and use of language tend to be delayed to a varying degree....Executive speech problems interfere with the development of independence may persist into adult life. Organic etiology is identifiable in only a minority of subjects. Includes- feeble-mindedness, mild mental sub normality , mild oligophrenia, moron'(ICD-10, p.228).	IQ range 50-55, approximately 70 Development of social and communication skills during preschool (0-5years) have minimal impairments in sensor-motor areas often not distinguishable from children without mental retardation until a later age....As adults, usually achieve social and vocational skills adequate for minimum self support, but may need supervision, guidance and assistance. Can usually live successfully in the community, either independently or in supervised settings (APA, 43).
Moderate	'IQ range 35 to 49. Some individuals achieving high levels in visuo-spatial tools while others are markedly clumsy but enjoy social interaction and simple conversation... Some can take part in simple conversations while others only have enough language to communicate their basic needs. Some never learn to use language, though they may understand simple instructions and may learn too use manual signs to compensate for speech disabilities. Organic etiology is identified in the majority Includes- imbecility, moderate mental sub normality, moderate oligophrenia' (ICD-10, p.229)	IQ level 35-40 to 40-55 Acquire communication skills during early childhood years. Profit from vocational training and with moderate supervision can attend to their personal care.....In their adult years, the majority are able to perform unskilled or semi-skilled work under supervision in sheltered workshops or in the general workforce. They adapt well to life in the community, usually in supervised settings. (APA, 43)
Severe	'IQ- 20-34. Marked degree of motor impairment or other associated deficits, indicating the presence of clinically significant damage to the central nervous system. Includes- severe mental sub normality, severe oligophrenia' (ICD-10,p.230).	IQ level 20-25 to 35-40 During early childhood years, they acquire little or no communication speech....they may be able to perform simple tasks in closely supervised settings. Most adapt well in the community, in group homes or with their families (APA, 43-44).
Profound	IQ- is under 20. Comprehension and use of language is limited to, at best, understanding basic commands and making simple requests. Most basic and simple visuo-spatial skills of sorting and matching maybe acquired. An organic etiology can be identified in most cases. Severe neurological or other physical disabilities affecting mobility are common. Includes- Idiocy, profound mental sub normality, profound oligophrenia. (ICD-10, p.230)	IQ level below 20 or 25 Identified neurological condition that counts for their Mental Retardation. In early childhood- display considerable impairments in sensor motor functioning. Motor development and self care and communication skills may improve if approaches training is provided (APA, 44).

11.5. Appendix 5- Historical attitudes towards disability and learning disability

11.5.1. Pre-Historic

Neanderthals	
Berkson (2004).	Individuals with physical abnormalities have been part of society since well before the evolution of human kinds. There is evidence of this in the existence of 'handicapped' individuals in subhuman primate groups. Individuals may survive in natural animal groups when their injury does not actually interfere with foraging or escape from predators.
Bernal (2006).	in pre-historic societies, given the focus on survival as well as a nomadic and self sufficient existence, it would be difficult for anyone with any sort of disability.
Davies & Underdown (2006).	compassion for people with disabilities is relatively improbably in all Neanderthal societies
Dettwyler (1991)	Ambivalent dichotomy exists in attitudes towards people with disabilities ranging from positive responses including adulation.
Dettwyler (1991:384).	'speculation about mental faculties of prehistoric hominids and man as questionable, at best'
Goodman , Thomas, Swedlund & Armelagos (1988).	More positive attitudes towards people with disabilities were noted from explorations of skeletal remains, whereby some anthropologists report care taking of children with disabilities living in prehistoric Nubia.
Goodman et al (1988:178)	Skeletal remains from the prehistoric Nubia in the X-Group (A.D 350 - 550) severe disabilities would have rendered them completely dependent on others for survival.
Heward & Orlansky (1984:66)	Early goal of human beings in primitive societies was survival. Later, as survival became less of a 24 hour concern and society separated into levels, ridicule of people with learning disabilities was common (Heward & Orlansky, 1984).
Manion & Bersani (1987) cites the work of Drew, Logan & Hardman (1984)	From eearly physical surgery methods shown from Paleolithic skulls, some anthropologists concluded that early humans believed abnormal behaviours were the result of demonic possession and holes drilled into the skull were intended to release the imprisoned demons.
Oxenham, Tilley, Matsumura, Nguyen, Nguyen, Nguyen et al. (2009)	Southeast Asian Neolithic communities and concluded that people with severe disabilities would have rendered them completely dependent on others for survival.
Scheerenberger (1983)	a person with a 'handicap' or disability functioned adaptively in a Neanderthal community.
Trinkaus & Zimmerman (1982:75)	Concluded that 'that the Neanderthals had achieved a level of societal development in which disabled individuals were well cared for by other members of the social group. All of these individuals show extensive healing of their injuries, usually with little or no evidence of infection. Several of them, particularly Shanidar 1 and 3, lived for many years with severe disabling conditions, which would have prevented them from actively contributing to the subsistence of the local group. These elderly individuals must have contributed in a more indirect manner to the well-being of their social groups; it is perhaps not surprising that many of these same individuals were intentionally buried.

11.5.2. Ancient Civilizations and Advent of Christianity (500 BC- 600 AD)

Ancient Egyptians	
Berkson (2004:201)	From artistic descriptions, in dynastic Egypt, achondroplastic dwarf were functioning members and even honored members of society. People with disabilities were sometimes honored, treated with honor and were believed to posses special powers
Ancient Greece	
Aristotle *Politics, Book 7.* Jowett (1900) translation	"As to the exposure of children, let there be a law that no deformed child shaii iive.
Aristotle *Nichomachean Ethics X*, 1178a. (Aristotle, 1976)	that the intellectual life as ''the best and most pleasant life for man''
Aristotle (1982).	On the pursuit of 'eudaimonia' that focuses on human flourishing requires both moral and intellectual virtues
Plato *Republic* (Plato, 1991)	Advocated both eugenics and infanticide: "...the offspring of the inferior, or the better when they chance to be deformed, will be put away in some mysterious, unknown place, as they should be".
Plato *Sophist*, 227d-228e, 230d, Jowett (1871a) translation	Implies negative depiction of people with learning disabilities by placing particular attention on 'wisdom' and 'intellectual virtues'. In Sophist 227d-228e, 230d, Plato depicts that 'ignorance, of which there are all sorts of varieties, to be a deformity'.
Plato *Symposium* (Jowett, 1871b) translations	Plato outlined 'wisdom is a most beautiful thing, and love is of the beautiful'
Davies (1999)	Reviews historical essays of Martha Edwards which depicts that disability was often prized in classical Greece, as impairments in war were viewed as gaining marks of honor and viewed as aesthetic.
Ancient Rome	
Gracer & Alexandria (2003)	In Rome (449 BC), contemporary Roman custom was codified in a legal document known as the Twelve Tables. The Twelve Tables granted the male head of the family (the paterfamilias) exclusive power over his sons and daughters, including power over life and death. Table IV of the Twelve Tables states: "kill quickly... a dreadfully deformed child." The life and death power of the paterfamilas disappeared by the second century C.E., and by the third century C.E. abandoning a child was considered murder'.
Berkson (2004); Bredberg (1999)	Following from such beliefs, infanticide, or killing of infants and children, was the accepted response to the birth of a child with disabilities in Ancient Greece and Ancient Rome
Braddock & Parish (2001).	In Sparta, any infant considered unfit for citizenship or warrior status was either drowned or abandoned
Braddock & Parish (2001) cites the work of Warkany (1959)	Manifestation of disability was viewed as a portent of things to come.
Smalley (2001).	People with learning disabilities were also used as forms of entertainment in Roman society
The Bible and advent of Christianity	
Berkson (2004); Covey (2005)	Detailed explorations, interpretations and reflection of attitudes towards disability from The Bible implied negative attitudes towards people with disabilities and compassionate and protective attitudes.
Covey (2005:109)	Cites Biblical passage from the Old Testament including Deuteronomy

	(28:65), Leviticus (26:16), Job (11:20), Proverbs (30:17), Zephaniah (1:17) where blindness and blinding are treated as a chastisement from God.
Covey (2005)	Through Christianity, people with disabilities were viewed as innocent victims of misfortune with Christianity as a provider of care. Covey (2005) highlights examples from the New Testament such a Matthew 8: 2-4 and Luke 17:13-17 that emphasized the role of Christ as a physician-healer which resulted in an emphasis on the treatment and care of people. A well as examples of Christ portrayed as having great compassion in Mark 10: 46-52 and empathy for blind and disabled people in Mark 8: 22-25.
Concannon, (2005:2).	through Christianity came 'the doctrines of compassion, universal love, charity and grace for people with disabilities
	Leviticus 21:18 whereby people with disabilities were portrayed in a negative light and also bans them from approaching the altar and from becoming rabbis and priests.
Leshota (2011)	Christian historical narratives highlight both implied negative attitudes towards people with disabilities and compassionate and protective attitudes.
Miles (1995:50)	It would be hard enough to state simply how Christianity has addressed disability as disabilities and disabled people appear in Christian contexts and literature across a vast spectrum, generating a plethora of views, in an ongoing, accelerating process.
	In Western society, creation of hospices and hospitals dating back to the fourth centuries (Bradshaw, 1996; Bennahum, 1996) in order to provide care for the poor, sick and the dying (Ley & Corless, 1988) were largely based upon teachings of Jesus (Saunders, 1986; Philpps, 1988) under Christian control (Cillers & Fetief, 2002) or a 'theological basis' (Bradshaw, 1996:412). As such, Covey (2005:109) reviews, early Christians were relatively tolerant of people with disabilities.

11.5.3. Middle Ages .(601- 1460 AD)

Medieval Literacy Texts	
Bragg (1997)	Cites examples of relative unconcern with impairments from the Eddic poem Hávamál: 'the deaf may be dauntless in batte; better to be blind than burned on a pyre'
Bragg (1997)	Cites examples from literary texts from the Medieval Celtic and Old Norse literature which feature deities who are themselves impaired or mutilated. For example, in the Pedeir Keinc y Mabinogi (Four Branches of the Mabinogi) includes examples of muteness as well as paralysis, resulting from contact with the Otherworld
Bragg (1997:174).	Notes examples from the Medieval Celtic and Old Norse literature which associate impairments with undesirables. For example, Bragg (1997) notes the examples of Icelandic bishop Gudmundr the Good, bishop of Holar was said the have cured the 'crippled' hand of a woman by kicking her and the 'withered' hand of a man who inserted in within the light that shone on the saintly bishop
Bragg (1997)	Quotes Jean-Michel Picard who wrote 'the specific power or function of a given mythological character is confirmed or stressed by the loss of the organ which is normally the instrument of this function.
Form of Entertainment	
Bertoti (1999); Heward & Orlanksy,	People with disabilities including people with learning disabilities posed as court jesters and clowns for nobles including royalty.

(1984); Manion & Bersani, (1987); Kanner (1964).	
Fiedler (1978)	Pagan practices of displaying 'freaks' for public entertainment were revived in the Middle Ages by the Catholic Church, which displayed disabled or deformed 'monsters' on feast day
Roam the streets	
Manion & Bersani, (1987).	During the Middle Ages, people with learning disabilities were allowed to roam the streets of Europe unharmed or were regarded as 'les enfants du Bon Dieu'
Monastries	
Boswell (1988) Levitas & Reid (2003) Sullivan (2003)	Practice of oblation which 'was the donation or 'offering' of a young child to a monastery to be brought up by monks without further control by parents (Boswell, 1988: 17).
Boswell (1988: 21)	'Constant complaints surface in monastic literature about the flood of physically or mentally defective children filling the monasteries: the blind, lame, one-eyed, one armed, leprous or deaf children whom parents could not bear to keep'.
Bragg (1997:176)	No sooner had Christianity introduced the monastic life as an alternative to social integration than the monastery was exploited as a dumping ground for people with impairments.
Hospitalization	
Andrews (1997:94)	If the Middle Ages operated a form of 'care in the community' it was very much a lassiz- faire, reactive system with violent and cruel treatments, although the aim was usually a therapeutic one'. Among its inventory listed chains, manacles and stocks (Andrews, 1997, 115).
Jones (1972:12)	During this era, the religious priory of St Mary of Bethlem in London which became known as the 'Bethlem' was used for 'lunatics', people with mental health problems and people with learning disabilities from 1377

11.5.4. Late Middle Ages, Renaissance and Reformation (1461- 1707 AD)

Associations with evil and demonic possessions	
Martin Luther (1483-1546). (cf Howitt, 2011: 73).	Luther reportedly said "Idiots, the lame, the blind, the dumb, are men in whom the devils have established themselves: and all the physicians who heal these infirmities, as though they proceeded from natural causes, are ignorant blockheads'
Martin Luther (1483-1546). (cf Bufe, 1992: 203).	Luther also said "A large number of deaf, crippled and blind people are afflicted solely through the malice of the demon. And one must in no wise doubt that plagues, fevers and every sort of evil come from him."
Martin Luther (1483-1546). (cf Corbitt 1978:16).	Furthermore, in one of Luther's Table Talks, Luther outlined that 'changelings were merely a mass of flesh a massa carnis, with no soul....the devil sits in such changelings where their soul should have been'
John Calvin (1509-1564). cf. Winzer (1997).	Frequently associates blindness with spirituality. Similarly, John Calvin preached that people with learning disabilities were possessed by Satan
Covey (2005).	Some individuals interpreted the mutterings of people with learning disabilities as conversations with the devils as well as demonic possession
Goodey, 2011; Goodey & Stainton (2001:239)	From a historiographical standpoint, the demonization of pre-modern authors seems itself to be a projection and a form of guilt displacement, away from a present whose values are not up for question.
Associations with purity, divine inspiration and innocence	
Barr (1904)	Others however believed people with learning disabilities connected with the unknown and their talk as evidence of divine inspiration
Cusack (1997:414)	possessed special gifts which were indicative of their privileged status as recipients of God's grace

Cusack (1997).	were 'innocent and exempted from commission of future sin by virtue of their exclusion from sexual activity'
Digby (1669, a3)	maintained the notion of the innocent by suggesting that idiots' souls were purer than the ordinary.
Taylor & Heber (1828: 355)	During prayer suggests that changelings were equally deserving of heaven as the rest of us and furthermore "do not deserve hell so much as we have done"
Literary hero	
Defoe (cf Braddock & Parish 2001)	Defoe also made a real deaf- mute person the hero in his book the History of the Life and Adventures of Mr Duncan Campbell in 1720.
Group distinctiveness	
John Locke *Ian Essay Concerning Human Understanding* (cf Braddock & Parish 2001; Locke, 1975).	In 1690, John Locke distinguished between 'idiots' and 'madmen' and noted that 'mad men put wrong ideas together, and so make wrong propositions, but argue and reason right from them: but idiots make very few or no prepositions, but argue and reason scarce at all'p.236
John Locke *Ian Essay Concerning Human Understanding* (cf Braddock & Parish 2001; Locke, 1975).	In Locke's view, one ought to consider whether the "drivling, unintelligent, intractable changeling" (p. 570) might be a species between humans and other animals.

11.6. Appendix 6- Historical attitudes towards Older People

11.6.1. Pre-historic

Neanderthals	
Appleby (2011)	In largely agricultural societies of the past, it is likely that relatively little technological knowledge was available to each generation, and learning would have been passed on directly from one generation of the next. In this situation, the very eldest individuals would have had a distinct advantage: they would have direct memories of times and situations that younger individuals did not. As the elderly had knowledge of advice in how to cope with traumatic events from previous events, the elderly may have been of critical importance to the survival of prehistoric communities. However, as Appleby (2011:234) notes, investigations of skeletons from elderly individuals is a difficult process confounded by variable environmental conditions and population differences.
Bahn (1998); Klein (2003); Mithen (1996: 135).	Neanderthal burials indicate that they at least occasionally buried their dead, and that the sick and elderly were cared for
Berger & Trinkaus (1995:849) (Trinkaus, 1983)	Due to a lack of older Neandertals and the absence of incapacitating lower limb injury, these hominids did not sacrifice the survival of the social group as a whole when it was threatened by an immobile individual
Gabora (2007)	Neanderthal burials indicate that they at least occasionally buried their dead, and that the sick and elderly were cared for.
Gargett (1999) and Crubézy & Trinkaus (1992) (cf Cole & Palmer, 2009).	Explored burial of an elderly Neanderthal male in Shanidar Cave, which is located in Iraq, involved respect for the elderly. Deformed male skeleton with lesions on its vertebrae and evidence of multiple traumatic and degenerative joint disease lesions due to injuries suffered prior to death. A violent blow to his face, perhaps from a rock fall, crushed his left orbit leaving him partially or totally blind in one eye. He had a withered right arm that had been fractured in several places causing him to lose his lower arm and hand, and perhaps leading to deformities in his lower legs and foot. What this suggests is not only that the Neanderthal looked after their sick and aged, but that this elderly man was considered to be important enough to be given a burial after his death, at a time when burials were apparently rare.
Trinkaus (1983).	Elderly Neanderthals such as Shanidar 1 and 3 must have contributed in an intellectual manner to the group well-being and it is not surprising that many of these individuals were intentionally buried
Agricultural societies	
Nelson (2005)	In most prehistoric and agrarian or agricultural societies, older people were often held in high regard. By virtue of their age and greater experience, they were regarded as wise and they were the custodians of the traditions and history of their people.
Gold & Kaufman (1970)	'For primitive nomadic groups, mobility was a matter of being able to find new food sources or grazing fields. Thus it was part of their culture to be rid of hampering seemingly useless persons

11.6.2. Ancient Classical Civilizations and Advent of Christianity (500 BC- 600 AD)

Ancient Greece	
Plato *Republic* (328d-330a) (cf Classen, 2007)	Presents a strikingly positive image of old considering the precedence given to spiritual and intellectual pleasures over the desires and impulses of the body
Aristotle *Rhetoric* Aristotle, Ross & Roberts, 2010).	'Old age has paved the way for cowardice' (Aristotle et al, 2010:86) the elderly 'are querulous and not disposed to jesting or laughter'.
Warren (1998:23-24)	Among the Ancient Greeks 'Erinna paints a charming picture of old ladies with silver hair gifted with golden thoughts'.
Niebyl (1971: 360)	Paracelsus used the physiological frame to assert that old age was simply a lack of wood for the fire that was going out.
Juvenal The Tenth Satire (cf Eichholz , 1956)	'Everyone prays for long life, but old age is a miserable state' (Satires 10: lines 188-239). ' The wretchedness of old age (cont.): even if you keep your mental powers, you'll get to see your loved ones die; but most of us end decrepit anyway' (Satires 10: 291-318).
Ciecero *De senectute* (cf Niebyl (1971:351)	Old age was to be combated like a disease with the proper regime for both body and soul, like lamps grow dim with time unless we keep them supplied with oil'
Aesop Fables Wortley (1997:183) explored attitudes to aging of the ancient-medieval Greek world from literary depictions in Aesop Fables.	'the celebrated Fable of the Tortoise and the Hare, although it was not specifically interpreted in this way in ancient times, best sums up the general attitude: that dogged persistence (the characteristic of the elderly) will ultimately prove superior to all the erratic bursts of youthful speed anytime'. Furthermore, the fable of the 'Elderly Lion and the Fox' begins 'an elderly lion no longer capable of hunting to deed himself would have to do by using his wits. Yet another *Aesopian fable* reminds us that 'an elder out of his wits is good for nothing, like an old garment' (Wortley, 1997).
Horace *Ars Poetica* Coffman (1934:250) translations	'The ills encompassing an old man include his desire for gain, his miserliness, his lack of energy, his greediness for longer life, his quarrelsomeness....and his condemnation of the younger generation'.
Hippocrates Cokayne, (2003: 35)	Aging was seen as a gradual process of degeneration caused by the cooling and dying of vital health which created an imbalance of the body' qualities. As imbalances were seen as the basic factor in the majority of diseases, by implication, old age would therefore be classified as an illness.
Schäfer, (2002:529)	Galen viewed old age as a natural condition because the decrease of the innate warmth made it unavoidable.
Ancient Rome	
Lucius Annaeus Seneca (cf Cokayne, 2003)	In the first century AD, similarly wrote 'for old age is a disease which we cannot cure'
Covey (1989b).	Ancient world caricatured old men as pale on the decline, but praised old age
De Luce (1989, 1993)	Roman exiled poet Ovid. In *Amores*, there are no sympathetic representatives of older people.
Finlay (1981:158)	'the ancients did not draw up demographic tables, graphs and curves, but they would have been fully aware of their high infant mortality and considerable chance of death at an age increased by epidemics and wars.
Harcum (cited from De Luce 1993).	Old age for the Romans was a time to be dreaded rather than hoped for.

Parkin (2003)	Determining a definitive conclusion about the reality of old age in the Roman world will have varied from place to place, from time to time and from individual to individual as well as potential bias from the original source.
Ritsema (2009)	Romans saw the elders position as esteemed and valuable, particularly has few people lived to be very old
The Bible and the Advent of Christianity	
Gold & Kaufman (1970: 263)	In Ecclesiastes and Psalms from the Old Testament, there are references about declining physical health of older people. For example, Ecclesiastes states 'remember also your Creator in the days of your youth, before the evil days come and the years draw near of which you will say, "I have no pleasure in them" *(Ecclesiastes* 12: 1) and 'In old age, your body no longer serves you so well'*(Ecclesiastes* 12: 3). Similarly, in Psalms 71:9 "Cast me not off in the time of old age; forsake me not when my strength faileth.'
Carter (2009) ; Ritsema, (2009); Sapp, 2008)	Further discussions on reference to old age in the New Testament.
Nelson (2005:28)	Evidence from the New Testament generally depicts a consistent pattern of reverence and esteem. For example, Paul's letter to Timothy instructs that an 'old man' is not to be rebuked sharply and 'older women' are to be treated with purity (1 Tim. 5:1, 2). Paul says elders should be considered worth of double honour and that no accusations should be held against them without two or three witnesses (1 Tim. 5:17, 9). However, the depictions of things that are old in the Gospels of Matthew and Mark, whereby 'old garments' are replaced with new ones (Mark 2:21) and the 'old wine' is replaced with the new (Mark 2:22). In biblical times, if one lived beyond age 50, it was believed that he or she was chosen by God for a divine purpose
Anglo-Saxon England	
Covey (1989b) cites a study conducted by Burrow (1986)	in which in Anglo-Saxon England, on one hand, older people were respected for the perceived moral and spiritual superiority, yet on the other hand they were sometimes characterized as losing their wits and becoming senile.

11.6.3. Medieval Britain, Renaissance and Reformation (601-1707 AD)

Coffman (1934: 274-275)	From a review of Chaucer's literacy tales, Chaucer makes numerous inferences to 'senile old age' and similes of aging associated with the dying fire.
Covey, (1989b:694)	During the 13th Century, Roger Bacon said that every day was a step towards old age and this process could be accelerated by disease
Covey (2000)	Some reviews of Shakespeare's work produced in the seventieth century show that old age was a time when individuals lost some abilities to function, particularly when it came to mental capacity and physical mobility
Covey (1989b)	Bodily decay was interpreted during the 15th and 16th centuries as a sign of human failure
	During the Middle Ages, benevolent societies began setting up institutions to care for others (Gold & Kaufman, 1970:263).
	As Eisenstein (1968) amongst others (Lucien, Victor & Henri-Jean, 1976) note, instead of relying on accumulating knowledge through conversations, the onset of the printing press and the increased production of printed books in Europe over the fifteenth century outlined precise codes for behaviour that individuals could observe. Nevertheless, Gunaratne (2001) challenges the 'European exceptionalism' of the 15th century by arguing that ancient Chinese dynasties used printing centuries before Europeans. As Nelson (2005, 2009) notes, the development of the printing press was responsible for a major change in the status of older people. The culture, tradition and history of a society or tribe now could be repeated in exact detail through books and the status and power elders once had as the village historians was greatly reduced and in many cases eliminated.

11.6.4. The Enlightenment and the Industrial Revolution (1708-1899 AD)

Covey, (1991:676).	As industrialization developed in the 18th and 19th centuries, older people lost power over the economic and economic and matrimonial decisions of their children
Covey, (1991:676).	By the 19th century, older people became increasingly viewed as economically dependent and useless
Covey, (1991:677).	Older peoples removal from the mainstream economic life meant that they had to find their own means of survival, mostly in low status and low paying job
Gold & Kaufman (1970:266)	However, asnotes, 'although it maybe thought that aged people did not have many supporters, since the happened to fall into what was considered an unpopular category of public attention, the evidence shows they did receive consideration at some almshouses being conducted as private charities that were very much like modern voluntary homes for the elderly'.

11.7. Appendix 7- Case scenarios and normality

	Case scenario of minority ethnic groups	Normality? Living in a mainstream home?
Gender and ethnicity	An Orthodox Jewish man spent most of his adult life surrounded by males.	Is it normal to move to a female dominated environment?
	A woman from the Caribbean who has spent most of her life caring for Caribbean relatives	Is it normal to be supported by an all white staff population?
Religion	A Muslim man doesn't eat pork and refuses to go into restaurant that serves pork products.	Is it normal to enter in an environment where pork is served daily and consumed by all other service users and care home staff?
	A Hindu woman who eats mostly vegetarian meals and has no contact with meat products	Is it normal to be living in an environment with meat eaters and surrounded by meat products?
	A Sikh woman lives on a diet of chapattis, chick peas and lentils	Is it normal to suddenly change to consuming care home menus of egg and chips or fish and chips?
	A Muslim man who prays 5 times a day , frequently visits a Mosque and is surrounded by religiously devout people of Muslim faith	Is it normal to live in an environment amongst people of all atheists? Is it normal to live within environments where people rarely worship either via personal pray or via visiting a religious building?
	A Hindu woman surrounds herself with images, photos and models of Hindu Gods, pictures of temples and burning incense.	Is it normal to live within an environment which contains no religious artifacts? Is it normal to live filled with Christianity religious artifacts?
	A Jewish man utilizes separate utensils, cooking equipment and cupboards for diary and meat products	Is it normal to live in environments which use the same utensils, cooking equipment and cupboards for all food groups?
Language needs	A Russian man who is verbally fluent in Russian but cannot understand English both in written and verbal form	Is it normal to live within an environment where it is not possible to understand the primary language utilized by others?
Activities	A Muslim woman doesn't cook pork	Is it normal to assist in cooking pork meals?
	An Orthodox Jewish man only watches TV programmes and films that have been approved by a Rabbi. If we watches TV, he prefers to watch TV and films which relate to his Jewish faith.	Is it normal to live within an environment where the care home plays secular TV programmmes such as *The Jeremy Kyle* show which frequently depict promiscuity and debates on child paternity?
	A Muslim woman doesn't drink alcohol	Is it normal to attend a public house or 'pub' filled with people drinking alcohol?
	A Muslim woman doesn't swim because she wants to preserve her modesty.	Is it normal to attend swimming classes and wear revealing swimming outfits?
	A Jewish man reads the Torah daily and only reads books written in Hebrew	Is it normal to live in an environment containing books and information only presented in English?
Personal care	A Jewish widow is used to wearing skirts and wears loose long sleeved tops to cover arms.	Is it normal to suddenly start wearing trousers and short tight sleeved tops? Is it normal to live within an environment where females all wear reveling clothes?
	A Muslim woman is used to bathing daily and washing herself after using the toilet and before worship.	Is it normal to live within environments where people bathe according to restricted bathing timetables set by the care home?

	Case scenarios	Examples within specialist care homes
Gender and ethnicity	A white British woman from London has spent all of her life living with male relatives	Is it normal to move to a female dominated environment?
	A white British man from Kent has spent all of his life living with female relatives.	Is it normal to move to a male dominated environment?
	A white British woman from Cumbria who has very limited contact with minority ethic people	Is it normal to move into an environment that contains care home staff from all differing minority ethnic groups?
Religion	A Christian woman doesn't eat meat on Good Friday	Is it normal to enter in an environment where halal beef and chicken is served on Good Friday and consumed by all other service users and care home staff?
	A Christian man attends church every week, insists on praying before his meals and devotedly adheres to the ten commandments	Is it normal to live in an environment amongst people of all atheists? Is it normal to live within environments where people rarely worship either via personal pray or via visiting religious buildings?
	A Christian woman surrounds herself with images and photos depicting the Christian faith.	Is it normal to live within an environment filled with religious artifacts depicting Hinduism?
Language needs	A white British man is verbally fluent in English but cannot understand Hindi both in written and verbal form	Is it normal to live within an environment where most people speak Guajarati and very few people speak or understand English?
Activities	A white British female enjoys watching TV progammes and films which depict examples of British History and enjoys listening to and singing to songs sung during war time Britain.	Is it normal to live within an environment where the only TV progammes , films played and songs played reflect Bollywood or Lollywood films, that is films and TV reflecting South Asian culture?
	A Christian man only watches TV programmes and films that have been approved by a vicar. He only prefers to watch TV and films which relate to his Christian faith	Is it normal to live within an environment where the care home plays religious programmes depicting Judaism? Or a care home which depicts films and TV programmes reflecting Islamic beliefs?
	A Christian woman doesn't drink alcohol	Is it normal to attend a public house or 'pub' filled with people drinking alcohol?
	A Christian woman doesn't swim because she wants to preserve her modesty.	Is it normal to attend swimming classes and wear revealing swimming outfits?
	A Christian man reads the Bible daily and only reads books written in English	Is it normal to live in an environment containing books and information only presented in Hindi?
Personal care	A young white British woman from London usually wears revealing clothing.	Is it normal to live within an environment where females insist on covering themselves with clothing?
	A Christian woman is used to bathing daily and washing herself after using the toilet and after prayer	Is it normal to live within environments where people bathe according to restricted bathing timetables set by the care home and with no personal washing facilities for individual use?

11.8. Appendix 8- Focus group forms

11.8.1. Focus group project information sheets- for staff

PSSRU
University of Kent

TIZARD
University of Kent

Study information for staff
Measuring Quality of Outputs in Care homes:
A Cultural Perspective via Discussion groups

This leaflet provides information on a research project which aims to improve the way quality is measured and monitored in care homes. The research is being carried out by the Personal Social Services Research Unit (PSSRU) and the Tizard Centre at the University of Kent. Your care home has kindly agreed to take part.

Background

Recognising cultural diversity within community care has become an important feature within governmental reports, organisations and legal legislation. Cultural diversity has been viewed as an essential part of an individuals identity as for many ethnic groups, ethnic heritage, culture, religion, customs and rituals are firmly embedded in an individuals usual living arrangements. However, researchers have argued that as the majority of community care research focuses on 'white' ethnic populations the needs of minority ethnic groups have become an invisible and marginalized group particularly amongst vulnerable groups such as for people with learning disabilities-PWLD and older adults. Moreover, at the service level, studies have also found that some care homes have remained insensitive to basic religious and cultural needs of community care residents from black and minority ethnic groups.

Furthermore, studies have found that at the individual level, a service user's cultural or ethnic background could have differing needs and aspirations from services. The opportunity therefore presents itself to explore the acknowledgement and consideration of cultural issues both at an individual and service level.

Aims of the study

1. Firstly, at an individual level, what are the needs with people from minority cultural groups?
2. Secondly, from a minority cultural perspective, what features of a care home are important for defining quality?
3. Thirdly, from a minority cultural perspective, what are people's experiences of residential services?

This project will be exploring these aims through usage of observation and questionnaires (PART ONE of the study) and via focus groups (PART TWO) of the study). Your care home will be involved with **PART TWO** of this study.

The focus groups have three main objectives:

1) Explore the needs of people from a minority cultural group (from a service user and relative perspective)
2) Explore features of a care home service which are considered important for a quality service from a minority cultural perspective (from a service user and relative perspective)
3) Explore people's experiences of care homes (from a service user and relative perspective)

What the researcher will be doing in your care home

While the researcher is in your care home they will be:

- Meeting with the care home manager
- Running a discussion group with a group of care home residents or a group of relatives
- Checking and collecting consent forms and short questionnaires from the discussion group participants

How you will be involved in this study

If you work in a care home you will probably see a researcher walking around the care home talking to residents and asking whether any residents would like to take part in the discussion group. However, some care staff may be asked about whether residents would be available to take part on the day of the discussion group.

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Confidentiality

All information will be treated as confidential and recorded anonymously in the following ways:

- Your name will not be used on any assessment forms or computer records to be seen outside of the University of Kent and will not be used in any publications or presentations as all data obtained will be anonymised
- All information will be locked away so that only people with permission can see it
- Data will only be held until all publications and presentations of the project are completed
- Participants within the discussion groups will be encouraged to keep confidential what they hear during the meeting.
- All information extracted from the focus groups will remain anonymous from the group
- A further objective will be to audiotape the focus groups. Audio taping will only take place if the participants have achieved consent
- Participants may decline to answer any questions with which they are not comfortable, they may leave the sessions at any time, their identity and responses will be kept confidential (audiotapes typed by a person unaware of the identity of the participants in the room), any identifying information will be removed from written transcripts, and that reports of the research will not identify participants or anyone mentioned during the discussion
- Paper data will be kept in storage under lock and key. After 10 years, paper records and audio recordings will be destroyed
- All electronic and paper copies will be kept anonymous but will be safely kept under password control. In order to protect participants' rights, all annonymised paper records will be kept secure in a locked cabinet at the PSSRU
- Any personal information typed up onto a laptop will be protected by passwords, back up procedures and recovery practices will be clearly documented and stored at the PSSRU department.
- All computer records will be password protected and computers will use a password enabled screen saver.

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Outputs

Once the data has been collected, it will be written up and used in the following ways:

- Data collected from this phase of research will be used in the main researchers PhD thesis.
- Copies of the report will be distributed to all those who request copies, and will also be publicly available on the university website.
- A number of academic papers may be produced.
- It may be presented at conferences.
- It may appear in a book.
- A report will go to the Care Quality Commission.

The principle output will be to illuminate the experience of community care services for people belonging to minority cultural groups and to encourage further research to recognise the importance of service users from a variety of cultural backgrounds.

Further information

If you would like any further information about this information or the project itself, please contact Jan Smith on:

Jan Smith- tel: 01227 82 7985, email: jes31@kent.ac.uk

Thank you for your assistance

11.8.2. Focus group project information sheets- participants

University of Kent

Project Information
Measuring Quality of Outputs in Care homes: A Cultural Perspective

Dear Participant,

I want to ask if it is OK for Jan Smith to come and speak with you and around 6 other people in a group for approximately 2 hours to talk about

- Your thoughts about residential services
- How you feel about residential services
- The support staff give you
- How things are organised

- The group will be tape-recorded so all members of the research team can get a full picture of the discussion. The tape will be kept confidential and it will be destroyed at the end of the project.

We are doing this because

- We want to find out more about what makes residential services good for residents.
- We want to find out what its like living within residential services
- Doing this work will mean that other people will be able to understand what its like living within residential services

The information would be used in the following ways:

To use in a **report** for Jan's college work

To use in **journals** and **departmental newsletters**

To use in **presentations**

Some things to remember:

- You **can say NO** to all of it
- You can **change your mind** whenever you want
- You can ask to **see or read to you the information** about you before it is used
- The information will be used in ways that **show respect for you**
- **Your name will not be used** on any assessment forms or computer records outside of the University of Kent
- **Your name will not be used** in any publications or presentations
- **All information will be locked away** so that only people with permission can see it.

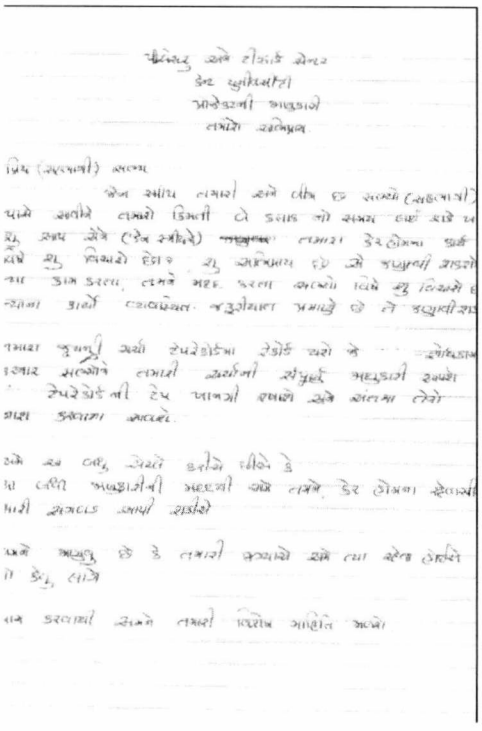
If you would like help with filling in the form or you would like someone to fill it in for you then please ask someone you trust to complete it

If you want to say OK, please fill in the form and give it to Jan. Many thanks for your help.

This is a picture of Jan

Yours sincerely,

Jan Smith



પ્રોજેક્ટનું નામ
કેર હોમ્સમાંના
ખોરાકની ગુણવત્તા
તમારો દૃષ્ટિકોણ

પ્રિય (ભાગીદારી) સભ્ય,

જેન સ્મીથ તમારી સાથે તથા છ અન્યો (સહભાગી) સાથે અંદાજે
૨ કલાક જેટલો (રેસ્ટ સહિતનો) સમય ગાળે તે ઇચ્છે છે
તેનો વિષય (રેસ્ટ સહિતનો) તમારા કેર હોમના વિષે
તમારા વિચારો હોવા જોઇએ તેના વિષે તમારી લાગણી
આ કામ કરવા તમને મદદ કરતા અન્યો વિષે તમે કેવું
તમારા કાર્યો વ્યવસ્થિત કરવામાં આવે છે તે વગેરે

તમારા ગ્રુપની ચર્ચા ટેપરેકોર્ડમા રેકોર્ડ થશે જે
દ્વારા સંશોધકોની આખી ટીમ પૂરેપૂરું ચિત્ર
મેળવી શકશે. ટેપરેકોર્ડની ટેપ ખાનગી રાખવા અને અંતમા તેનો
નાશ કરવામા આવશે.

અમે આ કામ એટલે કરીએ છીએ કે
જે વસ્તુ આપણી સારી રીતે તમને કેર હોમના રહેવાસી
માટે કેવી રીતે કામ કરી શકીએ

અમે ઇચ્છીએ છીએ કે તમારી જેવા અન્યો સમજી શકે
કે કેર હોમમાં

આ કામ કરવામાં અમને તમારી વિશેષ માહિતી મળશે

આ માહિતીનો ઉપયોગ નીચે મુજબ થશે
જેમકે જોનના કોલેજના કાર્યોમા આ વિષે અહેવાલો લખવો
દરેક જૂદા જૂદા જુથના અભિપ્રાયોનાં
મહત્વ માહિતી આપવી

વિભાગના સમાચારોમા મૂકવા

આ દરેક બાબત તમે ના-પસંદ કરી શકો છો

તમારો અભિપ્રાય બદલી શકો છો

તમારી વિષેની અહેવાલો તમે જોઈ શકો છો કે તમારી શું કહ્યું
લેખિત આપે તે પહેલા)

તમારું નામ કોઇપણ તે પ્રમાણે માહિતી ઉપયોગ થશે

તમારું નામ કોઇપણ પબ્લિકેશનમા કેર યુનિવર્સિટીની બહાર
ક્યારે નહીં કરાય.

અનુમતિ આપેલા વ્યક્તિ જ આ વિભાગ જોઈ શકશે માહિતીને
ખૂબ સંભાળપૂર્વક કેર કરશે.

તમને આ માહિતી ફોર્મમાં લખવા જે મદદની જરૂર હોય તો
બીજાની કોઈ વિશ્વાસુ વ્યક્તિની મદદ લેજો
તમે ફોર્મ ભરી તરત જ જેન જે પાસે રહો છે

તમારો ખૂબ આભાર

જેન ની તસ્વીર દોરો

જેન સ્મીથ

11.8.3. Focus group consent forms

PSSRU and Tizard Centre
University of Kent

Consent Form
Measuring Quality of Outputs in Care homes: A Cultural Perspective

This form is for you to give your consent to be a participant in the research project, 'Measuring and monitoring quality of outputs in care homes: A cultural perspective'

Your name.....

Your address.....

.....

I understand that the information will be used in the following ways:
- ☑ For journals and academic newsletters
- ☑ For a report for Jan's thesis
- ☑ For presentations

I understand that:
- ☑ I don't have to take part if I don't want to.
- ☑ The group discussions will be recorded on tape
- ☑ Even if I say yes now I can change my mind and withdraw my consent at any time.
- ☑ My name will not be used in any records, reports or presentations
- ☑ All the information collected will be kept private and that my name will never be used in anything that is written about the study
- ☑ I consent to taking part in this research project.

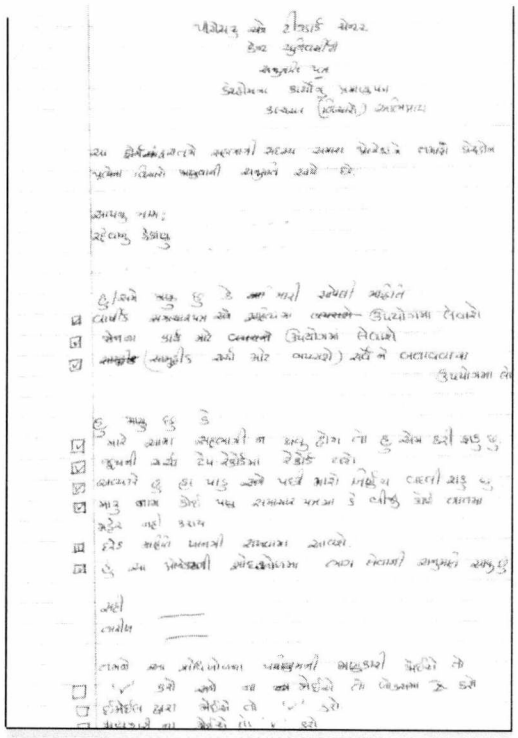
Signed.....

Date.....

If you would like to receive feedback please indicate below:

- ☐ I would like to receive feedback by Email and my Email address is .....
- ☐ Please send feedback of the focus groups via post
- ☐ I would not like to receive any feedback

Thank you for your assistance



11.8.4. Focus groups- Compliant form

PSSRU and Tizard Centre

University of Kent

Complaint Form

Measuring Quality of Outputs in Care homes:

A Cultural Perspective

This is a photo of Jan

Thank you for agreeing to talk to Jan to help with our research.

We hope that everything was alright when you talked to Jan.

It is Jan's job to treat people properly. This means she should:

- Be polite
- Treat you as an adult
- Make sure you know what is happening

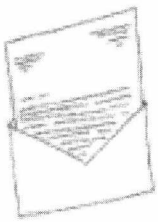
But if you did not like things Jan did, you can complain.

This means you tell us and we will try to do something about it.

HOW TO COMPLAIN

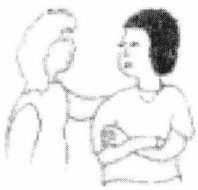
The first thing you could do is tell Jan herself about it, if you can.

If you would prefer to talk to someone else first, then you can phone Jan's boss. Her name is Ann Netten and his/her phone number is 01227 827 672.



Or you can write to her at the following address.

PSSRU at Kent, Cornwallis Building, George Allen Wing, University of Kent, Canterbury, Kent, CT2-7NF



If you find it hard to make a complaint, you can ask someone else to do it for you. Ask someone to help you.

Ann Netten will listen to you carefully. Then she will need to talk to other people. After a short while, she will get in touch with you to let you know what has happened. If something bad happened when Jan was talking to you, it will help us to know this. We want to learn how to stop this happening again. You will not get into trouble if you tell us.

Some complaints are big. Some complaints are small. It's always OK to tell us about it. Thank you.

11.8.5. Focus group questionnaire

Measuring Quality in Care homes: A Cultural perspective
Focus Group Questionnaire: About You

Please take the time to fill out this short questionnaire.

The questions in this questionnaire are designed to provide us with further details about you.

The information provided in this questionnaire is completely confidential.

Where the information from the questionnaire is included in a report or published paper, it will be done in a way that preserves the anonymity of all concerned.

Measuring Quality in Care homes: A Cultural perspective
Focus Group Questionnaire: About You

1. **Are you:**

Please tick [✓] one box only

Male ☐
Female ☐

2. **Please indicate how old you are:**

Please tick [✓] one box only

18-24 ☐
25-34 ☐
35-44 ☐
45-54 ☐
55-64 ☐
65 and over ☐

3. **What is your ethnic background?**

White

Please tick [✓] one box only

British ☐
Irish ☐
Any other White background ☐
Please state _____

Asian or Asian British

Indian ☐
Pakistani ☐
Bangladeshi ☐
Any other Asian background ☐
Please state _____

Black or Black British

Caribbean ☐
African ☐
Any other Black background ☐
Please state _____

Measuring Quality in Care homes: A Cultural perspective
Focus Group Questionnaire: About You

Mixed

White and Black Caribbean ☐
White and Black African ☐
White and Asian ☐
Any other Mixed background ☐
Please state _____

Chinese or other Ethnic group

Chinese ☐
Any other ethnic background ☐
Please state _____

4. **Are you currently practicing a religious belief?**

Please tick [✓] one box only

Yes ☐
No-*Please go to Question 7* ☐

5. **How would you describe your religious belief?**

Please tick [✓] one box only

	Please tick [✓]		Please tick [✓]
Buddhist		Muslim	
Christian		Sikh	
Hindu		Jewish	
Other. Please state:			

6. **On a scale of 1 to 5 with 1 representing unimportant and 5 representing very important, how important is religion in your life?**

Please tick [✓] one box only

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Unimportant — Very Important

7. **What is your nationality?** _____

8. **What was your country of birth?** _____

9. **How long have you lived in the UK?** _____ **(Years)** _____ **(Months)**

Thank you for completing this questionnaire

11.8.6. Focus Group Topic Guide

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Measuring and Monitoring Cultural Diversity within Care Homes, Spring 2008

Relative Group Discussion Topic Guide

Introduction

Welcome.

Thank you for agreeing to take part in our study and for coming along today.

My name is Jan, and this is my colleague, Vinod. I am a researcher from the Personal Social Services Research Unit and the Tizard centre at the University of Kent. Vinod works at the Confederation of Indian Organisation and is here today to assist me with these discussions.

Purpose of study

The research project we're working on is exploring:

- What characteristics are most important to you from services and why.
- What quality care homes should be like, what characteristics they should have.
- Whether you feel that care home services are meeting the needs for residents within care homes.

We are holding a series of discussion groups with relatives who have relatives currently living within care homes or who have had experience of care home services. We're going to use what you say to help us find out more about what care homes are like for residents. Today, we're particularly interested in finding out the views and opinions from a relative perspective. We feel that by having a group discussion to discuss these issues, we would be getting at more deeper, detailed and richer information which will help us in finding out about peoples experiences with care homes.

Confidentiality and tape recording

We really appreciate you sharing your views with us and would like to reassure you that

- Everything you say is confidential.
- You will remain anonymous.
- You've already signed consent forms allowing me to tape record today. The only reason we do this is because its really hard for me to listen, participate and write what your saying down all at the same time. I also have problems reading my own handwriting sometimes, so this tape will make sure that I'm correctly analysing what has been said within these discussions. The tape recording will be stored securely so only me and other people in my team can hear it. Voice recordings will be protected by passwords so that no one other

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than the team can listen to them. You will remain anonymous throughout this session, so nobody will be able to tell who said what. All recordings will be confidential. After the project has ended, the tape will be destroyed.

Ground rules of focus groups

Before we begin, I would like to go through a few ground rules for our discussion.

- Confidentiality. It's important to note that if you know each other, please keep what is said within this room.
- This session is voluntary. You can leave the discussion group at any time.
- You don't have to talk about something if you don't want to.
- It's important to point out that this isn't like school, there's no right or wrong answer.
- Today should be enjoyable for everyone and everyone should feel they have an opportunity to speak. Therefore all views are equally valid and valuable. It's important that everyone feels able to be involved so please be respectful and let everyone have their turn, don't voice you opinions too strongly so that other people are afraid to take part.
- As we're all individuals and have different backgrounds and experiences, which shape the way we see things, it's important to point out that different views are ok. We're particularly interested in finding out a wide range of views and we're not just looking for you to agree with each other.
- One more thing before we begin, is that we hope that this session will last about two hours to ensure that we cover all the material.

Before we begin, does anyone have any questions?

****

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1. Introductions/warm up (10mins)

First of all, just so that we could break the ice a bit, it would be really useful if we could all know each other's names and find out a bit about each other. Why don't we go round the room, everyone say their name and tell us something interesting about themselves. I'll start…

2. Needs (45 mins)

Ok, in this section, I would like you to think about how your relative feels about particular needs. Think about the kinds of needs that your relative requires from services such as care homes. In a minute, I would like you to think about all of the kinds of needs that you think are important both to you and your relative. We will then move onto talking about which need do you think is most important. Finally, we will then move onto discussing why the need is of particular significance.

a) What are the needs

You

- To start us thinking about needs, let us think about some of the things that during your day-to-day life you need.

BRAINSTORM

PROBE: What are some of the needs that you couldn't go on without if you were on a desert island.
PROBE: How important are these needs?
PROBE: What would be the most important need do you think? What would be the least important need?

Relative

BRAINSTORM

- Think for a moment about the day-to-day operations of your relative in a care home. What do you think residents need within care homes?
- PROBE: What do you think are the key needs that your relatives needs within care homes?
- PROBE: How important do you think these needs are to your relative?

Ok, thank you for telling us what needs you think are most important.

b) CfB domains

- You've mentioned some of the needs. As part of our study, we are looking at needs in the following areas. What do you think about some of these needs?

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PROBE-How important do you think your relative feels about these needs?

- Meals and Nutrition
- Accommodation-cleanliness
- Social participation and involvement
- Control over daily life
- Choice
- Personal cleanliness
- Safety
- Dignity and respect

- Ok, we've looked at these domains. Now I would like to find out which of these domains are most important to your relative. I would like to find out a bit more why these particular domains are so significant to you.

c) Why are these needs so important?

(Getting at religious requirements)

- PROBE: OK, you've mentioned that religion is an important influence in determines how significant this area is.
- PROBE: Could you tell me a bit more about your religious belief in relation to this area of need?
- PROBE: Tell me a bit more about how your religion influences these needs. For example, tell me a bit more about how religion influences meals and nutrition for example.

3. Quality service (45 mins)

Definition

- Let's talk about quality generally now. What does the word quality mean to you? What does it make you think about? Tell me the first things that come into your head.

Quality

1) Think about how your relative feels living within a care home /or previous experiences with care homes. Think about some of the things your relative has liked or disliked about a care home

- Tell me what you think a quality service would be like, how would it not behave, what would it do or not do?
- PROBE: How behaves
- PROBE: What things it would do/achieve
- PROBE: How it should treat them

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2) What characteristics would quality services have and what characteristics wouldn't they have?

What are the key aspects or characteristics of quality?

- Reliability
- Continuity
- Communication
- Flexibility
- Attitudes and skills of staff
- Understanding of your situation

4. Experiences of services (15 mins)

- Lets talk about care homes generally now. Think about care homes generally.
- How do you feel about care homes?
- Tell me a bit more about your experience with care homes.
- Do you feel that care homes are meeting your relative's needs? What about other care homes other than the one that your relative is or has stayed at.

Ok, that's the end of our discussion today. Many thanks for your very very helpful comments. I really appreciate your time, effort and contribution with this report.

Please could you complete this short questionnaire, it just tells us a bit about you....

Do you have any further questions..

****

11.8.7. Focus group reliability instructions and reliability table

Aim: Six focus groups were conducted in order to qualitatively explore care home residents and relatives definitions of service quality and also to find out about their experiences and views of care homes. A thematic analysis was applied to qualitatively explore the types of themes raised from residents and relatives.

The purpose of this task was to check whether two researchers were allocating the same codes to particular themes and also to check whether the codes outlined within the coding frame are objective, reliable indicators of the content of the text. This involves coding transcripts for two focus groups and involves reading through each line of each transcript, identifying a particular theme and noting the page number and extract within the coding table.

Documents

1. Please read through the document title 'Coding frame'. The coding frame includes a list of themes, descriptions and examples of quotations used to illustrate particular themes. (Document 1)

2. The documents titled *'relatives focus group- reliability* 1' and *'resident focus group- reliability 2-* contain the transcripts for focus groups conducted with residents and relatives respectively. (Document 2 and Document 3)

3. The two 'coding table' documents contain tables which were used to code the focus groups for thematic analyses. (Document 4 and Document 5)

Task

4. Familiarize yourself with each of the themes listed within the coding frame (Document 1).

5. Open the transcript documents (document 2 and document 3) and the two coding table documents.

6. Going through each transcript, line by line, if you spot one of the themes listed within the coding frames, please allocate a 'tick' [√] within the coding table, copy and paste the extracted theme into the extract column and note the page number.
    a. Note- to save time- open two windows on your computer screen and copy and paste extracted themes from the transcript into the coding table.

7. Once you've finished with the task, please save, attach to an email and send it to my email address asap. jan_eliza_smith@hotmail.com

8. **This task should take no longer than 1-2 days at the most.**

Focus group reliability tables

Reliability analyses 1- Focus group: Relatives					
No.	Coding frame	Present? (tick)		Extract(s)	Page number
		YES	NO		
1.	Needs- care and support- 24 hour care				
2.	Needs-care and support- types				
3.	Needs- care and support- one staff				
4.	Needs- care and support- staff gender preference				
5.	Needs- care and support- care home contains multilingual staff				
6.	Needs- care and support- medical care				
7.	Needs- care and support- by staff who are knowledgeable of cultural needs and from similar cultural backgrounds				
8.	Needs- care and support- staff qualities- care from good staff				
9.	Non specialist care homes- care and support				
10.	Needs- personal care- hair care				
11.	Needs- personal care- personal cleanliness- importance and purpose				
12.	Needs- personal care- personal cleanliness- clean clothes				
13.	Needs- personal care- cultural dress codes				
14.	Non specialist care homes and personal cleanliness				
15.	Needs- activities- importance and purpose				
16.	Needs- activities-types				
17.	Needs- activities- older adults- restrictions				
18.	Needs- activities- other restrictions				
19.	Needs- activities- reflective of cultural group				
20.	Non specialist care homes- activities				
21.	Needs- foods				
22.	Needs- fresh foods				
23.	Needs- foods- 'home cooking'				
24.	Needs- foods- cultural group and types of foods				
25.	Needs- food preparations				
26.	Non specialist care homes- and foods				

27.	Needs- religion- importance and propose				
28.	Needs- religion- frequency of worship				
29.	Needs- religion- religious items used to facilitate prayer				
30.	Needs- religion- different faiths				
31.	Non specialist care homes- religion				
32.	Needs- care home- accommodation- bedrooms				
33.	Needs- care home accommodation- homelike				
34.	Needs- care home accommodation- comfortable and luxurious environment				
35.	Needs- care home accommodation- technological devices used to maintain comfort and entertainment				
36.	Needs- care home environment- cleanliness				
37.	Needs- care home environment- good location				
38.	Needs- care home environment- specific rooms				
39.	Non specialist care homes- care home environment-				
40.	Needs- choice and control				
41.	Needs- choice and control- staff respect residents choice				
42.	Non specialist care homes- choice and control				
43.	Needs social contact- importance and purpose				
44.	Needs- social contact from residents with comparable cultural groups				
45.	Non specialist care homes- and social contact				
46.	Needs- safety and security				
47.	Non specialty care homes and safety and security				
48.	Needs- dignity and respect				
49.	Non specialty care homes and dignity and respect				
50.	Culture- segregation between cultural groups				
51.	Culture- similarities between cultural groups				
52.	Culture- Caribbean				
53.	Culture- Asian culture				
54.	Minority cultures- disadvantage				
55.	Specialist care homes- met				

	need				
56.	Specialist care homes- benefit to residents				
57.	Specialist care homes- unmet needs				
58.	Non specialist care homes- met need				
59.	Non specialist care homes- unmet need				
60.	Care homes- difficulties surrounding care homes and the future				

11.9. Appendix 9- MOPSU Study- Consent Forms

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AQAA REFERENCE

Consent Form for Residents

Measuring Quality in Care Homes
October 2007–December 2008

Consent form for _____ (your name)

I agree to Jan Smith coming to my house to watch and make notes about:

- What happens during the day
- The activities I do
- The support staff give me
- How things are organised

I understand that the information will be used in the following ways:

- To tell me about what was seen during the visit
- To match up different assessment forms
- For journals and academic newsletters
- For a report for a researcher's college work
- For presentations

I understand that:

- I don't have to take part if I don't want to.
- Even if I say yes now I can change my mind at any time.
- I can see or have read to me what is written down about me before Jan leaves the service.
- My name will not be used in any records, reports or presentations.

Signed_____ Date _____

If someone else is signing for you, please make sure they answer these questions:

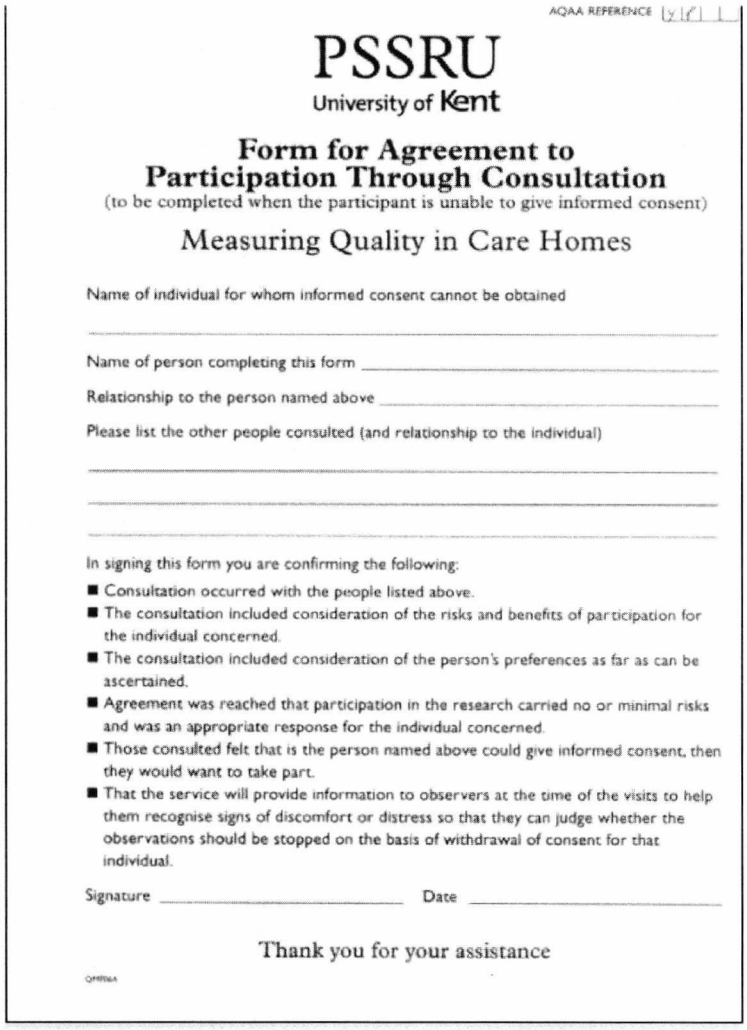
Name _____

Relationship to person named on the form _____

Thank you for your assistance

QMRRR

Consent form by proxy



AQAA REFERENCE [illegible]

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Form for Agreement to Participation Through Consultation

(to be completed when the participant is unable to give informed consent)

Measuring Quality in Care Homes

Name of individual for whom informed consent cannot be obtained

_____

Name of person completing this form _____

Relationship to the person named above _____

Please list the other people consulted (and relationship to the individual)

_____

_____

_____

In signing this form you are confirming the following:

- Consultation occurred with the people listed above.
- The consultation included consideration of the risks and benefits of participation for the individual concerned.
- The consultation included consideration of the person's preferences as far as can be ascertained.
- Agreement was reached that participation in the research carried no or minimal risks and was an appropriate response for the individual concerned.
- Those consulted felt that is the person named above could give informed consent, then they would want to take part.
- That the service will provide information to observers at the time of the visits to help them recognise signs of discomfort or distress so that they can judge whether the observations should be stopped on the basis of withdrawal of consent for that individual.

Signature _____ Date _____

Thank you for your assistance

QMHMA

11.10. Appendix 10- Minority Cultural Questionnaire (MCNQ)

Section 4: Cultural needs

This section need only be completed for residents who are from a cutural or ethnic group other than White British. If this resident is White British, please leave this section blank.

If you are filling in Section 4 because this resident is from a cultural or ethnic group other than White British, please begin with the communication section (Section A), religious beliefs (Section B) and additional needs (Section C)

Section A: Communication

1. Main language **(Please tick one box only)**

Arabic	☐	Sign Language	☐
Bengali	☐	Somali	☐
Cantonese	☐	Spanish	☐
English	☐	Turkish	☐
Greek	☐	Urdu	☐
Gujarati	☐	Other (please specify)	☐
Hindi	☐		

2. Speaks English **(Tick one)**

Please tick one box only

- Fluently, like an average native of an English speaking country. ☐
- Is able to sustain a conversation in English at a slow pace ☐
- Speaks some English, heavily aided by body language and/or mixed with their first language ☐
- Speaks no English ☐

3. Understands English ***(Tick one)***

Please tick one box only

- Fluently, like an average native of an English speaking country. ☐
- Is able to understand a conversation in English at a slow pace ☐
- Understands some English, heavily aided by body language ☐
- Understands no English ☐

Section B: Religious Beliefs

4. a) Does this person have a main religious belief? **Please tick one box**

Yes **(Go to Q4b)** ☐

No **(Go to Section C)** ☐

4 b) Which of the following religions best reflects the person's religion?

Please tick one box only

- ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Any other religion. Please specify

4 c) Does this person have religious items within their rooms? **Please tick one box only**

Yes **(Go to 4d)** ☐

No **(Go to 4e)** ☐

4 d) Please could you describe these religious items?

Question 4 Religious beliefs (continued)

4 e) Does this person attend or participate in religious practice/place of worship (i.e. attend a religious settlement i.e. Church, Synagogue, Mosque or participate in prayer time)?

Please tick one box only

- Yes (Go to Q4f) ☐
- No (Go to Q5a) ☐

4 f) Please tick how often the resident attends or participates in religious practice, for example attendance of a religious settlement (i.e. Church, Synagogue, Mosque):

- ☐ Extremely often- daily
- ☐ Very often- more than once a week
- ☐ Often- at least once a week
- ☐ Sometimes- at least once a month
- ☐ Rarely- at least once or twice each year

Section C: Additional needs:

5 a) Does this person have a particular diet specification?

- ☐ Yes (Go to 5b)
- ☐ No (Go to Q6a)

5 b) Please could you describe the resident's diet specifications (e.g. specifcations on meat, dairy and beverage products) **Please tick one box only**

5 c) Does this person have choice within the menu given their diet specification? **Please tick one box only**

- ☐ Yes
- ☐ No

5 d) Does this person consult with staff members on the best ways to cook meals in accordance with their diet specification?

- ☐ Yes (Please go to Q6a)
- ☐ No (Please go to 5e)

5 e) Please could you describe how the resident's diet specifications are met:

6 a) Does this person require particular skin and hair products?

Please tick one box only

- ☐ Yes (Please go to Q6b)
- ☐ No (Please go to 7a)

6 b) Please could you describe the residents skin and hair products:

6 c) How often does this resident use these particular skin and hair products?

Please tick one box only

- ☐ Extremely often- daily
- ☐ Very often- more than once a week
- ☐ Often- at least once a week
- ☐ Sometimes- at least once a month
- ☐ Rarely- at least once or twice each year

6 d) Does this person have easy access to these skin and hair products (i.e. products available and easily accessible to use at the persons own request)

Please tick one box only

- ☐ Yes
- ☐ No

7. a) Does this person require specific clothing needs (e.g. Hijab, an Islamic veil used by Muslim females)?

Please tick one box only

- ☐ Yes (Please go to Q7b)
- ☐ No (Please go to 8a)

b) If yes, please describe the residents clothing requirements:

c) How often does this resident wear these specific clothes?

Please tick one box only

- ☐ Extremely often- daily
- ☐ Very often- more than once a week
- ☐ Often- at least once a week
- ☐ Sometimes- at least once a month
- ☐ Rarely- at least once or twice each year

8. a) Does this person attend all social gatherings and outings such as attending pubs, and swimming sessions with all residents?

Please tick one box only

- ☐ Yes
- ☐ No

b) Does this person attend all social gatherings for minority cultural groups within the community?

Please tick one box only

- ☐ Yes
- ☐ No

This is the end of this questionnaire

Please check through the booklet and make sure that you haven't accidentally missed any questions and then keep this booklet in a safe place until it is collected by the researcher when he/she visits the service.

Thank you very much for your time.

11.11. Appendix 11- Cultural Care Home Observational Toolkit (CCHOT)

Q6 Cultural Care Home Observational Toolkit (CCHOT)	Service Code

Section 6: Cultural and Ethnic Needs

***Please complete this section ONLY if at least one of the five sample residents is from a minority cultural background ***

For each response, please use the space provided to note any evidence

Section 6.1 Quality of staff support and cultural needs

1. In terms of dignity and respect, did staff treat residents from minority cultural backgrounds differently from other residents? *Please tick one box only*

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Comments/Evidence

2. Did staff have different communication styles for residents from minority cultural backgrounds than for residents from other backgrounds?? For example, did staff speak louder, or use "pidgin" (simplified broken language) with cultural residents? *Please tick one box only*

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Comments/Evidence

3. Did staff use different languages to interact with residents for whom English was not their first language? *Please tick one box only. If bilingual languages were used by staff and if observers are unfamiliar with different languages spoken, please ask staff*

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Not observed

Comments/Evidence

4. Were staff immediately available, fluent and equipped with bilingual skills to communicate with residents? *Please tick one box only. May need to ask staff*

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Not observed
- ☐ Not applicable

Comments/Evidence

DEACTIVATED

5. Did staff attempt to verbally communicate equally with all residents (both minority cultural and other groups)? ***Please tick one box only.***

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Comments/Evidence

6. Did residents from minority cultural backgrounds appear to understand and respond to staff communication? ***Please tick one box only.***

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Comments/Evidence

7. Did staff attempt to communicate non-verbally with all residents? ***Please tick one box only.*** *For example, if a resident was unfamiliar with English by using few non-verbal communication such as gestures, i.e. waving, smiling etc.*

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Comments/Evidence

8. If staff communicated non-verbally with all residents, did it differ for residents from minority cultural backgrounds than residents from other backgrounds? ***Please tick one box only.***

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Comments/Evidence

9. Did the care home have accessible written information published in other languages besides English? ***Please tick one box only.***

- ☐ No
- ☐ Some were
- ☐ Yes

Comments/Evidence

10. Did all staff appear to be knowledgable, committed and sensitive to the needs of cultural groups? ***Please tick one box only.***

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Comments/Evidence

11. Did all staff appear to work as a team with regards to maintaining sensitivity to cultural issues ? ***Please tick one box only.***

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Comments/Evidence

Please use this section make any further observations relating to quality of staff support and cultural needs

Section 6.2: Physical Environment

12. Did the care home contain religious symbols or items? For example, with residents rooms, hallways, public and common areas contain religious images or objects such as crucifixes? ***Please tick one box only***

- ☐ Religious symbols in evidence throughout house
- ☐ Religious symbols in evidence in people's own rooms
- ☐ Religious symbols in evidence but not of that person's religion (e.g. crosses, star of David when person is Muslim)
- ☐ No religious symbols in evidence

Comments/Evidence

13. Within bathrooms, was there evidence of a bidet, basin or jugs to allow for residents to wash themselves with running water after occurances of elimination? ***Please tick one box only***

- ☐ Yes
- ☐ No

Comments/Evidence

14. Within the care home, was there any evidence of accessible prayer locations within the home? ***Please tick one box only***

- ☐ Yes
- ☐ No

Comments/Evidence

Section 6.3: Quality of Care Process - Cultural Issues

15. Were residents able to lock and close doors during sessions of personal cleanliness? ***Please tick one box only***

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Comments/Evidence

16. In situations of personal care did staff ensure that all doors were closed or screened, or that bed curtains were completely drawn? ***Please tick one box only***

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Not observed

Comments/Evidence

17. When a staff worker entered a room to help administer intimate care, examinations and practical care for residents, did someone of the same sex to the resident administer this care? ***Please tick one box only***

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Not observed

Comments/Evidence

18. Did residents have unrestricted access to personal cleaning facilities in order to maintain high levels of personal hygiene? ***Please tick one box only***

- ☐ Always
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

Comments/Evidence

19. Were residents from minority cultural backgrounds seen to access special skincare products such as oils and moisturisers? ***Please tick one box only***

- ☐ Yes
- ☐ Some were
- ☐ No
- ☐ Not observed

Comments/Evidence

20. Was the residents' hair well groomed (hair combed, healthy looking - not dry)? ***Please tick one box only***

- ☐ Yes
- ☐ To some extent - some were
- ☐ No, not at all well-groomed

Comments/Evidence

21. Did staff consult with residents whether they wanted their hair cut or shaved?
Please tick one box only

Comments/Evidence

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Not observed

22. Did staff consult with residents how they would like their hair to be cared for?
Please tick one box only

Comments/Evidence

- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never
- ☐ Not observed

23. Were residents able to access special hair care products such as wide toothcombs and oil for black hair to use at their own request? ***Please tick one box only***

Comments/Evidence

- ☐ Yes
- ☐ Some were
- ☐ No
- ☐ Not observed
- ☐ Not applicable

Clothing
The next sets of questions are about obtaining an overview of the residents clothing items. Particular interest will be placed on clothing items linked to the head, upper body and the lower body. If the resident(s) were female please complete question 24a). If residents were male please complete question 24b).

24. a) FOR FEMALE RESIDENTS ONLY:

HEADWEAR

i) Were any of the female residents wearing headwear? If no, please go to iii)

- ☐ Yes
- ☐ Some were
- ☐ No

ii) If residents were wearing headwear, please tick the box which best describes the residents headwear. *May need to ask staff for clarification.*

SU1 ☐☐☐☐☐☐

- Hat ☐
- Tuque: *A knitted hat* ☐
- Veil: Hajjab: *A square scarf that covers the head and neck but leaves the face clear* ☐
- Veil: Niqab: *The niqab is a veil for the face that leaves the area around the eyes clear, however it may be worn with a separate eye veil* ☐
- Veil: Burka: *The burka is a veil that covers the entire face and body, leaving just a mesh screen to see through* ☐
- Veil: other ☐
- Hair covering items ☐
- Other *(please specify)* ☐

SU2 ☐☐☐☐☐☐

- Hat ☐
- Tuque: *A knitted hat* ☐
- Veil: Hajjab: *A square scarf that covers the head and neck but leaves the face clear* ☐
- Veil: Niqab: *The niqab is a veil for the face that leaves the area around the eyes clear, however it may be worn with a separate eye veil* ☐
- Veil: Burka: *The burka is a veil that covers the entire face and body, leaving just a mesh screen to see through* ☐
- Veil: other ☐
- Hair covering items ☐
- Other *(please specify)* ☐

SU3 ☐☐☐☐☐☐

- Hat ☐
- Tuque: *A knitted hat* ☐
- Veil: Hajjab: *A square scarf that covers the head and neck but leaves the face clear* ☐
- Veil: Niqab: *The niqab is a veil for the face that leaves the area around the eyes clear, however it may be worn with a separate eye veil* ☐
- Veil: Burka: *The burka is a veil that covers the entire face and body, leaving just a mesh screen to see through* ☐
- Veil: other ☐
- Hair covering items ☐
- Other *(please specify)* ☐

SU4 ☐☐☐☐☐☐

- Hat ☐
- Tuque: *A knitted hat* ☐
- Veil: Hajjab: *A square scarf that covers the head and neck but leaves the face clear* ☐
- Veil: Niqab: *The niqab is a veil for the face that leaves the area around the eyes clear, however it may be worn with a separate eye veil* ☐
- Veil: Burka: *The burka is a veil that covers the entire face and body, leaving just a mesh screen to see through* ☐
- Veil: other ☐
- Hair covering items ☐
- Other *(please specify)* ☐

SU5 ☐☐☐☐☐☐

- Hat ☐
- Tuque: *A knitted hat* ☐
- Veil: Hajjab: *A square scarf that covers the head and neck but leaves the face clear* ☐
- Veil: Niqab: *The niqab is a veil for the face that leaves the area around the eyes clear, however it may be worn with a separate eye veil* ☐
- Veil: Burka: *The burka is a veil that covers the entire face and body, leaving just a mesh screen to see through* ☐
- Veil: other ☐
- Hair covering items ☐
- Other *(please specify)* ☐

UPPER BODY (HEAD TO HIPS)

iii) For each resident, please indicate in the boxes provided, which items of clothing were worn on the upper body ***(may need to ask staff for clarification). Tick all that apply***

SU1 ☐☐☐☐☐☐

T-shirt ☐ Blouse ☐ Vest ☐
Jumper ☐ Jacket ☐ Other ☐
Please state

SU2 ☐☐☐☐☐☐

T-shirt ☐ Blouse ☐ Vest ☐
Jumper ☐ Jacket ☐ Other ☐
Please state

SU3 ☐☐☐☐☐☐

T-shirt ☐ Blouse ☐ Vest ☐
Jumper ☐ Jacket ☐ Other ☐
Please state

SU4 ☐☐☐☐☐☐

T-shirt ☐ Blouse ☐ Vest ☐
Jumper ☐ Jacket ☐ Other ☐
Please state

SU5 ☐☐☐☐☐☐

T-shirt ☐ Blouse ☐ Vest ☐
Jumper ☐ Jacket ☐ Other ☐
Please state

iv) For each resident, please indicate in the boxes provided, how tight fitting the clothing items were on the upper body? ***Tick one box per resident***

SU1

Very loose fitting *(upper body outline completely obscured)* ☐ Average fitting *(upper body could be seen - but not too loose or tight)* ☐ Very tight fitting *(skin tight clothing)* ☐

Loose fitting *(upper body outline obscured, but could be seen)* ☐ Tight fitting *(upper body outline could be seen)* ☐

SU2

Very loose fitting *(upper body outline completely obscured)* ☐ Average fitting *(upper body could be seen - but not too loose or tight)* ☐ Very tight fitting *(skin tight clothing)* ☐

Loose fitting *(upper body outline obscured, but could be seen)* ☐ Tight fitting *(upper body outline could be seen)* ☐

SU3

Very loose fitting *(upper body outline completely obscured)* ☐ Average fitting *(upper body could be seen - but not too loose or tight)* ☐ Very tight fitting *(skin tight clothing)* ☐

Loose fitting *(upper body outline obscured, but could be seen)* ☐ Tight fitting *(upper body outline could be seen)* ☐

SU4

Very loose fitting *(upper body outline completely obscured)* ☐ Average fitting *(upper body could be seen - but not too loose or tight)* ☐ Very tight fitting *(skin tight clothing)* ☐

Loose fitting *(upper body outline obscured, but could be seen)* ☐ Tight fitting *(upper body outline could be seen)* ☐

SU5

Very loose fitting (upper body outline completely obscured) ☐ Average fitting (upper body could be seen - but not too loose or tight) ☐ Very tight fitting (skin tight clothing) ☐

Loose fitting (upper body outline obscured, but could be seen) ☐ Tight fitting (upper body outline could be seen) ☐

v) For each resident, on a scale of 1 to 5, with 1 representing completely obscure and 5 representing transparent, how transparent or "see through" do you think the item of clothing is? Transparency meaning whether underwear (i.e. bras, vests etc) could be seen through clothing. ***Please tick one box only for each resident.***

SU1 ☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU2 ☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU3 ☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU4 ☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU5 ☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

vi) Please indicate in the boxes provided for each resident, which parts of the anatomy of the upper body, were exposed or uncovered by clothing. ***Please tick all that apply.***

SU1

Hands ☐ Elbows ☐ Forearm (Elbow to Wrist) ☐ Shoulder ☐ Waist ☐

Wrists ☐ Neck ☐ Upper arm (Elbow to Shoulder) ☐ Chest ☐ Clavicle/Collar bone ☐

vi) Continued

Please indicate in the boxes provided for each resident, which parts of the anatomy of the upper body, were exposed or uncovered by clothing. ***Please tick all that apply.***

SU2

Hands ☐ Elbows ☐ Forearm (Elbow to Wrist) ☐ Shoulder ☐ Waist ☐

Wrists ☐ Neck ☐ Upper arm (Elbow to Shoulder) ☐ Chest ☐ Clavicle/Collar bone ☐

SU3

Hands ☐ Elbows ☐ Forearm (Elbow to Wrist) ☐ Shoulder ☐ Waist ☐

Wrists ☐ Neck ☐ Upper arm (Elbow to Shoulder) ☐ Chest ☐ Clavicle/Collar bone ☐

SU4

Hands ☐ Elbows ☐ Forearm (Elbow to Wrist) ☐ Shoulder ☐ Waist ☐

Wrists ☐ Neck ☐ Upper arm (Elbow to Shoulder) ☐ Chest ☐ Clavicle/Collar bone ☐

SU5

Hands ☐ Elbows ☐ Forearm (Elbow to Wrist) ☐ Shoulder ☐ Waist ☐

Wrists ☐ Neck ☐ Upper arm (Elbow to Shoulder) ☐ Chest ☐ Clavicle/Collar bone ☐

LOWER BODY (WAIST TO FEET)

vii) For each resident, please indicate in the boxes provided, which item of clothing was worn on the lower part of the body. ***Please tick all that apply.***

SU1

Trousers ☐ Skirt ☐ Leggings ☐ Shoes ☐

Shorts ☐ Dress ☐ Nightwear ☐ Other ☐ Please state

SU2

Trousers ☐ Skirt ☐ Leggings ☐ Shoes ☐

Shorts ☐ Dress ☐ Nightwear ☐ Other ☐ Please state

SU3

Trousers ☐ Skirt ☐ Leggings ☐ Shoes ☐

Shorts ☐ Dress ☐ Nightwear ☐ Other ☐ Please state

SU4

Trousers ☐ Skirt ☐ Leggings ☐ Shoes ☐

Shorts ☐ Dress ☐ Nightwear ☐ Other ☐ Please state

SU5

Trousers ☐ Skirt ☐ Leggings ☐ Shoes ☐

Shorts ☐ Dress ☐ Nightwear ☐ Other ☐ Please state

viii) For each resident, please indicate in the boxes povided, how tight fitting the clothing items were on the lower part of the body. ***Please tick one box only.***

SU1

Very loose fitting *(lower body outline completely obscured)* ☐ Average fitting *(lower body could be seen - but not too loose or tight)* ☐ Very tight fitting *(lower body could be clearly seen i.e. skin tight clothing)* ☐

Loose fitting *(lower body outline obscured, but could be seen)* ☐ Tight fitting *(lower body outline could be seen)* ☐

SU2

Very loose fitting *(lower body outline completely obscured)* ☐ Average fitting *(lower body could be seen - but not too loose or tight)* ☐ Very tight fitting *(lower body could be clearly seen i.e. skin tight clothing)* ☐

Loose fitting *(lower body outline obscured, but could be seen)* ☐ Tight fitting *(lower body outline could be seen)* ☐

SU3

Very loose fitting *(lower body outline completely obscured)* ☐ Average fitting *(lower body could be seen - but not too loose or tight)* ☐ Very tight fitting *(lower body could be clearly seen i.e. skin tight clothing)* ☐

Loose fitting *(lower body outline obscured, but could be seen)* ☐ Tight fitting *(lower body outline could be seen)* ☐

SU4

Very loose fitting *(lower body outline completely obscured)* ☐ Average fitting *(lower body could be seen - but not too loose or tight)* ☐ Very tight fitting *(lower body could be clearly seen i.e. skin tight clothing)* ☐

Loose fitting *(lower body outline obscured, but could be seen)* ☐ Tight fitting *(lower body outline could be seen)* ☐

SU5

Very loose fitting *(lower body outline completely obscured)* ☐ Average fitting *(lower body could be seen - but not too loose or tight)* ☐ Very tight fitting *(lower body could be clearly seen i.e. skin tight clothing)* ☐

Loose fitting *(lower body outline obscured, but could be seen)* ☐ Tight fitting *(lower body outline could be seen)* ☐

ix) For each resident, on a scale of 1 to 5, with 1 representing completely obscure and 5 representing transparent, how transparent or "see through" do you think the time of clothing is? Transparency meaning whether underwear (i.e. bras, vests etc) could be seen through clothing. ***Please tick one box only for each resident.***

SU1

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU3

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU2

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU4

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU5

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

x) Please indicate in the boxes, which parts of the anatomy of the lower body, were exposed or uncovered by clothing for each resident. ***Please tick all that apply.***

SU1

Ankle ☐ Shins ☐ Knees ☐ Upper leg (Knees to top of the Leg) ☐ Lower leg (Knees to Foot) ☐ Feet ☐

SU2

Ankle ☐ Shins ☐ Knees ☐ Upper leg (Knees to top of the Leg) ☐ Lower leg (Knees to Foot) ☐ Feet ☐

SU3

Ankle ☐ Shins ☐ Knees ☐ Upper leg (Knees to top of the Leg) ☐ Lower leg (Knees to Foot) ☐ Feet ☐

SU4

Ankle ☐ Shins ☐ Knees ☐ Upper leg (Knees to top of the Leg) ☐ Lower leg (Knees to Foot) ☐ Feet ☐

SU5

Ankle ☐ Shins ☐ Knees ☐ Upper leg (Knees to top of the Leg) ☐ Lower leg (Knees to Foot) ☐ Feet ☐

24. b) **FOR MALE RESIDENTS ONLY:**

HEADWEAR

i) Were any of the male residents wearing headwear? If no, please go to iii)

☐ Yes
☐ Some were
☐ No

ii) If residents were wearing headwear, please tick the box, which best describes the residents headwear. *May need to ask staff for clarification.*

SU1

Hat ☐ Kufi or Kulfi cap: *A Knitted hat* ☐ Other: *Please state* ☐

Turban: *Is a headdress consisting of a long scarf like single piece of cloth wound round the head or an inner hat* ☐ Kippaha or Yarmulke: *a brimless, short, rounded cap* ☐ please specify

SU2

Hat ☐ Kufi or Kulfi cap: *A Knitted hat* ☐ Other: *Please state* ☐

Turban: *Is a headdress consisting of a long scarf like single piece of cloth wound round the head or an inner hat* ☐ Kippaha or Yarmulke: *a brimless, short, rounded cap* ☐ please specify

SU3

Hat ☐ Kufi or Kulfi cap: *A Knitted hat* ☐ Other: *Please state* ☐

Turban: *Is a headdress consisting of a long scarf like single piece of cloth wound round the head or an inner hat* ☐ Kippaha or Yarmulke: *a brimless, short, rounded cap* ☐ please specify

SU4

Hat ☐ Kufi or Kulfi cap: *A Knitted hat* ☐ Other: *Please state* ☐

Turban: *Is a headdress consisting of a long scarf like single piece of cloth wound round the head or an inner hat* ☐ Kippaha or Yarmulke: *a brimless, short, rounded cap* ☐ please specify

SU5

Hat ☐ Kufi or Kulfi cap: *A Knitted hat* ☐ Other: *Please state* ☐

Turban: *Is a headdress consisting of a long scarf like single piece of cloth wound round the head or an inner hat* ☐ Kippaha or Yarmulke: *a brimless, short, rounded cap* ☐ please specify

UPPER BODY (HEAD TO HIPS)

iii) For each resident, please indicate in the boxes provided, which items of clothing were worn on the upper body ***(may need to ask staff for clarification). Tick all that apply***

SU1 ☐☐☐☐☐☐

T-shirt ☐ Shirt ☐ Vest ☐ Other ☐ Please state

Jumper ☐ Jacket ☐ Nightwear ☐

SU2 ☐☐☐☐☐☐

T-shirt ☐ Shirt ☐ Vest ☐ Other ☐ Please state

Jumper ☐ Jacket ☐ Nightwear ☐

SU3 ☐☐☐☐☐☐

T-shirt ☐ Shirt ☐ Vest ☐ Other ☐ Please state

Jumper ☐ Jacket ☐ Nightwear ☐

SU4 ☐☐☐☐☐☐

T-shirt ☐ Shirt ☐ Vest ☐ Other ☐ Please state

Jumper ☐ Jacket ☐ Nightwear ☐

SU5 ☐☐☐☐☐☐

T-shirt ☐ Shirt ☐ Vest ☐ Other ☐ Please state

Jumper ☐ Jacket ☐ Nightwear ☐

iv) For each resident, please indicate in the boxes provided, how tight fitting the clothing items were on the upper body? ***Tick just one box per resident***

SU1 ☐☐☐☐☐☐

Very loose fitting *(upper body outline completely obscured)* ☐ Average fitting *(upper body could be seen - but not too loose or tight)* ☐ Very tight fitting *(skin tight clothing)* ☐

Loose fitting *(upper body outline obscured, but could be seen)* ☐ Tight fitting *(upper body outline could be seen)* ☐

SU2 ☐☐☐☐☐☐

Very loose fitting *(upper body outline completely obscured)* ☐ Average fitting *(upper body could be seen - but not too loose or tight)* ☐ Very tight fitting *(skin tight clothing)* ☐

Loose fitting *(upper body outline obscured, but could be seen)* ☐ Tight fitting *(upper body outline could be seen)* ☐

SU3 ☐☐☐☐☐☐

Very loose fitting *(upper body outline completely obscured)* ☐ Average fitting *(upper body could be seen - but not too loose or tight)* ☐ Very tight fitting *(skin tight clothing)* ☐

Loose fitting *(upper body outline obscured, but could be seen)* ☐ Tight fitting *(upper body outline could be seen)* ☐

SU4 ☐☐☐☐☐☐

Very loose fitting *(upper body outline completely obscured)* ☐ Average fitting *(upper body could be seen - but not too loose or tight)* ☐ Very tight fitting *(skin tight clothing)* ☐

Loose fitting *(upper body outline obscured, but could be seen)* ☐ Tight fitting *(upper body outline could be seen)* ☐

SU5 ☐☐☐☐☐☐

Very loose fitting *(upper body outline completely obscured)* ☐ Average fitting *(upper body could be seen - but not too loose or tight)* ☐ Very tight fitting *(skin tight clothing)* ☐

Loose fitting *(upper body outline obscured, but could be seen)* ☐ Tight fitting *(upper body outline could be seen)* ☐

v) For each resident, on a scale of 1 to 5, with 1 representing completely obscure and 5 representing transparent, how transparent or "see through" do you think the item of clothing is? Transparency meaning whether underwear (i.e. vests etc) could be seen through clothing). ***Please tick one box only for each resident.***

SU1 ☐☐☐☐☐☐

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU2 ☐☐☐☐☐☐

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU3 ☐☐☐☐☐☐

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU4 ☐☐☐☐☐☐

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU5 ☐☐☐☐☐☐

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

vi) In terms of the upper body of each resident, please indicate in the boxes provided, which parts of the anatomy, were exposed or uncovered by clothing. ***Please tick all that apply.***

SU1 ☐☐☐☐☐☐

Hands ☐	Elbows ☐	Forearm (Elbow to Wrist) ☐	Shoulder ☐	Waist ☐
Wrists ☐	Neck ☐	Upper arm (Elbow to Shoulder) ☐	Chest ☐	Clavicle/Collar bone ☐

SU2 ☐☐☐☐☐☐

Hands ☐	Elbows ☐	Forearm (Elbow to Wrist) ☐	Shoulder ☐	Waist ☐
Wrists ☐	Neck ☐	Upper arm (Elbow to Shoulder) ☐	Chest ☐	Clavicle/Collar bone ☐

SU3 ☐☐☐☐☐☐

Hands ☐	Elbows ☐	Forearm (Elbow to Wrist) ☐	Shoulder ☐	Waist ☐
Wrists ☐	Neck ☐	Upper arm (Elbow to Shoulder) ☐	Chest ☐	Clavicle/Collar bone ☐

SU4 ☐☐☐☐☐☐

Hands ☐	Elbows ☐	Forearm (Elbow to Wrist) ☐	Shoulder ☐	Waist ☐
Wrists ☐	Neck ☐	Upper arm (Elbow to Shoulder) ☐	Chest ☐	Clavicle/Collar bone ☐

SU5 ☐☐☐☐☐☐

Hands ☐	Elbows ☐	Forearm (Elbow to Wrist) ☐	Shoulder ☐	Waist ☐
Wrists ☐	Neck ☐	Upper arm (Elbow to Shoulder) ☐	Chest ☐	Clavicle/Collar bone ☐

LOWER BODY (WAIST TO FEET)

vii) For each resident, please indicate in the boxes provided, which item of clothing was worn on the lower part of the body. ***Please tick all that apply.***

SU1

Trousers ☐ Shorts ☐ Leggings ☐ Shoes ☐ Other ☐ Please state

SU2

Trousers ☐ Shorts ☐ Leggings ☐ Shoes ☐ Other ☐ Please state

SU3

Trousers ☐ Shorts ☐ Leggings ☐ Shoes ☐ Other ☐ Please state

SU4

Trousers ☐ Shorts ☐ Leggings ☐ Shoes ☐ Other ☐ Please state

SU5

Trousers ☐ Shorts ☐ Leggings ☐ Shoes ☐ Other ☐ Please state

viii) For each resident, please indicate in the boxes povided, how tight fitting the clothing items were on the lower part of the body. ***Please tick one box only.***

SU1

Very loose fitting *(lower body outline completely obscured)* ☐ Average fitting *(lower body could be seen - but not too loose or tight)* ☐ Very tight fitting *(lower body could be clearly seen i.e. skin tight clothing)* ☐

Loose fitting *(lower body outline obscured, but could be seen)* ☐ Tight fitting *(lower body outline could be seen)* ☐

SU2

Very loose fitting *(lower body outline completely obscured)* ☐ Average fitting *(lower body could be seen - but not too loose or tight)* ☐ Very tight fitting *(lower body could be clearly seen i.e. skin tight clothing)* ☐

Loose fitting *(lower body outline obscured, but could be seen)* ☐ Tight fitting *(lower body outline could be seen)* ☐

SU3

Very loose fitting *(lower body outline completely obscured)* ☐ Average fitting *(lower body could be seen - but not too loose or tight)* ☐ Very tight fitting *(lower body could be clearly seen i.e. skin tight clothing)* ☐

Loose fitting *(lower body outline obscured, but could be seen)* ☐ Tight fitting *(lower body outline could be seen)* ☐

SU4

Very loose fitting *(lower body outline completely obscured)* ☐ Average fitting *(lower body could be seen - but not too loose or tight)* ☐ Very tight fitting *(lower body could be clearly seen i.e. skin tight clothing)* ☐

Loose fitting *(lower body outline obscured, but could be seen)* ☐ Tight fitting *(lower body outline could be seen)* ☐

SU5

Very loose fitting *(lower body outline completely obscured)* ☐ Average fitting *(lower body could be seen - but not too loose or tight)* ☐ Very tight fitting *(lower body could be clearly seen i.e. skin tight clothing)* ☐

Loose fitting *(lower body outline obscured, but could be seen)* ☐ Tight fitting *(lower body outline could be seen)* ☐

ix) For each resident, on a scale of 1 to 5, with 1 representing completely obscure and 5 representing transparent, how transparent or "see through" do you think the item of clothing is? Transparency meaning whether underwear (i.e. vests etc) could be seen through clothing. ***Please tick one box only for each resident.***

SU1

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU2

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU3

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU4

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

SU5

☐ 1- Completely obscure ☐ 2 ☐ 3 ☐ 4 ☐ 5 -Transparent

x) In terms of the lower body of each resident, please indicate in the boxes provided, which parts of the anatomy, were exposed or uncovered by clothing. ***Please tick all that apply.***

SU1

Ankle ☐ Shins ☐ Knees ☐ Upper leg (Knees to top of the Leg) ☐ Lower leg (Knees to Foot) ☐ Feet ☐

SU2

Ankle ☐ Shins ☐ Knees ☐ Upper leg (Knees to top of the Leg) ☐ Lower leg (Knees to Foot) ☐ Feet ☐

SU3

Ankle ☐ Shins ☐ Knees ☐ Upper leg (Knees to top of the Leg) ☐ Lower leg (Knees to Foot) ☐ Feet ☐

SU4

Ankle ☐ Shins ☐ Knees ☐ Upper leg (Knees to top of the Leg) ☐ Lower leg (Knees to Foot) ☐ Feet ☐

SU5

Ankle ☐ Shins ☐ Knees ☐ Upper leg (Knees to top of the Leg) ☐ Lower leg (Knees to Foot) ☐ Feet ☐

25. For each resident, please identify other observations about clothing where relevant. Please tick *Yes* if the statement applies, *No* if it doesn't and leave blank if you haven't seen the resident for any reason. ***May need to ask staff for clarification.***

SU1

	Yes	No
Do clothes exceed the residents ankles?	☐	☐
During prayer, are residents covered with clothing?	☐	☐
Are male residents wearing silk clothing?	☐	☐
Are male residents wearing gold jewellery?	☐	☐
Do clothes have attention worthy patterns i.e. vivid and bright colours, lots of patterns?	☐	☐
Are clothes dyed with saffron (yellow, red/yellow)	☐	☐
Are clothes comparable to the opposite sex? *i.e. are male residents wearing female clothing; are female residents wearing male clothing*	☐	☐
Do residents appear to be wearing night clothes for the majority of the day?	☐	☐
Do women appear to be wearing wigs or weaves?	☐	☐

SU2

	Yes	No
Do clothes exceed the residents ankles?	☐	☐
During prayer, are residents covered with clothing?	☐	☐
Are male residents wearing silk clothing?	☐	☐
Are male residents wearing gold jewellery?	☐	☐
Do clothes have attention worthy patterns i.e. vivid and bright colours, lots of patterns?	☐	☐
Are clothes dyed with saffron (yellow, red/yellow)	☐	☐
Are clothes comparable to the opposite sex? *i.e. are male residents wearing female clothing; are female residents wearing male clothing*	☐	☐
Do residents appear to be wearing night clothes for the majority of the day?	☐	☐
Do women appear to be wearing wigs or weaves?	☐	☐

SU3

	Yes	No
Do clothes exceed the residents ankles?	☐	☐
During prayer, are residents covered with clothing?	☐	☐
Are male residents wearing silk clothing?	☐	☐
Are male residents wearing gold jewellery?	☐	☐
Do clothes have attention worthy patterns i.e. vivid and bright colours, lots of patterns?	☐	☐
Are clothes dyed with saffron (yellow, red/yellow)	☐	☐
Are clothes comparable to the opposite sex? *i.e. are male residents wearing female clothing; are female residents wearing male clothing*	☐	☐
Do residents appear to be wearing night clothes for the majority of the day?	☐	☐
Do women appear to be wearing wigs or weaves?	☐	☐

SU4

	Yes	No
Do clothes exceed the residents ankles?	☐	☐
During prayer, are residents covered with clothing?	☐	☐
Are male residents wearing silk clothing?	☐	☐
Are male residents wearing gold jewellery?	☐	☐
Do clothes have attention worthy patterns i.e. vivid and bright colours, lots of patterns?	☐	☐
Are clothes dyed with saffron (yellow, red/yellow)	☐	☐
Are clothes comparable to the opposite sex? *i.e. are male residents wearing female clothing; are female residents wearing male clothing*	☐	☐
Do residents appear to be wearing night clothes for the majority of the day?	☐	☐
Do women appear to be wearing wigs or weaves?	☐	☐

SU5

	Yes	No
Do clothes exceed the residents ankles?	☐	☐
During prayer, are residents covered with clothing?	☐	☐
Are male residents wearing silk clothing?	☐	☐
Are male residents wearing gold jewellery?	☐	☐
Do clothes have attention worthy patterns i.e. vivid and bright colours, lots of patterns?	☐	☐
Are clothes dyed with saffron (yellow, red/yellow)	☐	☐
Are clothes comparable to the opposite sex? *i.e. are male residents wearing female clothing; are female residents wearing male clothing*	☐	☐
Do residents appear to be wearing night clothes for the majority of the day?	☐	☐
Do women appear to be wearing wigs or weaves?	☐	☐

lease use this section to note down any further observations not outlined above relating to any bservations around the care home, which reflects cultural need

Section 6.4 Health and Cultural Issues

26. In terms of the evening meal, were all residents given the same meal? If residents were given different meals, please complete question 28. ***Please tick one box only.***

- ☐ No
- ☐ Some were
- ☐ Yes

27. If residents were given the same meal, please write a description of the foods served.

28. If residents had different meals, for each resident, please provide a description of foods served.

29. Were residents eating at the same time? If NO, please provide a reason as to why. *(May need staff clarification).*

Comments/evidence

- ☐ No
- ☐ Some were
- ☐ Yes

30. Was there any evidence of specially prepared foods such as Halal meat, Kosher foods? *(May need to ask staff)*

Comments/evidence

- ☐ No
- ☐ Yes

31. Was there any evidence of any separate food utensils used for separate food groups such as for meats and dairy products? ***Please tick one box only.***

Comments/evidence

- ☐ No
- ☐ Yes

32. Was there any evidence of any meals and wheels services (or assistance from outside sources) for types of food? ***Please tick one box only.***

Comments/evidence

- ☐ Yes
- ☐ No
- ☐ Not observed

Please use this section to note down any further observations not outlined above relating to any observations around the care home, which relates specifically to health related cultural needs.

Section 6.5: Other cultural needs

33. Were other religious festivals (other than the Christian denomination festivals) acknowledged and celebrated within the home? ***Please tick one box only.***

Please give details

- ☐ No
- ☐ Some were
- ☐ Yes

Please use this section to note down any further observations relating to minority cultural issues not outlined above.

Cultural Care Home Observational Toolkit - Handbook

Cultural Care Home Observational Toolkit
Handbook for observers

The overall aim of the cultural observational toolkit is explore whether services are sensitive to cultural diversity for residents from minority cultural groups, such as individuals from black and ethnic minority groups. The focus of the cultural observational toolkit will be to determine, via observation, as to whether care homes are aware and actively responsive to needs from individuals from cultural groups. In particular, whether needs specific to cultural group (identified from the cultural questionnaire information) and other cultural level needs (identified as important from previous research) are being met within care homes.

Cultural group:

Referring to a resident from a minority ethnic group (i.e. non White British AND/OR a resident from a non mainstream religion (i.e. non Christian denominations).

Procedure
At the end of day 1 or day 2, read through and complete the cultural observational toolkit (Section 6 of the observational toolkit). For each response, it will be necessary to make note of any observations used to support each rating.

Focus throughout the observations will be directed at the cultural residents from the five focal residents of the sample only.

Cultural Care Home Observational Toolkit (CCHOT)

The CCHOT is divided into five sections:

- Section 6.1: Quality of staff supports and cultural needs
- Section 6.2: Physical environment
- Section 6.3: Quality of care process
- Section 6.4: Health and cultural issues
- Section 6.5: Other cultural needs

1) SECTION 6.1: QUALITY OF STAFF SUPPORTS AND CULTURAL NEEDS

The aim of this section is to explore whether the quality of staff support differs between residents from a cultural group and residents from a non-cultural group.

Questions have been designed to cover the following areas:

- Dignity and respect
- Communication
- Staff-Knowledgeable
- Teamwork

DIGNITY AND RESPECT

Dignity consists of many overlapping aspects, involving respect, privacy, autonomy and self-worth. The provisional meaning of dignity, based on a standard dictionary definition: *a state, quality or manner worthy of esteem or respect; and (by extension) self-respect*

1. Question 1: **In terms of dignity and respect, did staff treat residents from cultural backgrounds differently from non-cultural residents?**

Each person is an individual and has different needs. Staff should be responsive to individual levels of needs and treat residents with the same levels of dignity and respect regardless of cultural background. The aim of this question is to determine whether during the visit, any differences between residents by staff were observed in terms of dignity and respect.

COMMUNICATION

Essence of care (DH, 2003c) defined communication as a process that involves a meaningful exchange between at least two people to convey facts, needs opinions, thoughts, feelings or other information through both verbal and non-verbal means, including face-to-face exchanges and the written word.

The CCHOT will be exploring communication in both the verbal, non-verbal and written sense.

Communication-verbal: CV

2. Question 2.: **Did staff have different communication styles for residents from cultural backgrounds than residents from non-cultural backgrounds? For example, did staff speak louder, or use 'pidgin' (simplified broken language) with cultural residents?**

This question is important has it focused at whether staff during the visit, change their communication styles for cultural residents in comparison with residents from non-cultural groups. In other words, do staff speak in different tones, paces, differing complexity of speech with cultural residents as opposed to residents from a non-cultural background? Staff should be aware and very familiar with residents' language abilities and adapt their communication styles accordingly. Regardless of levels of resident's competency with English, do staff seem to make the assumption that residents from cultural background require different communication styles?

3. Question 3: **Did staff use different languages to interact with cultural residents?** *If bilingual languages were used by staff and if observers are unfamiliar with different languages spoken, please ask staff*

Observing the availability and accessibility of staff using bi-lingual skills may be important for some residents, particularly those unfamiliar with English. Having the availability of bi-lingual staff reduces the chances of confusion from the staff perspective of discovering the residents' requests and needs. Furthermore, residents may feel increasingly isolated if the remaining individuals within the home are unable to communicate with others.

4. Question 4: **Were staff immediately available, fluent and equipped with bilingual skills to communicate with residents?** *May need to ask staff*

Having a staff member immediately available who is familiar with languages most familiar to them could be important for some residents. Having an interpreter or bi-lingual staff immediately available for staff is different from having bi-lingual staff on the few occasions or dependent on shift.

5. Question 5: **Did staff attempt to verbally communicate with all residents (both cultural and non-cultural groups)?**

In other words, are levels of verbal communication different between cultural residents and residents from non-cultural groups? Considering of competency of English and levels of dependency of residents, staff should be verbally communicating with all residents regardless of cultural group.

6. Question 6: **Did residents from cultural backgrounds appear to understand and respond to staff communication?**

Taking into account residents abilities and dependency on services; residents belonging cultural groups, particularly from older generations maybe unfamiliar with dialects and colloquial words used within a particular language. Staff may claim to be able to speak similar languages, but residents maybe familiar with particular dialects etc that a staff member maybe unfamiliar with.

Communication- (non verbal): CNV

Non-verbal communication (for example, smile, eye contact, touch etc) is as important as verbal communication. Non-verbal communication can tell you a lot about the relationships in the facility. Smiles, eye contact and touch indicate friendly, caring relationships.

7. Question 7: **Did staff attempt to communicate non-verbally with all residents? For example, if a resident was unfamiliar with English by using few non-verbal communication such as gestures, i.e. waving, smiling etc.**

This item is aiming to explore whether non-verbal behaviours are noted from staff with all residents. For example, do staff irrespective of whether the person can or cannot speak English attempt to use some form of non-verbal communication to encourage interaction.

8. Question 8: **If staff communicated non-verbally with all residents, did it differ for residents from cultural backgrounds than residents from non-cultural backgrounds?**

This item is attempting to highlight whether staff use different forms of non-verbal behaviours between groups. Did usage of non-verbal behaviours differ between residents from cultural and non-cultural groups?

Communication-Written: **CW**
Written information could be in the form of books, leaflets, information on activities etc. Failure to have translated information available for individuals who are unfamiliar with English may potentially increase feelings of isolation and unfamiliarly with care home protocols. Moreover, production of written information in the English language only could potentially imply to other residents and staff that such needs are insignificant and inelevant.

9. Question 9: **Did the care home have accessible written information published in other languages besides English?**

This item is about whether written information is available and presented in different languages other than English within the care home. This item is concerned with whether information presented in different languages is observed to be within easy access for residents.

Accessibility is defined in this sense by having information easily available that is information available around the home, not just restricted to office spaces. For example, is translated information available in living areas or is such information accessible only within locked offices?

KNOWLEDGEABLE

10. Question 10 (KN): **Did all staff appear to be knowledgeable, committed and sensitive to needs for cultural groups?**

All staff should be aware of all residents' needs, abilities and requirements. In doing so, staff should appear to be knowledgeable about residents needs. Staff should be aware of needs and requirements which may be present, more so for cultural residents, such as dietary and personal cleanliness requests. In doing so, all staff should be aware and knowledgeable of such requests and tailor their levels of interaction and care accordingly. Staff should be willing and sensitive to meeting such requests without resistance.

TEAMWORK

11. Question 11 (TE): **Did all staff appear to work as a team with regards to maintaining sensitivity to cultural issues?**

This item is exploring whether all staff are working as a team with cultural issues. For example, are all staff involved and sensitive towards cultural issues, or is issues of cultural diversity the responsibility of staff members from black and minority backgrounds?

2) SECTION 2: PHYSICAL ENVIRONMENT

The physical environment of a dwelling has been found to have important areas of concern for some cultural groups, particularly for residents practicing religious faiths.

RELIGIOUS ITEMS

12. Question 12: **Did the care home contain religious symbols or items? For example, within residents' rooms, hallways, public and common areas contain religious images or objects such as crucifixes?**

If residents' main religion is different from the Christian faith, within the home, was there any evidence of religious items relating to different faiths? Religious items such as holy books, holy pictures, statues and beads must be treated with great respect. They should be moved only if it is essential and then only with clean hands. Within this question, if religious items are moved, consider whether these items have been moved with respect. Are items moved without clean hands? Are religious items moved without thought or care

BATHROOMS

13. Question 13: **Within bathrooms, was there evidence of a bidet, basin or jugs to allow for residents to wash themselves with running water after occurrences of elimination?**

In traditional South Asian culture, maintaining personal cleanliness through usage of running water is linked to spiritual pollution and purity. Ideally, staff should provide a bidet or jugs in each lavatory to enable people to wash themselves with running water after using the lavatory.

PRAYER LOCATIONS

14. Question 14: **Within the care home, was there any evidence of accessible prayer locations within the home?**

Prayer is an essential part of some religions.

As prayer is such an important part of a person's life for some cultures, it is important to note whether there are any prayer locations located within the home. The mere presence of a room used for prayer could be an important aspect of a service for certain groups. This question is looking at whether there is a space within cares homes designed to cater for groups who may wish to pray.

In considering prayer, it would also be interesting to note any staff interactions in relation to prayer. During the observations is staff respectful of individual prayer times?

Also note whether staff consider separating males and females during prayer

3) SECTION 3: ADAPTATION OF THE NURSING HOME CARE QUALITY INSTRUMENT –CULTURAL ISSUES

PERSONAL CLEANLINESS

PRIVACY

15. Question 15 **Were residents able to lock and close doors during sessions of personal cleanliness?**

During the observations it would be important to note whether residents have the option of closing and locking doors during sessions of personal cleanliness. For example, do staff insist of having doors open during sessions of personal care? If a resident has closed a door to elicit personal care, do staff walk into rooms without knocking etc. Do staff allow for residents to lock doors during personal care? Were locks present on the doors?

Take note that observers should NOT enter bathrooms and/or bedrooms during personal care sessions

16. Question 16: **In situations of personal care, did staff ensure that all doors were closed or screened, or that bed curtains were completely drawn?** *Please tick one box only*

During personal care, staff should be ensuring that all doors should be closed or screened or that bed curtains were completely drawn?

17. Question 17: **When a staff worker entered a room to help administer intimate care, examinations and practical care for residents, did someone of the same-sex to the resident administer this care?** *Please tick one box only*

It is important that during intimate personal care sessions, staff ensure that residents have the choice and option to be assisted with same gender staff to the resident. During the observations, in situations of personal care, did residents have the option of being cared for by staff from different genders? Were male staff workers caring for female residents during personal care sessions?

18. Question 18: **Did residents have unrestricted access to personal cleaning facilities in order to maintain high levels of personal hygiene?** *Please tick one box only*

Maintaining high levels of personal hygiene is an important and significant area for cultural groups. Staff should be maintaining high levels of cleanliness and allow for residents to use cleanliness facilities with unrestricted access. Staff should therefore allow for residents to use these facilities at their own request. Staff should be sensitive and aware of the significance of maintaining high levels of cleanliness.

19. Question 19 **Were residents from cultural backgrounds seen to access special skin care products such as oils and moisturisers?** *Please tick one box only*

Staff should be aware that darker skin requires additional and increased care. This question is looking at whether residents have skin products such as moisturisers available in order to maintaining good skin health. Are skin products such as moisturisers available for people with darker skin to use? Within the residents bedrooms or bathrooms, were there any skin products designed for darker skin?

20. Question 20 **Was residents' hair well groomed? (Hair combed, healthy looking-not dry)** *Please tick one box only*

Hair care is an important issue for people from cultural groups in terms of ethnic group and religious belief.
Given the care needed for Afro hair, staff should be aware and responsive to this hair care needs. During the observations, observe whether individuals with Afro hair appeared to be dry or unhealthy looking. Unhealthy Afro hair could be an indication that services are not responding to this individual need.
Well-groomed hair has significance for some cultural groups, particularly for Muslim residents. Residents should therefore have neat, tidy and presentable groomed hair.

21. Question 21 **Did staff consult with residents whether they wanted their hair cut or shaved?** *Please tick one box only*

For South Asian cultures, the head is traditionally regarded as sacred and is not touched by others without good reason. Staff should check and consult with residents as to whether they wish to have their haircut. Furthermore, staff should be sensitive to cultural beliefs associated with cutting hair. For example, long hair has been known to symbolise spirituality. Moreover, practicing Sikhs are forbidden from cutting hair.

22. Question 22 **Did staff consult with residents how they would like their hair to be cared for?** *Please tick one box only*

Individuals may have specific ways for caring for hair. If staffs are unsure about hair care, staff should be consulting with residents (or staff) on the best ways to care and look after hair. In other words, hair care should be reflective of the individuals hair care needs.

23. Question 23 **Were residents able to access special hair care products such as wide toothcombs and oil for black hair to use at their own request?** *Please tick one box only*

As noted in question 20, black hair requires additional care needs. Residents should be able to access hair care products in order to maintain healthy hair. During the visit, look out for hair products designed for black hair.

24. Question 24: Clothes

Clothing
Clothes are strongly influenced by our cultural and religious values, including our ideas of modesty. Modesty comprises a set of culturally or religiously determined values that relate to the presentation of the self to others. Many religions and traditional cultures require people to dress more modestly than is customary in the West today. In order to explore clothing requirements or guidelines for cultural groups, the next section attempts to explore how clothing differs between cultural groups. As gender is an important issue with clothing requirements and cultural groups, males and females within cultural groups will be explored separately. The purpose of this section is to provide a series of guidelines of clothing worn by males and females to be looking out for during the observations within care homes. As residents may be wearing clothes, which are applicable to a cultural group, examples of clothing worn by cultural groups have been provided.

The underlying objective of the CCHOT is to determine whether staffs within care homes are responsive to cultural guidelines such as with clothing. For example, consider an Islamic elderly female resident within a care home. Part of the Islamic faith for all females is to maintain high levels of modesty at all times, particularly in public and a mixed gender environment. In order to maintain levels of modesty for Muslim females, Islamic guidelines outline that clothing should cover the female, in some cases, from head to toe. In other words, an Islamic female should not be

dressed in clothing, which exposes parts of the anatomy, which should be covered. Care home staff should therefore be responsive to this need; staff should not place a vulnerable resident with an Islamic faith in clothing, which exposes large parts of the anatomy. In this section, aspects of clothing for males and females will be further divided into headwear and clothes of the upper and lower body. For each of these divisions, guidance or requirements for each cultural group will be explored. This guidance has included the following:

- Examples of headwear (males and females)
- Examples of cultural clothing of the upper and lower body (males and females)
- Cultural issues associated with headwear (males and females)
- Cultural issues associated with clothing of the upper and lower body (males and females)
  - Covering and maintaining modesty for males and females
  - Loose fitting of clothing for males and females
  - Other issues for males and females.

For the purposes of clarity and comparisons purposes, guidelines or requirements have been summarised through usage of tables. A [√] represents a requirement for a particular aspect, for example, parts of the anatomy, anatomical parts which are required to be covered. A [√√] represents the beliefs of orthodox women. A [√*] represents a requirement according to particular situation.

CLOTHING AND FEMALES (QUESTION 24a)

CLOTHES: HEADWEAR (Females)

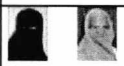
Table 1 provides a summary of headwear worn by females from different religious faiths. As shown from Table 2, females of the Islamic and Jewish faith are expected (particularly for married women) to wear some form of headwear in order to preserve modesty. Table 2 provides visual examples of headwear worn by religious groups.

Table 1-Headwear split by cultural group

	Muslim	Hinduism	Judaism	Sikhism
Headwear	√	√*	√√*	√
		By choice	*=Marriage particularly	

From Table 1, Muslim, Hindu, Jewish and Sikh females are to an extent required to wear some form of headwear. All practicing Muslim females (unless out of choice) should therefore be wearing some form of headwear. In particular an Islamic veil. Headwear for Hindu females is not an essential issue for some Hindus, although headwear maybe worn during worship. All married Jewish females should be wearing some form of headwear. Jewish women may or may not be wearing headwear depending on how orthodox their views are.

Table 2-Examples of headwear

Headwear items	Visual examples of headwear	Cultural group
		All
TUQUE: *A knitted hat*		All
VEIL: **Hajjab** *A square scarf which covers the head and neck but leaves the face clear*		Islam
VEIL: **Niqab**: *The niqab is a veil for the face that leaves the area around the eyes clear.*		Islam
VEIL: **Burka**: *The Burka is a veil that covers the entire face and body, leaving just a mesh screen to see through*		Islam
Other Veils **Al-Amira:** *The al-amira is a two-piece veil. It consists of a close fitting cap, usually made from cotton or polyester, and an accompanying tube-like scarf.* **Khimar**: *is a long, cape-like veil that hangs down to just above the waist. It covers the hair, neck and shoulders completely, but leaves the face clear.*	  **Al-Almira** (Muslim) **Khimar** (Muslim)	All
HAIR COVERING ITEMS Ie. Headscarf, Bandana	  Bandana Headscarf	All
OTHER: *Please state* **Turban/Pagri** The turban is a headdress consisting of a long scarf-like single piece of cloth wound round the head or an inner hat. **Chunni or Dupatta** Is a long scarf that is essential to many Indian and South Asian women's suits.	  Turban and a Chunni	Sikh

CLOTHES: UPPER BODY AND LOWER BODY (Females)

Covering
Different religions differ in terms of how conservatively women should dress and cover the upper and lower body. Table 3 provides a summary of parts of the anatomy, which are required or suggested to be covered split by religious groups. The Islamic and Jewish faiths have particular guidelines and requests in relation to covering and clothing. Anatomical parts allocated with a tick [√] indicate parts, which are suggested to be covered according to religious belief. However, it should be noted that these are particular *guidelines* of parts of the anatomy, which should be covered, depending on cultural belief. However, covering of the body, varies according to how orthodox the person is

Table 3

	Muslim	Hinduism	Judaism	Sikhism
Hands	√√ (only)			
Wrists	√√			
Elbows	√		√	
Neck	√			
Forearm (Elbow to Wrist)	√√			√
Upper arm (Elbow to Shoulder)	√	√	√	√
Shoulder	√		√	√
Chest	√	√	√	√
Waist	√		√	√
Clavicle/Collar bone	√		√	√
Ankle	√	√	√	√
Shins	√	√	√	√
Knees	√	√	√	√
Upper leg (Knees to top of the leg)	√	√	√	√
Lower leg (Knees to foot)	√	√	√	√

Summary
Physical modesty is extremely important in most South Asian communities, especially for more conservative and older people. Backless gowns and garments that leave the legs bare are immodesty and degrading for many women, particularly in the presence of strangers. Women traditionally cover their legs, upper body and upper arms. Some women, such as Muslims, Jewish and Sikh women keep themselves covered at all times.

Tight fitting?
As shown from Table 4, females from Muslim and Jewish faiths are required to be dressed in clothes, which are loose fitting and obscure the outline of the body.
Table 4-Tight fitting clothes, split by religious belief

	Muslim	Hinduism	Judaism	Sikhism
Very loose fitting (lower body outline completely obscured)	√		√	
Loose fitting (lower body obscured, but could be seen)				
Average fitting (lower body could be seen-but not to loose or tight)				
Tight fitting (lower body outline could be seen)				
Very tight fitting (lower body could clearly be seen i.e. skin tight clothing).				

Summary: Clothing observational cues
- Observant Muslim and Jewish women should be dressed in loose fitting clothes

Transparency
Females are required by some cultures to wear clothes, which obscure undergarments such as bras and vests. Exposure of undergarments through clothing could be extremely distressing to some residents from cultural groups where a high level of modesty is paramount. Therefore, during the observations, underwear should be completely obscure and invisible from view.

CLOTHES: MAIN BODY GARMENTS (Females)
Many women wear traditional styles that reflect their background, culture and religion. Some South Asian women who wear Western clothes prefer to keep their legs covered with trousers or a long skirt. They may change into traditional clothes when in their own community and when relaxing.
During the observations, female residents maybe wearing items which are specific to religious groups. Table 5 provides some of examples of clothing items worn by females from cultural groups. If the five focal residents wear any of these clothing items, please make note of the garment worn

Table 5-Some examples of cultural clothing (females)

Clothing	Visual examples of clothes	Group
SARI A sari is a strip of unstitched cloth ranging from four to nine metres in length that is draped over the body in various styles. The most common style is for the sari to be wrapped around the waist with one end then draped over the shoulder baring the midriff.The sari is usually worn over a petticoat (*pavadai/pavadai* in the south, and *shaya* in eastern India), with a blouse known as a *choli* forming the upper garment.		Traditional Indian dress
CHOLI: It is worn with a sari. The *choli* is a tight-fitting top with a bare midriff and an open back. It has a rounded neckline; some have ties at the back neck and across the shoulder blades. It was originally served as a bust support but now often replaced with commercial blouses.		Traditional Indian dress
SALWAR KAMEEZ It consists of a tunic (*kameez*) covering loosely fitting trousers (*salwar*).		Traditional Indian dress

CHAGRA It is a pleated or gathered skirt reaching to mid-shin/ankle length, which may use up 20 to 30 yards of fabric. Worn with a choli or kameez		Traditional Indian dress
KURTA It is a loose shirt falling either just above or somewhere below the knees of the wearer, and is worn by both men and women		Traditional Indian dress
JILBAB The jilbab is an outer garment or over garment which could be a robe, coat, dress which covers all but the head and hands and worn over the regular clothing.		Islamic
ABAYA An abaya is a cloak like garment, which covers all, but the head and hands.		Islamic

Other issues (females)
In terms of clothing, during observation, for female residents, it will be important to look out for items such as the following:

- **Nightclothes?**

Are females dressed in nightclothes for the majority of the day?

- **Resemble male clothing?**

Are females dressed in clothes, which resemble clothes worn by males?

- **Attention worthy?**

Are clothes particularly attention worthy?

- **Wigs or Weaves?**

Do women appear to be wearing wigs or weaves?

- **Jewellery**

In most cases, there is no need to ask anyone to remove jewellery or other items with religious or cultural significance. Religious jewellery should be treated with respect.

CLOTHING AND MALES (QUESTION 24b)
CLOTHES: HEADWEAR (Males)
Table 6 provides a summary of headwear worn by males.

	Muslim	Hinduism	Judaism	Sikhism
Headwear	√ (By choice)		√	√

From Table 6, observant Jewish and Sikh males particularly should be wearing some form of headwear. Table 7 provides some examples of headwear worn by males.

Table 7-Examples of headwear

Headwear items	Examples	
		All
TUQUE: *A knitted hat*		All
TURBAN Is a headdress consisting of a long scarf like single piece of cloth wound round the head or an inner hat		Sikh
KUFI or KUFI CAP A brimless, short, rounded cap		Islam
KIPPAH or YARMULKE A "small cap" sometimes known as *yarmulke* sometimes rendered *yamelke* or *yamulka*, is a thin, slightly-rounded skullcap traditionally worn at all times by Orthodox Jewish men		Jews
HAIR COVERING ITEMS I.e. Headscarf, Bandana	 Headscarf Bandana	All
OTHER: *Please state* **PATKA** A turban worn by young Sikh males	 Patka (Sikh)	

CLOTHES: MAIN BODY GARMENTS (Males)

Many South Asian men wear Western style shirt and trousers outside the home, but may relax in traditional dress.

During the observations, male residents maybe wearing items which are specific to religious groups. Table 8 provides some of examples of clothing items worn by males from cultural groups.

If the five focal residents wear any of these clothing items, please make note of the garment worn.

Table 8-Some examples of cultural clothing-Males

Clothing	Visual examples of clothes	Group
SHERWANI It is a coat like suit, worn by men, fitted close to the body, of knee-length or longer and opening in front with button-fastenings. It is worn together with a pair of drawstring pants, which is floppy and wide at the top and tied with a string at the waist, and also around the legs and ankles. It is a very elegant outfit for the men and mostly worn during ceremonies.		Traditional Indian dress
KURTA-PYJAMA The Kurta or the top is a knee length collarless shirt that is adorned in mostly white or pastel colours. But today you will find Kurtas made out of the most wonderful and colourful of fabrics. It is worn together with a pair of pyjama like loose white trousers with a string tied at the waist.		Traditional Indian dress Sikh
GALABEYA / THAWB/ MALE HAIJAB A thawb/ thobe, is an ankle-length garmenet ussually with long sleeves similar to a robe.		Islamic
TALLET Worn on the shoulders during prayer		Jewish
TEFFILIN Worn on the arm during prayer or when reading the Torah.		Jewish

UPPER BODY AND LOWER BODY (Males)

Covering

Traditionally, for South Asian cultures, men cover themselves from the waist to the knees. To be naked, even in the presence of other men, may be very humiliating. Religions such as the Islamic and Jewish faith have particular *guidelines* of parts of the anatomy, which should be covered. However, covering of the body, varies according to how orthodox the person is. While Muslim men are allowed in Islam to expose more of the body than Muslim females in faith, it is preferred for men to cover themselves fully and we find that Muslim men all over the world tend to wear conservative clothing and even cover their heads in public. For Muslim men, the minimum amount to be covered is between the navel and the knee. For many Hindus, modesty is a religious requirement. Observant Jews are required to dress modestly.

Table 9 provides a summary of anatomical parts of the body, which have been suggested to be covered by particular faiths. Anatomical parts allocated with a tick [√] indicate parts, which are suggested to be covered split by religion.

Table 9-Covering for males; split by religious belief

	Muslim	Hinduism	Judaism	Sikhism
Hands				
Wrists				
Elbows	√			
Neck	√			
Forearm (Elbow to Wrist)	√			
Upper arm (Elbow to Shoulder)	√			
Shoulder	√			
Chest	√			
Waist	√	√		√
Clavicle/Collar bone	√			
Ankle	√	√		√
Shins	√	√		√
Knees	√	√		√
Upper leg (Knees to top of the leg)	√	√		√
Lower leg (Knees to foot)	√	√		√

As shown from Table 9, males from the Islamic, Hindu and Sikh faiths are expected to have specific parts of the body covered.

Tight fitting

Table 10 provides a summary of these guidelines of how tight fitting a garment should be. As shown from Table 10, the Islamic male Muslim should wear clothes are of a loose fit.

Table 10-Tight fitting clothes split by religious belief

	Muslim	Hinduism	Judaism	Sikhism
Very loose fitting (lower body outline completely obscured)	√			
Loose fitting (lower body obscured, but could be seen)				
Average fitting (lower body could be seen-but not to loose or tight)				
Tight fitting (lower body outline could be seen)				
Very tight fitting (lower body could clearly be seen i.e. skin tight clothing).				

Transparency

For males, exposure of undergarments through clothing could be extremely distressing to some residents from cultural groups where a high level of modesty is paramount. Therefore, during the

observations, underwear should be completely obscure and invisible from view.

Other issues

25. Question 25-Any further observations

- Length of garment

Consider the length of the garment. Do clothes exceed the residents ankles?

- Covered during prayer

During prayer, are residents covered with clothing?

- Silk

Are male residents wearing silk items?

- Jewellery

Are male residents wearing gold jewellery?

- Patterned clothing

Are clothes covered in attention worthy clothes?

- Coloured garments

Are clothes dyed with saffion (yellow, red/yellow) colours?

- Resemble female clothes?

Are clothes comparable to female clothing?

Section 6.4 Health and cultural issues

DIETARY REQUIREMENTS: (QUESTION 26-32)
Some cultural groups have restrictions on some foods. During the observations, it will be necessary to observe the foods consumed (food groups) and the nature of the meal.
Food group (Question 26-28)
During the observations, please note the foods consumed as part of the meal. Food groups are important area for concern for religious groups. Table 11 provides a summary of the types of foods consumed split by religious group. A [√] represents foods which are consumed although this has restrictions; an [X] represents a food, which is forbidden. An empty space indicates that the food group is consumed. Questions 26-29 require descriptions of the foods consumed. If residents are given foods, which are considered problematic or forbidden, this could be an important area of concern for some residents. In considering foods, residents may consume foods, which are traditional cultural foods. Table 12 provides some visual examples of multi-cultural meals.
Summary-Table 11

- **Muslims are only allowed to Halal meats.**
- **Jews are only allowed to eat Kosher prepared meats.**
- **Sikhs are only allowed to eat Jahtka prepared meats only.**
- **Pork products are forbidden for Muslims, Hindus, Jews and in some cases Sikhs.**
- **Hindus are forbidden to eat any type of food products derived from animal produce. All foods should be clear of animal products.**
- **All Muslims, Hindus and Sikhs consume fruits and vegetables. However, Jews only consume fruits and vegetables if its dirt free.**
- **Alcohol is forbidden by Muslims.**
- **Shellfish is forbidden by Hindus and Jews**

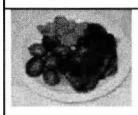
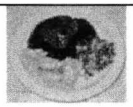
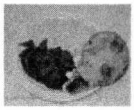
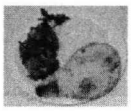
Meals
Questions 30-32 refer to the nature of the meal consumed. As shown from Table 11, cultural groups may have requirements for specially prepared meals or food groups; for example, Halal meat, Kosher or Jahtka foods. These are foods which have either special preparation requirements or particular slaughtering techniques. Religions such as the Jewish faith also have particular meal preparation techniques, in this case, separation of all meats and diary products. Notice from Table 12, that meats are separate from diary products

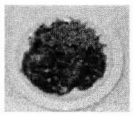
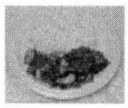
Table 11-Consumption of food groups and religious belief

Food group	Muslim	Hinduism	Judaism	Sikhism
Meat Beef	√*		√**	√* / X
Lamb	√*	X	√**	√*
Pork	X	X	X	X
Goat	√*	X	√**	√*
Rabbit	√*	X	√**	√*
Poultry/Game: Chicken, Duck, Turkey	√*	X	√**	√*
Fish Shellfish	√**	X		
Scaled Fish (Tuna, Cod)	√**	X	√*	
Non-Scaled Fish (bass, catfish)		X	X	
Eggs	√**	X		
Pulses				
Bread				
Pasta				
Rice				
Cereals				
Potatoes			√****	
Fruit and Vegetables (Fresh)			√****	
Fruit and Vegetables (Frozen)			√****	
Fruit and Vegetables (Dried)			√****	
Fruit and Vegetables (Canned)			√****	
Dairy products (Milk, cream, butter)	√***	√*		
Confectionary (chocolate, sweets)	√***	√*	√***	
Snacks (crisps)	√***		√***	
Deserts (cakes, ice-cream)	√***	√*	√***	
Beverages (Tea, coffee, fruit juice)		√^	√^	
Alcohol			√*****	
	*=Halal meat ONLY **= With preparations ***=No animal fats which are non-halal	*=Free of animal fat ^=Some avoid tea/coffee	^=Some avoid tea/coffee *=White fish only **=Kosher only ***=Free of animal products only *****=Dirt and insect free ONLY	*=Jhatka or Chakar meat ONLY (Animals killed in one stroke)

			*****=Approved source only	

Table 12: Some examples of multicultural meals

Visual examples of meals		Group
		Judaism
Roast beef meal (Kosher)	Cod in tomato sauce (Kosher)	
		Islam
Lamb Dansak (Halal) Potato (Halal)	Lamb and	

		Caribbean
		
Jerk Chicken, Fish and White Rice Rice and Peas (Caribbean)	Steamed Brim (Caribbean	

26. Question 26 **In terms of the evening meal, were all residents given the same meal? If residents were given different meals, please complete question 28.** *Please tick one box only*

This question may require staff clarification as to whether all residents are given the same meal. Taking into account individual choice, if all residents are given the same meal, given the restrictions outlined in Table 11, this could be argued as a lack of appreciation of cultural issues with food. For example, if a resident is of an Islamic faith and is served alcohol or foods, which are not Halal, prepared, this is against the cultural guidelines associated with the Islamic faith.

27. Question 27: **If residents were given the same meal, please write a description of the foods served.**

As part of the observation, it will be important to note and describe the food consumed by cultural group residents within the sample.

Pay particular attention to the foods and drink consumed. Furthermore, note if food groups are mixed, for example, diary with meat products (particularly relevant for Jewish residents).

28 Question 28: **If different residents had different meals, for each resident, please provide a description of the foods served**

See question 27

29. Question 29: **Were residents eating at the same time? If No, please provide a reason as to why** *(May need staff clarification).*

Some cultural groups have specific fasting dates. A resident eating at different times may reflect a resident currently fasting or could be a matter of choice.

According to the Islamic faith, fasting is generally regarded as a valuable form of worship, enabling people to come closer to Allah, to practice self-denial and to share and understand the suffering of hungry people all over the world. Fasting means taking no liquid or food at all between dawn (about one and a half hours before the sun rises) and when darkness falls. The sick and infirm are not obliged to fast, nor are people who have chronic illnesses or who must take medication throughout the day. However, some Muslim patients, even if they are seriously ill, will wish to fast whatever the circumstances.

30. Question 30: **Was there any evidence of specially prepared foods, such as Halal meat, Kosher foods?** *May need to ask staff*

Individuals from the Islamic and Jewish faiths are only allowed to eat certain types of foods if it's been specially prepared, such as Halal and Kosher foods. During the observations, check with staff whether meats are Halal meats (for Muslims) or Kosher meals (for Jewish residents)

31. Question 31: **Was there any evidence of any separate food utensils used for separate food groups, such as for meats and diary products?** *Please tick one box only*

According to the Jewish faith, meats and diary products should be clearly separated both within meals and during the cooking process. During the observations, check with staff, or observe during the cooking process whether staff use separate utensils for meats and diary products.

32. Question 32: **Was there any evidence of any meals and wheels services (or assistance from outside sources) for types of food?** *Please tick one box only*

Given the requirements for specially prepared meals, it would be interesting to find out whether homes use meals and wheels services in preparing meals. During the observations, are meals brought from outside sources?-May need to check with staff.

Section 6.5: Other cultural needs

RELIGIOUS FESTIVALS (Question 33)
Different religions celebrate different religions; it follows that celebration of certain religious festivals maybe important for some residents. Table 13 and Table 14 provide a summary of the main festivals celebrated by the religions of interest.

Table 13: Islam and Hinduism

Religious group	Religious events and festivals		
Islam	**Events**	**Description**	**Action**
	Friday	Friday is the holy day. In some communities, Friday is the official day of rest.	Men in most communities and women in a few communities are expected to attend the mosque at noon to say a special additional Friday prayer. Some male patients may want to attend a mosque for Friday prayers.
	Ramadan	Fasting in the month of Ramadan	Requires abstaining from food and drink and sexual contact from dawn to sunset
	Eid al-Fitr (Marking the end of the holy month of Ramadan)	Festival marks the end of the Ramadan month of fasting	Both Eid festivals are joyful and begin with special prayers. Many people visit friends and relatives, and exchange gifts and sweets.
	Eid al- Adha (commemorating the willingness of the Prophet Abraham to sacrifice his son at Allah's command)	Festival of sacrifice that marks the end of Hajj.	
	Milad al-Nabi	Celebration of the birthday of the holy prophet	
Hinduism			
	Holi (February/March full moon)	A spring festival celebrated in northern and central India. Celebrates an ancient legend in which Good triumphs over Evil	Bonfires are lit and coloured water and dyes thrown at participants.
	Raksha Bandhan August full moon	Celebration of the strong bond between brothers and sisters	Exchange of gifts
	Navratri Festival of nine lights (September/October)	Festivals of the nine lights dedicated to the goddess Lakshami, Durga and Sarasvati	
	Diwali (or Deepavali) Festival of lights October/November	Five-day celebration of the victory of Good over Evil, as told in the Ramayana. Also the festival of the goddess Lakshmi.	Candles and lamps are lit. Family celebration. (SIKHS ALSO CELEBRATE DIWALI)

Table 14: Judaism and Sikhism

Judaism	**Event**	**Description**	**Description**
	Rosh Hashana (Jewish New Year-Sept/Oct	Lasts for two days	Solemn festival, a time for reflection rather than celebration. It is a day of rest
	Yom Kippur (Day of Atonement-Sept/Oct : 10 days after Rosh Hashana)	It is a day of repentance and the most solemn festival in the Jewish year.	No work is allowed and many activities are avoided.
	Sukkot (Tabernacles-Oct	A joyful festival of harvest and thanksgiving, lasting eight or nine days.	
	Chanukah (Hanneaka) (December)	The Feast of Lights. Lasts eight days. Each night people light an increasing number of candles on an eight-branched candlestick-chanukiah.	Normal daily life and work continue.
	Purim (February/March)	A joyful festival. Children dress up and the story of Purim is told.	It is important for Orthodox Jews to hear the story every year. Normal daily life and work continue.
	Pesach or Passover (March/April)	Eight-day festival commemorating the flight (Exodus) of the Jews from Egypt under the leadership of Moses.	Observant Jews do not eat foods containing flour or yeast to commemorate the fact that there was no time to make proper bread before the flight from Egypt. Instead people eat unleavened bread and special cakes and biscuits.

Sikhism	Event	Description	Description
	Birthday of Guru Gobind Singh (December/January)	Birthday celebration of the last living Sikh guru	Celebrated in a spirit of gratitude and thanksgiving
	Vaisakhi Usually April 13th	Sikh New Year festival. Celebrates the day on which Guru Gobind Singh founded the Khalsa, the community of initiated Sikh men and women.	Celebrated in a spirit of gratitude and thanksgiving
	Martyrdom of Guru Arjan Dev May/June	The fifth Sikh guru	Celebrated in a spirit of gratitude and thanksgiving
	Bandhi Chhord October/November	Commemorates the realise from prison of Guru Hargobind, the sixth Sikh guru.	Celebrated in a spirit of gratitude and thanksgiving
	Birthday of Guru Nanak October/November	The first Sikh guru	Celebrated in a spirit of gratitude and thanksgiving
	Martyrdom of Guru Teg Bahadur November/December	The ninth living Sikh guru	Celebrated in a spirit of gratitude and thanksgiving

33. Question 33: Were other religious festivals (other than the Christian denomination festivals) acknowledged and celebrated within the home? *Please tick one box only*

Observations
During observations it would be important to note whether services are responsive to these festivals for religious resident. If homes only celebrate religions within the Christian faith, such as Christmas and Easter and neglect other festivals celebrated by other residents within the home, this could be potentially isolating for residents.

11.12. Appendix 11- Post Hoc- Cultural Index

Cultural index for religiously diverse groups (CI-RD)

- This cultural index focuses on needs associated with religion, diet, personal care, and dress codes identified from literature reviews and focus groups with Asian BME and Black BMEs that **may** be important for observant individuals from religiously diverse faiths for individuals observant of Islam, Hinduism, Sikhism and Judaism
- This index divides met cultural needs according to 'all cultural needs met', 'some cultural needs met' and 'no cultural needs met' which corresponded to whether care homes met all religious needs, some religious needs and no religious needs respectively. Decisions surrounding 'all cultural needs met' and 'no cultural needs met' were determined from literature reviews of aspects of religious law that were important for observant followers outlined from Islam, Hinduism, Sikhism and Judaism and also a consideration for resident preferences.

Religious needs

- Chapter 3 highlighted that religion plays an important part of minority cultural vulnerable adults lives, particularly with older adults.
- Therefore, residing in an environment that embraces religious beliefs in accordance with residents faiths and celebrates religions other than Christianity and encourages residents to participate in worship maybe particularly significant for some care home residents.
- This index explores whether religion was acknowledged within care homes, with particular attention on observation of religious symbols, prayer locations and celebration of religiously diverse festivals which may be of particular relevance and importance to some care home residents from religiously diverse faiths.

Religious needs	MOP SU code	Recode	Cultural needs category
1. Observed religious symbols (S.6 CCHOT,Q12)			
Religious symbols in evidence throughout the house	1	2	All cultural needs met
Religious symbols in evidence in peoples rooms	2	1	Some cultural needs met
Religious symbols in evidence but not of that persons religion	3	0	No cultural needs met
No religious symbols in evidence	4	0	No cultural needs met
2. Accessible prayer locations (S.6.CCHOT, Q14)			
Yes	1	1	All cultural needs met
No	2	0	No cultural needs met
3. **Celebration of non Christian festivals (S.6.CCHOT, Q33)**			
No	1	0	No cultural needs met
Some were	2	1	Some cultural needs met
Yes	3	2	All cultural needs met
Scoring			
Religious needs scoring • Maximum score of all cultural needs met= 6 • Minimum score of no cultural needs met= 0			

Dietary requirements

- Given the significance of dietary requirements with some religions outlined in previous chapters, this index attempts to guide an observer to particular food groups and dietary requirements that ***may*** be important for vulnerable adults who observe religiously diverse faiths of Islam, Hinduism, Sikhism and Judaism.
- However, as researchers have argued, consumption of particular food groups is largely dependent on individual preferences and beliefs associated with particular foods, it's important to note individual preferences in observing consumption of foods.
- This index attempted to incorporate differences within religiously diverse faiths, such as differences between non vegetarians and vegetarians and differences between devout observant followers and observers who were not so strict with their dietary requirements. In highlighting differences within religious practices, this index also aims to highlights the relative heterogeneity within religiously diverse faiths.
- Generally, 'all cultural needs met' relates to dietary practices whereby residents were either consuming foods were appropriate for religious dietary laws and practices conducted by the home that were in accordance with religiously diverse faiths. Conversely, 'no cultural needs met' reflects food practices and consumption of foods which were contrary to religious beliefs or reflected individual preferences.
- In summary, this dietary part of the index was devised to explore care homes sensitivity to dietary practices and foods consumed for residents from Islamic, Hindu, Sikh and Jewish faiths. The actual food groups consumed by care home residents from religiously diverse faiths are largely unknown. Although in conducting observations, given individual preferences, it was very important to ask if foods consumed were as a result of individual preferences.

Dietary requirements-Islam	MOP SU	Recode	Cultural needs category
1. Evidence of specially prepared foods -Halal meat *only* *(Foods prepared for other religions does not count)* **(S.6 CCHOT,Q.30).**			
No	1	0	No cultural needs met
Yes	2	1	All cultural needs met
2. Evidence of separate food utensils for separate food groups (clear separation of halal and non halal products) **(S.6.CCHOT, Q31)**			
No	1	0	No cultural needs met
Yes	2	1	All cultural needs met
Dietary requirements-- part 1: Special food preparations- Muslim- • Maximum score of all cultural needs met= 2; Minimum score of no cultural needs met= 0			
3. Food groups			

	Halal products and clear separation from non halal		i.e. non halal and mixing with non halal foods	
Alcohol	0	No cultural needs met	0	No cultural needs met
Blood	0	No cultural needs met	0	No cultural needs met
Meat: Pork and pork products	0	No cultural needs met	0	No cultural needs met
Non-Scaled Fish (eels, catfish, shark)	0	No cultural needs met	0	No cultural needs met
Meat: Beef, Lamb, Goat, Rabbit	1	All cultural needs met	0	No cultural needs met
Poultry/Game: Chicken, Duck, Turkey,	1	All cultural needs met	0	No cultural needs met
Shellfish	1	All cultural needs met	0	No cultural needs met
Scaled Fish (Tuna, Cod)	1	All cultural needs met	0	No cultural needs met
Eggs	1	All cultural needs met	0	No cultural needs met
Dairy products (Milk, cream, butter)	1	All cultural needs met	0	No cultural needs met
Fruit and Vegetables (Fresh, Frozen, Dried, Canned, Potatoes, other vegetates)	1	All cultural needs met	0	No cultural needs met
Bread, Pasta, Rice, Cereals	1	All cultural needs met	0	No cultural needs met
Confectionary (chocolate, sweets), snacks, deserts,	1	All cultural needs met	0	No cultural needs met
Beverages (Tea, coffee, fruit juice)	1	All cultural needs met	0	No cultural needs met

Dietary recruitments- part 2-Foods consumed: Scoring: Maximum score of all cultural needs met= 1- ***only if home implemented specially prepared foods***; Minimum score of no cultural needs met= 0

Dietary requirements- Hinduism	MOPSU code	Recode	Cultural needs category
1.. Evidence of separate food utensils for separate food groups (clear separation of meat and non meat products) **(S.6.CCHOT, Q31)**			
No	1	1	All cultural needs met
Yes	2	0	No cultural needs met

Dietary requirements- special food preparations part 1- Hindu

- Maximum score of all cultural needs met= 1
- Minimum score of no cultural needs met= 0

3. Food groups (precise level of dietary observance varies from family to family and individual to individual- *this is a guide*).

	Non vegetarian Hindus		Vegetarian Hindus		Strict /devout Hindus	
Meat: Beef	0	No cultural needs met	0	No cultural needs met	0	No cultural needs met
Meat: Lamb. Goat, rabbit	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Poultry/Game: Chicken, duck, turkey,	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Shellfish	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Scaled Fish (Tuna, Cod)	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Eggs	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Dairy products (Milk, cream, butter)	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Fruit and Vegetables (Fresh, Frozen, Dried, Canned, Potatoes, other vegetables)	1	All cultural needs met	1	All cultural needs met	1	All cultural needs met
Bread, Pasta, Rice, Cereals	1	All cultural needs met	1	All cultural needs met	1	All cultural needs met
Confectionary (chocolate, sweets), Snacks, Deserts	1	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Beverages (Tea, coffee)	1	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Alcohol	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Blood	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Onions and garlic	1	All cultural needs met	1	All cultural needs met	0	No cultural needs met

Foods consumed: Maximum - all cultural needs met= 1- ***only if home implemented special prepared foods***; Minimum -no cultural needs= 0

Dietary requirements- Sikhism	MOP SU code	Recode	Cultural needs category
1. Evidence of specially prepared foods –Jhatka meat *only* *(Foods prepared for other religions does not count)* **(S.6 CCHOT,Q.30).**			
No	1	0	No cultural needs met
Yes	2	1	All cultural needs met
1.. Evidence of separate food utensils for separate food groups (clear separation of meat and non meat products) **(S.6.CCHOT, Q31)**			
No	1	0	No cultural needs met
Yes	2	1	All cultural needs met
Dietary requirements- **part 1- special food preparation- Sikh : Maximum -all cultural needs met= 2: Minimum-no cultural needs= 0**			
3. Food groups (precise level of dietary observance varies from family to family and individual to individual-*this is a guide*).			

	Sikh: Non vegetarian Jhatka meat only		Sikh: Vegetarian		Devout Sikhs	
Meat: Beef	0	No cultural needs met	0	No cultural needs met	0	No cultural needs met
Meat: Lamb, Goat, Rabbit,	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Poultry/Game: Chicken, Duck, Turkey,	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Shellfish	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Scaled Fish (Tuna, Cod)	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Eggs	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Dairy products (Milk, cream, butter)	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Fruit and Vegetables (Fresh, Frozen, Dried, Canned, Potatoes, Other vegetables)	1	All cultural needs met	1	All cultural needs met	1	All cultural needs met
Bread, Pasta, Rice, Cereals,	1	All cultural needs met	1	All cultural needs met	1	All cultural needs met
Confectionary, Snacks, Deserts	1	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Beverages (Tea etc	1	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Alcohol	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Blood	1*	All cultural needs met	0	No cultural needs met	0	No cultural needs met
Onions and garlic	1	All cultural needs met	0	No cultural needs met	0	No cultural needs met

Foods consumed: Max- all cultural needs met= 1- ***only if home implemented special prepared foods***; Minimum--no cultural needs met= 0

Dietary requirements- Judaism	MOPSU	Recode	Cultural needs category

1. Evidence of specially prepared foods –Kosher foods only *(Foods prepared for other religions does not count)* **(S.6 CCHOT,Q.30).**			
No	1	0	No cultural needs met
Yes	2	1	All cultural needs met
2. Evidence of separate food utensils for separate food groups (clear separation of kosher and non kosher products) **(S.6.CCHOT, Q31)**			
No	1	0	No cultural needs met
Yes	2	1	All cultural needs met
Dietary requirements- part 1- special food preparations - Jewish • Maximum score of all cultural needs met= 2; Minimum score of no cultural needs met= 0			

3. Food groups (precise level of dietary observance varies from family to family and individual to individual- *this is a guide*).				
	Special preparations: Kosher products, clear separation from non kosher & free from pork		No special preparations: i.e. non kosher and mixing with non kosher foods	
Alcohol	0	**No cultural needs met**	0	No cultural needs met
Blood	0	**No cultural needs met**	0	No cultural needs met
Meat: Pork and pork products	0	**No cultural needs met**	0	No cultural needs met
Non-Scaled Fish (eels, catfish, shark)	0	**No cultural needs met**	0	No cultural needs met
Meat: Beef, Lamb, Mutton, Goat, Rabbit	1	All cultural needs met	0	No cultural needs met
Poultry Chicken, Turkey	1	All cultural needs met	0	No cultural needs met
Poultry/Game: Duck	0	**No cultural needs met**	0	No cultural needs met
Shellfish	0	**No cultural needs met**	0	No cultural needs met
Scaled Fish (Tuna, Cod)	1	All cultural needs met	0	No cultural needs met
Eggs	1	All cultural needs met	0	No cultural needs met
Dairy products (Milk, cream, butter)	1	All cultural needs met	0	No cultural needs met
Fruit and Vegetables (Fresh, Frozen, Dried, Canned, Potatoes, other vegetables	1	All cultural needs met	0	No cultural needs met
Bread, Pasta, Rice, Cereals,	1	All cultural needs met	0	No cultural needs met
Confectionary (chocolate, sweets) , Snacks, Deserts	1	All cultural needs met	0	No cultural needs met
Beverages (Tea, coffee, fruit juice)	1	All cultural needs met	0	No cultural needs met
Dietary requirements - part 2- Scoring: Maximum score of all cultural needs met= 1- ***only if home implemented special prepared foods***; Minimum score of no cultural needs met= 0				

Personal care needs

- Chapter 3 outlined that ideas about purity and pollution are explicit some religions such as Islam, Hinduism and Judaism, whereby, high levels of personal cleanliness were associated with purity and an important requirement for observant people. It follows therefore that residing in unclean environments or if an individual was feeling dirty and or 'polluted', this may feel particularly distressing if they cannot keep clean, especially if they are bed bound

and cannot wash themselves (Henley& Schott, 1999). Following on from the significance of personal cleanliness with purity for some religions a cultures, this section equates high levels of personal cleanliness with 'all cultural needs met' and low levels of personal cleanliness with 'no cultural needs met'.

Personal care	MOP SU	Recod e	Cultural needs category
1. Residents wearing dirty, soiled or marked clothes (S.4, Q.20)			
Yes	1	0	No cultural needs met
No	2	1	All cultural needs met
Not seen	3	0	No cultural needs met
1. Residents wearing clothes that needed repair (S.4, Q.20)			
Yes	1	0	No cultural needs met
No	2	1	All cultural needs met
Not seen	3	0	No cultural needs met
1. Residents dressed and clean (S.4, NHQ. Q19)			
No	1	0	No cultural needs met
Rarely seen	2	0	No cultural needs met
Occasionally	3	0	No cultural needs met
Sometimes	4	1	Some cultural needs met
Often	5	1	Some cultural needs met
Very often	6	2	All cultural needs met
2. Residents well groomed (S.4, NHQ, Q.25)			
No	1	0	No cultural needs met
Most were not	2	0	No cultural needs met
A few were	3	0	No cultural needs met
Some were	4	1	Some cultural needs met
Many were	5	1	Some cultural needs met
Most were	6	2	All cultural needs met
2. Residents regularly toileted (S.4, NHQ, Q.26)			
No	1	0	No cultural needs met
Most were not	2	0	No cultural needs met
A few were	3	0	No cultural needs met
Some were	4	1	Some cultural needs met
Many were	5	1	Some cultural needs met
Most were	6	2	All cultural needs met
3. Incontinent residents changed quickly (S.4, NHQ, Q.27)			
No	1	0	No cultural needs met
Most were not	2	0	No cultural needs met
A few were	3	0	No cultural needs met
Some were	4	1	Some cultural needs met
Many were	5	1	Some cultural needs met
Most were	6	2	All cultural needs met
4. Personal care was conducted in a way which preserves peoples dignity (S.4, NHQ, Q.28)			
Not true for most people	1	0	No cultural needs met
True for a few people	2	0	No cultural needs met
True for some	3	0	No cultural needs met
True for many people	4	1	Some cultural needs met
True for many people	5	1	Some cultural needs met
True for most	6	2	All cultural needs met
5. Presence of odours of urine or faeces noticeable in the facility S.4, NHQ, Q.29)			
Pervasive throughout	1	0	No cultural needs met
In most areas	2	0	No cultural needs met
Occasionally	3	0	No cultural needs met
			Some cultural needs met
Not at all	5	2	All cultural needs met
6. Other unpleasant odours noticeable in the facility S.4, NHQ, Q.30)			

Pervasive throughout	1	0	No cultural needs met
In most areas	2	0	No cultural needs met
Occasionally	3	0	No cultural needs met
Hardly at all	4	1	Some cultural needs met
Not at all	5	2	All cultural needs met
7. Residents rooms, hallways and common areas clean? S.4, NHQ, Q.32)			
Dirty	1	0	No cultural needs met
Somewhat dirty	2	0	No cultural needs met
More or less clean	3	1	Some cultural needs met
Clean	4	2	All cultural needs met
Very clean	5	2	All cultural needs met

X. Within bathrooms, was there evidence of a bidet, basin or jugs to allow for residents to wash themselves with running water after occurrences of elimination? (S.6, CCHOT, Q.13)			
Yes	1	1	All cultural needs met
No	2	0	No cultural needs met
8. Residents able to lock doors during personal care S.6, CCHOT, Q.15)			
Always	1	2	All cultural needs met
Sometimes	2	1	Some cultural needs met
Rarely	3	0	No cultural needs met
Never	4	0	No cultural needs met
9. Staff ensure all doors were closed or screened during personal care S.6, CCHOT, Q.16)			
Always	1	2	All cultural needs met
Sometimes	2	1	Some cultural needs met
Rarely	3	0	No cultural needs met
Never	4	0	No cultural needs met
Not observed	5	0	
10. Care home ensured that examinations and practical care for residents was administer by same sex carers (S.6, CCHOT, Q.17)			
Always	1	2	All cultural needs met
Sometimes	2	1	Some cultural needs met
Rarely	3	0	No cultural needs met
Never	4	0	No cultural needs met
11. Residents had unrestricted access to personal cleaning facilities to maintain high levels of personal hygiene S.6, CCHOT, Q.18)			
Always	1	2	All cultural needs met
Sometimes	2	1	Some cultural needs met
Rarely	3	0	No cultural needs met
Never	4	0	No cultural needs met
Not observed	5	0	
12. Residents with well groomed hair (S.6, CCHOT, Q.20)			
Yes	1	2	All cultural needs met
To some extent- some were	2	1	Some cultural needs met
No not at all well groomed	3	0	No cultural needs met
13. Staff consult with residents whether they wanted their hair cut or shaved (S.6, CCHOT, Q.21)			
Always	1	2	All cultural needs met
Sometimes	2	1	Some cultural needs met
Rarely	3	0	No cultural needs met
Never	4	0	No cultural needs met
Not observed	5	0	
Personal care domain- summary			

• Maximum score of all cultural needs met= 29 • Minimum score of no cultural needs met= 0			

Personal care- CCHOT

Clothes

- For some researchers, different cultures and religions place high value on personal modesty and many religions and traditional cultures require people to dress more modestly than customary in the West today.
- Given the significance of dress codes attached to observant women, this section focuses on dress codes and maintenance of modesty with observant women for women from Islamic, Hindu, Sikh and Jewish religions. In contrast to women from Islamic, Sikh and Jewish faiths, researchers have noted that Hindu women do not practice the same level of stringency with dress codes which is reflected in this index.
- Older adults tend to be more observant of modest religious dress codes than younger women, therefore maintaining modesty may be particularly important for older adults.
- However, as with dietary requirements, caution needs to apply in observing dress codes. Firstly, rather than sensitivity to dress codes from the care home, dress codes for religiously diverse women may differ according to an individual sensitivity to religious practices, preference and depending on how orthodox the individual is, whereby, the more orthodox women were, the stricter the adherence to religious dress codes. Secondly, for some religions such as Islam and Judaism, adherence to dress codes differs according to non married and married women, with married women tending to wear more conservative or modest clothing than non married women.
- This index aims to explore the presence of modest dress codes for observant women from religiously diverse faiths, although an acknowledged limitation is that observed dress codes may be associated more with individual preferences rather than sensitive care home practices. Nevertheless, the extent of adherence of sensitivity to dress codes for observant religiously diverse faith women residing within care homes is largely unknown.
- Generally, **'all cultural needs met'** relates to dress code practices with women residents who wore modest clothing in accordance with dress codes specified with Muslim, Jewish and Sikh faiths, whereas **'no cultural needs met'** reflected observations which inhibited levels of modesty.

Female dress codes- Upper and lower body

Females- CCHOT- Upper body:	**Muslim**			**Hindu**			**Sikh**			**Jewish**		
Upper body	MOPSU		Category	MOPSU		Category	MOPSU		Category	MOPSU		Category
Very loose fitting	1	2	All cultural needs met	1	1	All cultural needs met	1	2	All cultural needs met	1	2	All cultural needs met
Loose fitting	2	2	All cultural needs met	1	1	All cultural needs met	1	2	All cultural needs met	1	2	All cultural needs met
Average fitting	3	1	Some cultural needs met	1	1	All cultural needs met	1	1	Some cultural needs met	1	1	Some cultural needs met
Tight fitting	4	0	No cultural needs met	1	1	All cultural needs met	1	0	No cultural needs met	1	0	No cultural needs met
Very tight	5	0	No cultural	1	0	No cultural	1	0	No cultural	1	0	No

fitting			needs met			needs met			needs met			cultural needs met
Obscure												
Completely obscure	1	2	All cultural needs met	1	2	All cultural needs met	1	2	All cultural needs met	1	2	All cultural needs met
	2	1	Some cultural needs met	2	1	Some cultural needs met	2	1	Some cultural needs met	2	1	Some cultural needs met
	3	1	Some cultural needs met	3	1	Some cultural needs met	3	1	Some cultural needs met	3	1	Some cultural needs met
	4	1	Some cultural needs met	4	1	Some cultural needs met	4	1	Some cultural needs met	4	1	Some cultural needs met
Transparent	5	0	No cultural needs met	5	0	No cultural needs met	5	0	No cultural needs met	5	0	No cultural needs met
Anatomy exposure- upper body												
Covered hands	0	1	**All cultural needs met***	0							1	**All cultural needs met***
Covered necks	0	1	All cultural needs met	0			0	1	All cultural needs met	0	1	All cultural needs met
Covered collarbones	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met
Covered shoulders	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met
Covered upper arms	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met
Covered elbows	0	1	All cultural needs met	0			0	1	All cultural needs met	0	1	All cultural needs met
Covered forearms	0	1	All cultural needs met	0			0	1	All cultural needs met	0	1	All cultural needs met
Covered wrists	0	1	**All cultural needs met***	0			0	1	**All cultural needs met***	0	1	**All cultural needs met***
Covered chest	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met
Covered Waist	0	1	All cultural needs met	0			0	1	All cultural needs met	0	1	All cultural needs met
*= Orthodox only												

Females- CCHOT- Lower body: Dress codes	**Muslim**			**Hindu**			**Sikh**			**Jewish**		
	MOPSU		Category	MOPSU		Category	MOPSU		Category	MOPSU		Category
Lower body												
Very loose fitting	1	2	All cultural needs met	1	1	All cultural needs met	1	2	All cultural needs met	1	2	All cultural needs met
Loose fitting	1	2	All cultural needs met	1	1	All cultural needs met	1	2	All cultural needs met	1	2	All cultural needs met
Average fitting	1	1	Some cultural needs met	1	1	All cultural needs met	1	1	Some cultural needs met	1	1	Some cultural needs met
Tight fitting	1	0	No cultural needs met	1	1	All cultural needs met	1	0	No cultural needs met	1	0	No cultural needs met
Very tight fitting	1	0	No cultural needs met	1	0	No cultural needs met	1	0	No cultural needs met	1	0	No cultural needs met
			Max score=2			Max score=1			Max score=2			Max score=2
Obscure												
Completely obscure	1	2	All cultural needs met	1	2	All cultural needs met	1	2	All cultural needs met	1	2	All cultural needs met
	2	1	Some cultural needs met	2	1	Some cultural needs met	2	1	Some cultural needs met	2	1	Some cultural needs met
	3	1	Some cultural needs met	3	1	Some cultural needs met	3	1	Some cultural needs met	3	1	Some cultural needs met
	4	1	Some cultural needs met	4	1	Some cultural needs met	4	1	Some cultural needs met	4	1	Some cultural needs met
Transparent	5	0	No cultural needs met	5	0	No cultural needs met	5	0	No cultural needs met	5	0	No cultural needs met
Anatomy exposure- lower body												
Covered thighs/upper leg	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met
Covered shins/lower leg	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met
Covered knees	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met	0	1	All cultural needs met
Covered ankles	0	1	**All cultural needs met***	0	1	**All cultural needs met***	0	1	**All cultural needs met***	0	1	**All cultural needs met***
Covered feet	0	1	**All cultural needs met***	0	1	**All cultural needs met***	0	1	**All cultural needs met***	0	1	**All cultural needs met***

*= Orthodox only	*= Orthodox only	*= Orthodox only	*= Orthodox only

Cultural index for Black ethnic groups (CI-B)

- Previous commented that in general, some care home staff has little awareness of appropriate skin and hair care for people from black ethnic groups. This index aims to explore and validate previous research by exploring whether care homes implemented appropriate skin and hair care for people from black ethnic groups.
- Care homes which appeared to be implementing appropriate skin and hair care practices such as the availability of skin care products for darker skin and appropriate hair care products for afro hair, were awarded with higher scores and 'all cultural needs' met, whereas services with no awareness of appropriate skin and hair care needs received lower scores of 'no cultural needs met'.

Appropriate skin and hair care- Black BME groups

Skin care	MOP SU code	Recode	Cultural needs category
1. Residents were able to access special skin care products such as oils and moisturizers **(S.6, CCHOT. Q19)**			
Yes	1	2	All cultural needs met
Some were	2	1	Some cultural needs met
No	3	0	No cultural needs met
Not observed	4	0	No cultural needs met
Skin care needs for black BME groups • Maximum score= 2 • Minimum score= 0			
Hair care	MOP SU code	Recode	Cultural needs category
2. Residents with well groomed hair **(S.6, CCHOT, Q.20)**			
Yes	1	2	All cultural needs met
To some extent- some were	2	1	Some cultural needs met
No, not at all groomed	3	0	No cultural needs met
3. Residents were always able to access special hair care products such as wide toothcombs and oil for black hair **(S.4, CCHOT, Q.23)**			
Yes	1	2	All cultural needs met
Some were	2	1	Some cultural needs met
No	3	0	No cultural needs met
Not observed	4	0	No cultural needs met
Not applicable	5	0	No cultural needs met
Hair care needs for black BME groups • Maximum score= 4 • Minimum score=0			
Summary of appropriate skin and hair care needs = Maximum score of 6 =Minimum score of 0			

Cultural index for communication needs (CI-C)

- Chapter six outlined thematic analyses from Asian residents and relatives. Chapter six revealed that appropriate communication is a key part of service quality in order to communicate with residents for whom English is not their first language.
- This section focuses on whether care homes implemented practices such as use of different languages from staff and presence of written material presented in other languages in order to meet the communication needs for residents for whom English is not their first language
- Whether care home staff was equipped with the skills to communicate with residents via verbal or written means for whom English is not their first language is largely unknown.

Communication needs

Communication needs		Recode	Cultural needs category
1. Staff always used different languages to communicate with residents for whom English was not their first language **(S.6, CCHOT. Q.3)**			
Always	1	2	All cultural needs met
Sometimes	2	1	Some cultural needs met
Rarely	3	0	No cultural needs met
Never	4	0	No cultural needs met
Not observed	5	0	No cultural needs met
2. Staff were always immediately available with bilingual skills to communicate with residents **(S.6, CCHOT, Q.4)**			
Always	1	2	All cultural needs met
Sometimes	2	1	Some cultural needs met
Rarely	3	0	No cultural needs met
Never	4	0	No cultural needs met
Not observed	5	0	No cultural needs met
3. Homes that contained accessible written information published in other languages besides English **(S.6, CCHOT, Q.10)**			
No	1	0	No cultural needs met
Some were	2	1	Some cultural needs met
Yes	3	2	All cultural needs met

11.13. Appendix 12- Specialist home directory

Development

This review focused on the following care homes:

- Learning disability care homes with nursing
- Learning disability care homes without nursing
- Older people care homes with nursing
- Older people care home without nursing

For each of the homes identified in the above categories, the 'brief description of care homes' was screened for any mention of a specialist care home within each care homes CQC inspection report. If a care home was a specialist care home, the brief description of care home specified whether the care home was a specialists care home. Given the objective of the current study, any care homes that mentioned a specialist service for minority ethnic groups, a religious specialism were illuminated as part of this review. Care homes with a particular specialism for care home residents from allocated societies such as Freemasons or retired individuals from specific professions such as ex military were also included as part of this review.

Limitations of this review

This review was dependent on CQC inspectors to disclose a specialist care home and this review based upon the availability of online inspection reports.

This review took place in 2009. Given the changing nature of care homes, this directory is subject to change.

Specialist care home directory- summary table

	Adults with learning disabilities		Older people	
	Care homes- adults with learning disabilities without nursing	Care homes- adults with learning disabilities with nursing	Care homes with older people without nursing	Care homes- with older people with nursing
	60	**4**	**144**	**106**
1. Care homes for minority ethnic groups				
South Asian	7 (11.7%)	0 (0%)	10 (6.9%)	5 (4.7%)
African-Caribbean	0 (0%)	0 (0%)	3 (2.1%)	1 (0.9%)
Chinese	0 (0%)	0 (0%)	0 (0%)	2 (1.9%)
2. Care homes with specific reference to religious practices				
Christianity ethos (Methodist, Salvation Army homes)	18 (30%)	4 (100%)	94 (65.3%)	57 (53.8%)
Care homes for retired members of the clergy, members of religious orders i.e. nuns	0 (0%)	0 (0%)	10 (6.9%)	6 (5.7%)
Christadelphian faith	0 (0%)	0 (0%)	3 (2.1%)	2 (1.9%)
Christian scientist	0 (0%)	0 (0%)	0 (0%)	1 (0.9%)
Jehovah witness	0 (0%)	0 (0%)	2 (1.4%)	2 (1.9%)
Judaism	31 (51.7%)	0 (0%)	3 (2.1%)	16 (15.1%)
Orthodox Judaism	3 (5%)	0 (0%)	4 (2.8%)	1 (0.9%)
3. Care homes for European residents (excluding the UK)				
Italians	1 (1.7%)	0 (0%)	0 (0%)	1 (0.9)
Greek as first language	0 (0%)	0 (0%)	0 (0%)	1 (0.9%)
Polish	0 (0%)	0 (0%)	6 (4.2%)	3 (2.8%)
Latvian	0 (0%)	0 (0%)	1 (0.7%)	0 (0%)
Ukrainian	0 (0%)	0 (0%)	1 (0.7%)	0 (0%)
Polish, Ukraine and Russian	0 (0%)	0 (0%)	1 (0.7%)	0 (0%)
4. Care homes for residents from allocated societies				
Ex-servicemen and women and relatives (Royal British Legion- Armed forces)	0 (0%)	0 (0%)	1 (0.7%)	6 (5.7%)
Former Royal Navy marines and relatives	0 (0%)	0 (0%)	0 (0%)	1 (0.9%)
Royal Air Force	0 (0%)	0 (0%)	1 (0.7%)	1 (0.9%)
Freemasons and relatives	0 (0%)	0 (0%)	2 (1.4%)	1 (0.9%)
Farming community	0 (0%)	0 (0%)	2 (1.4%)	0 (0%)

11.13.1. Learning disability specialist care homes with nursing

Christianity ethos

No	Group	Region	Care home name	Brief description (CQC inspection report)
1	Christian	London	Maryville Care Home- TW8 8BQ	Majority of residents are Catholics. However, the home accepts residents from other faiths
2	Christian	South East	Martha House- CT14 OPG	Christian values and ethoses. The organization has a Christian ethos which we aim to reflect in how we care for our residents, their families and of course our staff
3	Christian	North West	Thingwall Hall Nursing Home- L14 7NY	Mission statement- 'we are an organisation with Christian values'
4	Christian	North West	Lisieux Hall- PR6 7DX	Mission statement- 'we are an organisation with Christian values'

11.13.2. Learning disability specialist care homes- without nursing

South Asian

No	Group	Region	Address	Brief description of home
1	South Asian	Greater London	Two Rivers-N3 2HX	The aims of the service are to provide a culturally appropriate environment for Asian women who have mental health concerns or learning disabilities....The service sets out to provide an appropriate environment for Asian women
2	South Asian	Greater London	Sudbury House- HAO 3AR	Offer culture specific care services for (amongst others) the Gujarati, Punjabi, Pakistani and Bengali communities
3	South Asian	West Midlands	Links Care Home/ Satya Nivas -CV6 3DQ	The service is specifically orientated to meet the cultural needs of Asian service users, however the new management team is working to widen service to people of all cultures.
4	South Asian	Greater London	Bourne Hill- N13 4LH	The homes stated aims are to provide care and support for five Asian women who have a learning disability
5	South Asian	Greater London	3-5 High Worple- HA2 9SJ	The home specializes in the care of Asian people from various cultural and religious background
6	South Asian	Greater London	385 Torbay Road- HA2 9QB	Presently it is providing a service for Asian women who have a learning disability
7	South Asian	East Midlands	Satya Nivas-LE4 5ES	Its primary purpose is to meet the cultural, religious and language needs of Asian people. The furniture and decoration in the home is authentically ethnic to suit Asian needs

Jewish

No	Group	Region	Address	Brief description of home
1	Jewish	London	94 Station Road- NW4 3SR	All of our services reflect and promote Jewish culture, but we also welcome adults who are non Jewish
2	Jewish	London	Edgeworth Crescent 55	The home is owned and run by Norwood, a Jewish Charity that provides a service to children, adults and their families
3	Jewish	London	Hannah Schwalbe- NW11 OLA	Is managed by Kisharon, a chartable trust providing both education and care for Jewish children and adults with a learning disability
4	Jewish	London	Station Road 159a	The home specializes in providing care to Jewish residents with learning disabilities
5	Jewish	South East	Eretz-RG45 6DQ	The ethos of Eretz is derived from the Jewish faith; belief, practice and values of Judaism underpin all aspects of residents lives
6	Jewish	London	1 Woodcock Dell Avenue-HA3 OPW	The home provides a Jewish way of life to service users
7	Jewish	South East	Rachel Mazzier /Sussex Tikvah-BN1 5DB	The home caters for people of the Jewish faith who have low to medium needs

8	Jewish	North West	Brookvale-M25 2SF	Seeks to cater for Jewish people although non Jewish service users are also accommodated
9	Jewish	North West	Langdon Foundation-M25 0HG	Jewish adults with learning disabilities
10	Jewish	North West	Langdon Foundation, Clore House-M25 9WA	Jewish adults with learning disabilities
11	Jewish	North West	Outreach Community and Residential Services- 86 Meade Hill Road- M25 0DJ	Mainly to Jewish people with a learning disability
12	Jewish	North West	Outreach Community and Residential Services-110 Kings Road- M25 OFY	Mainly to Jewish people with a learning disability
13	Jewish	North West	Outreach Community and Residential Services-118 Kings Road- M25 OFY	Mainly to Jewish people with a learning disability
14	Jewish	North West	Outreach Community and Residential Services-122 Butterstile Lane-M25 9PT	Mainly to Jewish people with a learning disability
15	Jewish	North West	Outreach Community and Residential Services-17 York Avenue- M25 0FZ	Mainly to Jewish people with a learning disability
16	Jewish	North West	Outreach Community and Residential Services-Devonshire Place- M25 3FF	Mainly to Jewish people with a learning disability
17	Jewish	North West	Outreach Community and Residential Services-Highbury Court- M25 1QP	Mainly to Jewish people with a learning disability
18	Jewish	London	Norwood 30 Old Church Lane-HA7 2RF	Is a Jewish care home registered to provide personal care, and accommodation for 8 adults with LD
19	Jewish	London	Norwood 54 Old Church Lane- HA7 2RP	Specializes in providing services to people of a Jewish culture'
20	Jewish	London	Norwood 60 Carlton Avenue- HA3 8AY	Care home is owned by Norwood, which is a Jewish organisation that provides care for children and adults with LD
21	Jewish	London	Cranmer Scheme-LS17 5PX	Purposely built to provide a residential setting for Jewish people with a LD. The scheme operates in accordance with Jewish Cultural requirements
22	Jewish	London	Diamond Lodge, 116 Beattyville Gardens, Ilford, Essex, IG6 1JZ	It is run by Norwood, a not for profit Jewish organisation. Hence, the ethos of the home is based around Jewish beliefs, customs and faith. All staff have attended training in the Jewish Way of Life to be able to meet the cultural and religious needs of the service user
23	Jewish	London	33 Seymour Gardens, Ilford, Essex, IG1 3LP	Seymour Gardens is a five bedded home for adults with learning and physical disabilities run by Norwood, a not-for-profit, Jewish organisation, and providing services for people of the Jewish faith. Hence the ethos of the home is based around Jewish beliefs, customs and faith

24	Jewish	London	2 Southwood Gardens, Ilford, Essex, IG2 6YF	All the service users are Jewish and follow the Jewish way of life. All
25	Jewish	South East	Nine Mile Ride, Ravenswood Village, Crowthorne, Berkshire, RG45 6BQ	Ravenswood Village provides a culturally appropriate environment for Jewish individuals, and accepts non-Jewish individuals who are happy to be part of a Jewish service.
26	Jewish	South East	Ravenswood Village, Nine Mile Ride, Crowthorne, Berkshire, RG45 6BQ	Ravenswood Village provides a culturally appropriate environment for Jewish individuals, and accepts non-Jewish individuals who are happy to be part of a Jewish service.
27	Jewish	South East	Eretz , Nine Mile Ride, Ravenswood Village, Crowthorne, Berkshire, RG45 6BQ	The ethos of Eretz is derived from the Jewish faith; belief, practice and values of Judaism underpin all aspects of residents' lives.
28	Jewish	South East	Kadimahm Ravenswood Village, Nine Mile Ride, Crowthorne, Berkshire, RG45 6BQ	Ravenswood Village provides a culturally appropriate environment for Jewish individuals, and accepts non-Jewish individuals who are happy to be part of a Jewish service.
29	Jewish	South East	The Green, Nine Mile Ride, Ravenswood Village, Crowthorne, Berkshire, RG45 6BQ	The Green cares for 15 adults with learning disabilities. It is set in Ravenswood Village, which is a community operating within the Jewish faith, although it also caters for non-Jews
30	Jewish	South East	Tikvah Tovah, Nine Mile Ride, Ravenswood Village, Crowthorne, Berkshire, RG45 6BQ	Tikvah Tova is registered to provide support and care for five adults with learning disabilities. It is set in Ravenswood Village, which is a Jewish community. The village is situated near to Crowthorne; a controlled barrier protects the entrance drive. The ethos of Tikvah Tova is derived from the Jewish faith; belief, practice and values of Judaism underpin all aspects of residents' lives
31	Jewish	South East	Tova, Ravenswood Village, Nine Mile Ride, Crowthorne, Berkshire, RG45 6BQ	Tovas underpinning ethos is derived from the Jewish faith and the beliefs practices and values of Judaism underpin all aspects of residents' lives
32	Jewish	London	Neve Shalom- N16 6HX	Neve Shalom is an ultra-Orthodox Jewish residential care home accommodating 4 males with LD
33	Jewish	London	Queen Elizabeth Walk (57)	57 Queen Elizabeth Walk is Jewish Orthodox care home for 7 females with LD and one respite bed.
34	Jewish	London	Queen Elizabeth Walk (64)	64 Queen Elizabeth Walk is a care home for Orthodox Jewish males with LD

Christianity ethos

No	Group	Region	Address	Brief description of home
1	Christian	South West	Marion House	The home reflects Christian principles. There is however no requirement for anyone to engage in religious activity
2	Christian	South East	Tablehurst Farm Cottage- RH18 5DP	Is inspired by Christian ideas as articulated by Rudolph Steiner and is based on the acceptance of spiritual uniqueness of human each human being, regardless of religious or racial background'.
3	Christian	South East	The Mount- TN5 6PT	The Mount Campbell Community is inspired by Christian ideals as articulated by Rudolph Steiner and is based on the acceptance of spiritual uniqueness of each human being, regardless of racial or religious background
4	Christian	South East	97 Luncies Road- SS14 1SD	Later refurbished and registered as a Christian based home run by Walsingham

5	Christian	South West	The Paradise House-GL6 6TN	The community aims to provide a therapeutic environment based on Christian values and the teachings of Rudolf Steiner
6	Christian	South West	The Knole-GL51 7BE	The Knole is a care home operating within Christian principles'
7	Christian	South East	Lynton House- CT10 1EB	Operates within a distinctive Christian ethos'
8	Christian	South East	Scotts Project Trust-TN11 9NN	Is a Christian based registered charity
9	Christian	Yorkshire and the Humber	West Haven- WF13 2RW	Vision of how people can live together in Christian charity
10	Christian	North West	New Hutte Lane, 9-L26 9UD	Mission statement- 'we are an organisation with Christian values'
11	Christian	North West	Rosehedge- L14 7NY	Mission statement- 'we are an organisation with Christian values'
12	Christian	London	Gothic Lodge-SE27 9HG	Part of the Ecumenical Christian community that welcomes people of all faiths and people of no stated faith. L'Arche Lambeth is a diverse ecumenical Christian community of people with an without LD who welcome people of all faiths and o none.
13	Christian	North West	L'Arche Community (Preston)	L'Arche is a faith community in the Christian tradition that welcomes people of all faiths or none
14	Christian	Yorkshire and the Humber	Ashlar House0 LS7 3LW	Leeds Autism Services- is a Christian foundation and open to all, regardless of race, colour or creed
15	Christian	London	Caroline House- KT3 6HE	Roman Catholic religious congregation, but accepting of other faiths
16	Christian	South East	Framland- OX12 9DL	Home belongs to Pilgrim homes, a registered Christian charity, and offers care for older people who share a Protestant Evangelical Christian faith
17	Christian	East Midlands	Main Street, Market Overton, Rutland, LE15 7PL	The Lodge Trust was established in 1984. The Lodge Trust is an Evangelical Christian Community. People who choose to live there make a decision to live by Christian principles.
18	Christian	South East	Orchard Lane, Sundial House, East Molesey, Surrey, KT8 0BN	The Sons of Divine Providence, which is a Roman Catholic order of priest and brothers who are dedicated to the care of adults with learning disability

European service users

No	Group	Region	Address	Brief description of home
1	Italian	South East	Parkview-MK40 2JY	The home caters predominately for people of Italian origin

11.13.3. Specialist older people care homes with nursing

South Asian

	Group	Local authority	Address	Brief description
1	South Asian	Barnet	Amonet Residential Care home- N3 1SL	Asian older adults only
2	South Asian	Birmingham	Edwin Arrowsmith House- B21 0HR	South Asian-one unit dedicated for older adults
3	South Asian	Bolton	Lilian Hamer House	South Asian
4	South Asian	Bradford	Beckfield-BD2 4BN	Multicultural- South Asian and East European
5	South Asian	Bradford	Britannia Care home- BD8 9NU	Predominately South Asian residents

African- Caribbean

	Group	Local authority	Address	Brief description
1	African Caribbean	Birmingham	Mary Street, -B12 9RN	offers services to the African Caribbean community

Chinese

	Group	Local authority	Address	Brief description
1	Chinese	Liverpool	Bentley Care Home-L8 3SE	A number of Chinese residents live at the Bentley and the home provides Chinese television channels and Chinese meals for them
2	Chinese	Manchester	Abbotsford Nursing Home-M16 8BB	The home provides accommodation to a number of Chinese residents

Other European

	Group	Local authority	Address	Brief description
10	Polish	Barnet	Seaforth Lodge- N11 3EX	Polish
37	Polish	Bromley	Antokol, BR7 6PE	Polish only
44	Polish	Devon	Ilford Park Polish Home- TQ12 6QH	Polish residents only
14	Italian	Bedfordshire	Parkview Lodge-MK40 2JY	Primarily for Italian origin residents

Membership with organizations and societies

	Group	Local authority	Address	Brief description
1	Membership and Societies	Ealing	St David's Nursing Home for Disabled Ex-Servicemen and women- W5 1TE	Ex servicemen and women
2	Membership and Societies	Norfork	Halsey House-NR27 0BA	safeguarding the welfare of those who have served in the Armed Forces, and their dependant
3	Membership and Societies	North Yorkshire	Lister House, The Royal British Legion-HG4 1PG	The Royal British Legion owns the home and admission there is normally limited to those people who have served or have served in the Armed Forces or their dependants.
4	Membership and Societies	Salford	Broughton House-M7 4JD	nursing and personal care services for up to fifty ex service men
5	Membership and Societies	Somerset	Dunkirk Memorial House-TA4 3BT	limits admissions to those who have served in the armed forces and/or their spouses.
6	Membership and Societies	Warwicks hire	Galanos House-CV47 2BL	country home for elderly and incapacitated ex-servicemen and women and their dependents (residents must fulfill certain eligibility criteria).
7	Membership and Societies	Medway towns	Pembroke House-ME7 4BS	provides residential and nursing care to former Royal Naval Ratings, other ranks from the Royal Marines, their wives and widows.
8	Membership and Societies	North Somerset	Flower down House-BS23 1BH	serving or ex-serving members of the RAF family, their spouses and adult dependants.

Christianity denominations only

	Group	Local authority	Address	Brief description
1	Christianity only	Birmingham	King sleigh House-B38 OAD	Christadelphian faith
2	Christianity only	Bournemouth	Fair Haven- BH1 3QQ	Christadelphian faith-mainly
3	Christianity	Birmingham	Vermont House-	Christian scientists

	only		B74 2PR	
4	Christianity only	Wigan	Jah Jireh	Jah Jireh Care Home is a faith home for brothers and sisters who are baptized members of the Jehovah's Witness faith.
5	Christianity only	Blackpool	Jah Jireh	Jehovah Witness
6	Christianity only	Bradford	Elmleigh Convent- LS29 9AT	Catholic- retired Sisters of the Convent only
7	Christianity only	Hillingdon	Marian House - UB8 3PW	Roman Catholic Convent for Religious Sisters only
8	Christianity only	Manchester	St Euphrasia's - M9 6GN	Admission to the home is restricted to the Sisters who belong to the Order of The Good Shepherd. Roman Catholic
9	Christianity only	North Yorkshire	Convent Society Of The Holy Child Jesus The-HG2 8PU	Roman Catholic: 'Only the Sisters of the Order are entitled to reside at the home'.
10	Christianity only	Kent	Cornford House-TN2 4QS	Originally opened to meet the needs of retired missionaries. Has a strong religious focus with prayer meetings being central to life in the home. Previously owned by OMF international (Christian missionary)
11	Christianity only	Surrey	Manormead Nursing Home-GU26 6RA	The board offers a variety of services throughout the country to retired clergy, licensed church workers and their spouses and widows (widowers). routine of the home is greatly influenced by the services held in Chapel and the Christian Calendar. Christian community
12	Christianity only	Surrey	College Of St. Barnabas-RH7 6NJ	Service provision is specifically for members of the Clergy of the Church of England or its sister churches. Provision is also extended to the spouses of clergy, retired licensed readers and full time church workers.

Christianity ethos

	Group	Local authority	Address	Brief description
1	Christianity ethos	Barnet	Grace House	Christian environment
2	Christianity ethos	Barnet	Nazareth House -N2 ORU	Roman Catholic
3	Christianity ethos	Bath and North East Somerset	Smallcombe House - BA2 6EJ	Salvation army home
4	Christianity ethos	Bath and North East Somerset	Stratton House-BA1 2XH	Methodist
5	Christianity ethos	Birmingham	Annie Bright	Catholic
6	Christianity ethos	Blackburn with Darwen	The Franciscan Convent	Roman Catholic
7	Christianity ethos	Bradford	Glen Rosa & Kitwood House	Methodist
8	Christianity ethos	Brent	Lawnfield House- NW2 4DJ	Methodist
9	Christianity ethos	Brent	Riverview Lodge-NW9 8SE	Methodist
10	Christianity ethos	Brighton and Hove	Bethesda Home	Christian: Gospel Standard Churches
11	Christianity ethos	Brighton and Hove	Pilgrim Homes	Protestant Christian

12	Christianity ethos	Brighton and Hove	St Mary's House- BN1 6HG	Catholic
13	Christianity ethos	Bristol	St Angela's Convent- BS8 3LU	Roman Catholic
14	Christianity ethos	Bromley	Burrell Mead- BR4 OQS	Christian ethos
15	Christianity ethos	Bury	Holt House-The Salvation Army	Christian ethos
16	Christianity ethos	Cambridge	The Hope Residential and Nursing Care home- CB2 2BQ	Catholic roots' but open to all faiths
17	Christianity ethos	Cumbria	Boarbank Hall Nursing Home- LA11 7NH	Catholic
18	Christianity ethos	Derbyshire	Osmaston Grange Care Centre	Christian home
19	Christianity ethos	Derbyshire	Presentation Sisters Care Centre	Roman Catholic
20	Christianity ethos	East Sussex	Holy Cross Nursing Unit- TN21 OTS	Christian atmosphere and home
21	Christianity ethos	East Sussex	Lauriston Christian Nursing Home	Christian ethos
22	Christianity ethos	Hackney	St Anne's Care home for the elderly	Roman Catholic
23	Christianity ethos	Hammersmith and Fulham	Nazareth House	Christian ethos
24	Christianity ethos	Hampshire	Chandlers Ford Christian Nursing Home	Methodist ethos
25	Christianity ethos	Hillingdon	St Vincent`s Nursing Home- HA5 2NB	A long Roman Catholic tradition' : members of religious orders, retired priests, laity workers and to people from any religious background '
26	Christianity ethos	Hounslow	Maryville Care Home- TW8 8BQ	Majority of residents are catholic but supports residents of other faiths
27	Christianity ethos	Hounslow	St Mary`s Convent & Nursing Home- W4 2QE	An extended Christian family'. Christian focus.
28	Christianity ethos	Kent	Lourdes Nursing Home- CT8 8LX	Located on the grounds of Ursuline Convent. Strong Christian ethos
29	Christianity ethos	Kent	Pilgrim Homes Milward House- TN2 5SZ	nursing care and accommodation for older people with Christian beliefs
30	Christianity ethos	Kent	The St John Home- CT5 2DS	Christian home
31	Christianity ethos	Lambeth	St Mary`s Care Home-SW16 1HP	As it was formerly a home run by a Catholic congregation there is a high percentage of Catholic service users
32	Christianity ethos	Lancashire	Cross And Passion Convent-FY8 5EU	Roman Catholic

33	Christianity ethos	Lancashire	Jeanne Jugan Residence Little Sisters Of The Poor	Care is offered to residents based on an ethos of Christianity with management and senior staff belonging to the religious order'
34	Christianity ethos	Leeds	Gledhow Christian Care Home-LS8 1SF	Christian ethos
35	Christianity ethos	Leeds	Mount St. Joseph's	Catholic ethos
36	Christianity ethos	Lewisham	Morton House-SE13 6QZ	Mission Care which is an inter-denominational Christian registered charity owns it.
37	Christianity ethos	Manchester	St Joseph`s Nursing Home-M13 OAR	Roman Catholic order for women
38	Christianity ethos	Merton	St Teresa's Home for the Elderly-SW20 8AN	Strong Christian ethos but all faiths are welcome'
39	Christianity ethos	Newcastle upon Tyne	St Catherine's Care Home-NE15 7PY	A Catholic home'
40	Christianity ethos	Newcastle upon Tyne	St Josephs Home-NE4 7QA	Catholic ethos
41	Christianity ethos	North Yorkshire	Berwick Grange-HG2 7SD	Methodist ethos- 'Service users do not necessarily have to be of the Methodist denomination or of the Christian faith'
42	Christianity ethos	Northamptonshire	Rushden Park Nursing Home-NN10 6XZ	Christian based home- Methodist
43	Christianity ethos	Oxfordshire	Green Pastures Christian Nursing Home-OX16 9FA	Christian ethos
44	Christianity ethos	Oxfordshire	St Katharine's House-OX12 8EA	Strong Christian ethos
45	Christianity ethos	Oxfordshire	St Luke's Hospital-OX3 7PF	Christian home
46	Christianity ethos	Oxfordshire	The Homestead-OX18 1NA	Methodist home
47	Christianity ethos	Plymouth	Nazareth House-PL1 3QR	The home provides care for mainly white, British Christians'
48	Christianity ethos	Sefton	Ince Blundell Hall-L38 6JL	The Home has strong catholic links and provides support to many members of he catholic clergy and faith
49	Christianity ethos	Sefton	St Joseph`s Hospice- L23 4UE	The home was founded within a Catholic ethos and this is reflected in the character of both the interior and grounds of St. Joseph's. St. Joseph's is not exclusive to those of the Catholic faith and all denominations and non-believers are eligible for admission
50	Christianity ethos	Southampton	Fair Havens Christian Home-SO16 7DD	supportive Christian ethos'
51	Christianity ethos	Staffordshire	Oulton Abbey Nursing Home-ST15 8UP	The building has been home to a community of Benedictine nuns since 1853 (St Mary's Abbey, also known as Oulton Abbey). Cultural and religious beliefs are a particular consideration and members of all denominations are welcomed.
52	Christianity ethos	Staffordshire	St Joseph`s Convent Nursing Home-ST17 4LG	Catholic home, but respects all cultures etc
53	Christianity ethos	Staffordshire	St Mary`s Nursing Home-	main emphasis of the home is to create a Christian environment'

			ST15 8EJ	
54	Christianity ethos	Suffolk	All Hallows Nursing Home, Adele House (part of the community of All Hallows)	home is part of the Anglican Community of All Hallows'
55	Christianity ethos	Trafford	Lady Of The Vale-WA14 3HA	The Home is a Catholic foundation and there is daily Mass or a Communion Service for all the Residents and Sisters in the Home
56	Christianity ethos	West Sussex	St Josephs Nursing Home-BN17 6AU	Christian home
57	Christianity ethos	Wirral	Nazareth House Nursing Home-CH43 1UG	Although it's a home that is based on Christian values there is no religious requirements for admittance.

11.13.4. Specialist older people care homes without nursing

South Asian

	Group	Local authority	Address	Brief description
1	South Asian	Harrow	SEVA Care Home-HA1 1SB	The homes Statement of Purpose clarifies that the home specializes in providing a service to the Hindu Gujarati community, but welcomes people from any background.
2	South Asian	Hounslow	Heston House Care Home-TW5 0AH	Two units are designated to Asian elders and three are for the frail elderly.
3	South Asian	Lambeth	Aashna House-SW16 5BP	Aashna House is a purpose built residential care home providing care and accommodation for frail elderly people of Asian origin.
4	South Asian	Leicester city	Asra House-LE4 5LE	The home is part of the Asra Midlands Housing Association and provides care for older persons with an Asian lifestyle
5	South Asian	Leicester city	Diwali Nivas-LE3 0QR	a residential home for an Asian lifestyle and cosine'- from website no inspection reports available
6	South Asian	Leicester city	Gokul Nivas-LE4 5DT	Gokul Nivas is an 'Asian (Gujarati) Lifestyle' care home situated in a multicultural area of Leicester, close to the Melton Road
7	South Asian	Leicester city	Vishram Ghar-LE5 1HF	Vishram Ghar care home is registered to care for up to forty older persons who may have Dementia, Physical Disabilities or Mental Health issues in an Asian lifestyle environment.
8	South Asian	Leicestershire	Fosse Court-LE3 2FU	The home promotes itself as offering a service for people who wish to live an 'Asian lifestyle'.
9	South Asian	Manchester	Shassab-M16 0DZ	The service specializes in culturally appropriate care of Asian people.
10	South Asian	Redbridge	Hyleford- IG3 9AP	The home also provides care to elderly Asian residents

Black ethnic groups

	Group	Local authority	Address	Brief description
1	Black ethnic groups	Birmingham	Annie Wood	Suited for African Caribbean residents given the location'
2	Black ethnic groups	Haringey	Broadwater Lodge-N17 6NN	One unit provides care tailored to the needs of Elders from the Caribbean Community
3	Black ethnic groups	Leeds	UCA House-LS7 3HE	The home specializes in providing care for people predominantly (but not exclusively) from an African Caribbean origin, with a staff

				group that is representative of the ethnic origins of the people who live at the home

European

		Local authority	Address	Brief description
1	European	Ealing	Kolbe House-W5 3HH	mainly to accommodate for Polish refugees. The majority of the service users continue to be Polish and Catholic. Accommodation for people from Polish and other Central European backgrounds.
2	European	Ealing	Visitation Of Our Lady-W5 2PU	The Sisters are all from Poland, as are the residents. The emphasis of the home is on maintaining Roman Catholicism and Polish cultural links and language
3	European	Kingston upon Hull	Olivia Residential Care Home (2)-KT3 3EG	The home is much influenced by Polish language, food, religion, media and culture. This meets the needs of residents ideally, as some of the residents are Polish and it is clear that this influence is much valued by those who live here. It should be noted that the service is not exclusive to residents from Poland, but any prospective residents should be aware of the influence of Polish culture in the Home.
4	European	Kingston upon Hull	Jasna Gora-HD2 2JQ	Jasna Gora is a well-maintained home offering care and accommodation for up to twelve, predominately Polish, older people.
5	European	Manchester	Dom Polski-M16 8BB	The home provides a specialist service for older Polish people. The home is owned and operated by the Fathers Of The Society of Christ (Great Britain), a Polish religious organization and a registered charity.
6	European	Manchester	Polonia-M16 8HG	The home specializes in providing residential care to older people who are Polish, Ukrainian and Russian.
7	European	Northamptonshire	Laxton Hall-NN17 3AU	The home provides care for Polish people of retirement age whose main language is Polish. A Religious Order of Nuns provides staffing in most part
8	European	Nottingham	Yolanta House- NG5 1BS	A majority of the residents and a large number of the staff are of Polish origin, although there are residents from a range of ethnic backgrounds

Membership and Societies

	Group	Local authority	Address	Brief description
1	Membership and Societies	Isle of Wight	St Vincents-PO33 3NB	St Vincent's is a registered care home for 18 older residents who are ex-service men and women
2	Membership and Societies	Lancashire	Richard Peck House-FY8 1JL	Richard Peck House is owned and managed by The Royal Air Force Association (RAFA) and joint funded by The Royal Air Force Benevolent Fund. The home provides short welfare breaks to service personnel and their relatives in a comfortable, hotel style environment
3	Membership and Societies	Leicestershire	Catthorpe Manor-LE17 6DF	Catthorpe Manor provides residential care to older members of the Latvian community. The registered care home is part of the Latvian Cultural Centre, which provides cultural and social support to the wider Latvian Community
4	Membership and Societies	Salford	Ecclesholme-M30 0DG	Places in the home are offered to older Freemasons' and their dependent female relatives over the age of 65. Applicants have to provide information about their Masonic eligibility.
5	Membership and Societies	Somerset	Beaufort House- TA8 2BY	Provides safe and secure long term care for older members of the farming community
6	Membership and Societies	Suffolk	Manson House-IP33 1HP	Accommodation to older people from the farming and agricultural community
7	Membership and Societies	Surrey	Royal Cambridge House- KT8 9AH	Provides care for the widows and female dependents of all persons who have served in the Armed Forces. It also includes women who themselves have served in the armed forces.
8	Membership and Societies	Surrey	Shannon Court- GU26 6DA	Care for older people and provides care for older Freemasons and dependent females of Freemasons.

9	Membership and Societies	Surrey	Sydenhurst-GU8 4SJ	Residents who are Ukrainian or who have Ukrainian connections
10	Membership and Societies	Warwickshire	Musmajas-CV8 3FZ	A care home to service the Latvian community
11	Membership and Societies	York	Connaught Court Nursing & Residential Home St Oswald's Road, Fulford, York, North Yorkshire, YO10 4FA	Connaught Court is a care home owned by the Royal Masonic Benevolent Institution R.M.B.I. and provides residential and nursing care to men and women who are freemasons, or their dependants. The home has 4 residential areas for people receiving personal care only.

Jewish

	Group	Local authority	Address	Brief description
1	Jewish	Camden	Kay Court-NW3 7AJ	it is a Volunteer Organisation and a Registered Charity that runs a number of specialist services for different age ranges and care needs for the Jewish people.
2	Jewish	Liverpool	Stapely Home For Aged Jews-L18 8BR	Jewish home
3	Jewish	Newcastle upon Tyne	Philip Cussins House-NE3 4EY	Philip Cussins House is a long established charity that provides residential care for elderly Jewish people. It also warmly welcomes non-Jewish residents
4	Jewish	Nottingham	Miriam Kaplowitch House-NG5 2EL	Offers care specifically to the Orthodox Jewish Community
5	Jewish	Salford	Beenstock House- M7 4RP	Home offers a culturally specific service for Orthodox Jewish people
6	Jewish	Southend on Sea	Raymond House-SS1 1DT	It provides specialist care for people of the Jewish faith and caters for all their cultural, religious and dietary needs

Christian only

	Group	Local authority	Address	Brief description
1	Jehovah Witness	Staffordshire	The Rosewood-ST2 7NE	Whilst the home is respectful to all religious beliefs, service users need to be sensitive to the religious traditions and beliefs of Jehovah Witnesses. 'They are all Jehovah's Witnesses and attend religious meetings regularly
2	Jehovah Witness	Cumbria	Jah Jireh-CA15 7DX	The residents and staff of the home are all Jehovah's Witnesses and this commitment is essential before anyone comes to live - or work- in the home.
3	Jehovah Witness	Lancashire	Jah-Jireh-PR5 2WA	Jah-Jireh homes have been established and are run wholly and solely to giveaccommodation and care to members of the community of Jehovah'sWitnesses.
4	Christadelphian	Torbay	Bethesda-TQ2 5UD	All members at Bethesda are members of the Christadelphian community

5	Christadelphian	Warwickshire	Peacehaven-CV32 5TL	Provides care for people from the Christadelphian community
6	Christadelphian	Warwickshire	Bethany-CV32 5QN	Individuals or couples who are members of the Christadelphian Church
7	Retired clergy members, nuns and monks	West Sussex	Clayton Court-GU33 7QP	Home caters exclusively for retired Brothers of the De L Salle teaching order of monks
8	Retired clergy members, nuns and monks	Wandsworth	Duchesne House-SW15 5ND	All residents belong to the Order of the Scared Heart. The home does not accept any other people. (Members of Catholic Religious Orders)
9	Retired clergy members, nuns and monks	Sefton	St Vincents-PR9 0EX	Retired sisters from the Community of St Vincent de Paul and sisters from other religious communities.
10	Retired clergy members, nuns and monks	North Yorkshire	St Hilda's Priory-YO21 3QN	It is designed to provide care for up to ten Sisters of the Order of the Holy Paraclete. Only Sisters of the Order are eligible for admission and with support from the care staff are able to continue with their chosen lifestyle
11	Retired clergy members, nuns and monks	Essex	Seton Unit-CM13 3BL	All the residents are Sisters of Charity of St Vincent de Paul
12	Retired clergy members, nuns and monks	Lancashire	Franciscan Convent-BB11 3BS	Only retired Sisters Religious needing care from this Order live in the home at the present time. The Roman Catholic faith underpins the life of the home and Mass is celebrated daily in the Convent's Chapel.

Christianity ethos

	Group	Local authority	Address	Brief description
1	Christian	Cheshire	Park Mount-SK11 8NT	Catholic but accepts other faiths. Mass is held daily in the chapel at the home. All denominations are welcome to attend.
2	Christian	Cornwall	St Mary`s Haven-TR18 2DH	Christian atmosphere
3	Christian	Cornwall	St Mary`s Haven Respite Unit-TR18 2DH	St Mary's Haven is an inter-denominational home working within Christian principals,
4	Christian	Cornwall	St Andrews-CV5 6FP	This is a Christian home, however, other faiths are welcome
5	Christian	Cumbria	Emmaus House-CA28 8XR	The home is owned and operated by the Emmaus Trust, a charitable organisation set up by the Christian Brethren Church. Some, but not all residents are members of this church.
6	Christian	Cumbria	Claremont-DE4 3GY	Claremont is a Christian Residential Home registered for 19 older people and is a non-profit making organisation.

7	Christian	Derbyshire	The Brooklands-DE45 1AQ	Although the home was originally founded with strong Christian principles, and communion is still arranged through the local church, a commitment to this is no longer a requirement for coming to live there.
8	Christian	Devon	Moreton-EX8 4AA	Methodist home- although people do not have to be a Methodist to live here.
9	Christian	Devon	Rest Haven-EX8 2SD	The home is a Christian home and residents are supported to maintain their religious beliefs by staff at the home.
10	Christian	Devon	Rose Lawn-EX10 8EX	It is owned by Key Change, a not-for-profit organisation, which has a Christian and spiritual ethos.
11	Christian	Doncaster	St Anne's Rest Home-DN6 9JL	Strong Anglican community/home
12	Christian	Dorset	Tree Tops Residential Care Home-DT7 3HQ	Tree Tops operates in accordance with Christian values and welcomes residents and staff of all faiths, or of none.
13	Christian	Durham	St Mary`s Convent-DH8 0QD	Catholic atmosphere
14	Christian	East Riding of Yorkshire	Willersley House-HU10 6BY	Methodist home: The best example of this was during the regular church services when several of the service users read lessons and led the prayers. The majority of the service users attended the church services.
15	Christian	East Sussex	Berry Pomeroy-BN21 4EN	Christian home: aim to work and worship together in unity.
16	Christian	East Sussex	Highwood-BN20 8DU	Highwood is a Christian home that is situated in a quiet residential road in Eastbourne.
17	Christian	East Sussex	Holy Cross Priory-TN21 0TS	Care staff and residents are principally from the religious community.
18	Christian	Essex	Beech House-SS14 1QD	Christian environment
19	Christian	Essex	Ernest Luff Home-CO14 8SW	The home was originally established to run along Christian principles and still has a strong Christian ethos.
20	Christian	Essex	The Franciscan Convent Residential Home-CM7 9RS	Strong Catholic home
21	Christian	Essex	St Michael`s Care Home-CO15 6JW	Strong Christian home
22	Christian	Glos	More Hall Convent-GL6 6EP	Although the Order is Catholic, any denomination is welcome at More Hall.
23	Christian	Glos	Nazareth House-GL52 6YJ	The Home is owned and managed by the Sisters of Nazareth, an order of Roman Catholic nuns, but people of any religious faith are welcome at the Home.
24	Christian	Glos	Wisma Mulia-GL2 7HE	The core philosophy of the home is based on a spiritual following called 'Subud'. This is an association of people of all races, religion and creeds. Its foundation is the simple worship of God without dogma or teaching. This does not preclude

				anyone from living there
25	Christian	Hampshire	Bethany-RG26 3TH	The home is registered to provide care and accommodation to 37 elderly Christians.
26	Christian	Hampshire	Maryfield Convent-RG27 9LA	Catholic home
27	Christian	Haringey	Meadow, The-N10 1PL	The aim of the home is; "To improve the quality of life for older people inspired by Christian concern".
28	Christian	Havering	Parkside-RM2 5EH	The home is run on a Christian basis, and most of the staff are Christians. However, the registered providers accept people from all beliefs and backgrounds.
29	Christian	Herefordshire	Dulas Court-HR2 0HL	The purpose of this home is to provide continuous and holistic care for elderly people in a Christian environment, enabling and supporting them in their increasing frailty
30	Christian	Kensington & Chelsea	St Teresa`s Home-SW7 3PW	Catholic home but open to non-Catholics
31	Christian	Kent	Cliff Dene-CT5 2BQ	Although Christian values underpin all aspects of the organisation, there is a commitment to support service users to follow other faiths
32	Christian	Kent	Euphrasie Barbier House-CT2 0HP	The premises have been extended and adapted to accommodate twelve sisters who are part of the religious order; the admission to the home is therefore restricted to female and is exclusive.
33	Christian	Kent	Rosset Holt Home-TN2 3RB	The website states that all its centers are run on Christian principles.
34	Christian	Kent	St Joseph`s-CT14 9NB	The home cares for sisters from the order of Our Lady of the Missions and does not accept residents outside this category
35	Christian	Kent	St Peters Convent-CT6 8RQ	St. Peter's Convent, owned and operated by a religious order, provides accommodation and support for older people. Support is, in accordance with the aims of the organisation, provided exclusively for female residents. Sisters of the order retain occupancy of the 3rd floor and some other parts of the premises as part of their convent.
36	Christian	Kent	Sunset Lodge-TN2 3QT	The home has a strong Christian ethos and is a no smoking, no alcohol environment.
37	Christian	Kent	Villa Maria-CT21 5QE	It is a purpose built home that is owned by a religious order, the Sisters of the Marist Congregation and linked to the adjoining convent. The majority of people for whom care is provided are Sisters of the Marist Congregation.
38	Christian	Kingston upon Hull	St Catherine's Home-HU9 3AJ	Although the home is owned by a Catholic religious order, people of other faiths (or no faith) are welcome to move into the home
39	Christian	Knowsley	Thornton Leigh Care Home-L36 7XG	The home is managed around the Christian Ethos. Prayer meetings are held twice weekly and daily readings from the bible are read at lunchtime for those residents who follow a Christian faith and wish to be involved. Residents who are non-Christians are also welcome at the home

40	Christian	Lambeth	St Johns House-SW16 5SH	The aims and objectives of St John's House are stated as being to provide 'a 'home for life' within a warm, caring Christian environment.
41	Christian	Lambeth	St Peter`s Residence-SW8 1QH	Christian environment
42	Christian	Lancashire	Bethany House-PR2 6TQ	Bethany House is a Residential Care Home for the Elderly, built and managed by Preston Bethany Trust, a Christian Charity (Registration No. 511535). Assistance is provided to enable each service user to follow their religious faith within the home and encouragement to participate in a local church of their particular denomination
43	Christian	Lancashire	Cardinal Heenan House-WN8 0QR	Roman Catholic. Many residents attend daily mass in the chapel, some said this was very important to them. Some residents are supported by ministers from other faiths, these are welcomed at the home.
44	Christian	Lancashire	McAuley Mount-BB12 6TG	The philosophy of care is underpinned by the Roman Catholic faith, Mass is held on a daily basis in the home's Chapel. The main aim of the home is to provide high quality care for older people, both male and female, who feel comfortable and supported in an environment where the Christian values and lifestyle are paramount. Residents' do not have to follow the Catholic faith and are free to choose their own lifestyle; everyone is welcome in the Chapel
45	Christian	Lancashire	Nazareth House-LA1 5AQ	This is a retirement home (Roman Catholic)
46	Christian	Lancashire	Stella Matutina Convent-FY8 5RQ	Christian home-Stella Matutina is owned and run by The Sisters of Charity of Jesus and Mary, which is a religious order with a charitable status.
47	Christian	Leeds	Dyneley House-LS7 3QB	It was originally set up to provide care and support specifically to members of the Christian Science Church, but now people of all faiths are welcome.
48	Christian	Leicester city	Melbourne Home-LE2 3BE	The Home is owned by a charitable trust and describes itself as a Christian residential care home. The Home organises in house religious services every week, which is generally appreciated by service users.
49	Christian	Leicestershire	Pilgrim Homes (Hornsey Rise Memorial Home)-CV13 6PA	It is owned by Pilgrim Homes, a 200-year-old Christian charity that was founded in 1807 as the Aged Pilgrims' Friends Society with a vision to care for elderly, needy Christians
50	Christian	Linconshire	Chandos House-NG31 9LH	Christian charity accepts all religions
51	Christian	Linconshire	Digby Court-PE10 9AG	Christian charity accepts all religions
52	Christian	Linconshire	Eresby Hall-PE23 5HT	Christian charity accepts all religions
53	Christian	Linconshire	Stones Place-LN6 0PA	There is a Christian ethos to the home but there are people of varying denominations cared for within the home.

54	Christian	Lincolnshire	Westerley-LN10 6SQ	The organization is a Christian charity set up specifically for Methodist Local Preachers and their dependents. However, their homes now accept applications from Lay Preachers and service users from other denominations.
55	Christian	Liverpool	Christopher Grange-L14 2EW	The home is owned by the Catholic Blind Institute and has its own chapel in which a daily mass is held. However, residents are accepted from any faith and local ministers of other religions visit to provide pastoral support.
56	Christian	Luton	Rowles House-LU3 2BB	Committed Christians own Rowles House. Everyone living in the home has the opportunity to join in services and prayer meetings held in the house
57	Christian	Norfolk	Corton House-NR1 3AP	It is owned by Corton House Ltd. a charitable Housing Association with a Christian ethos, which is managed by a committee whose members in the main are representatives from the Norwich Free Churches. 'To provide in line with Christian values, residential and sheltered housing that recognizes the individual rights, privacy, dignity and independence of residents and tenants.'
58	Christian	Norfolk	Quebec Hall Christian Eventide Home-NR19 2QY	Quebec Hall Trust is a Christian Eventide home providing personal care and accommodation for twenty older people and has a strong Christian ethos.
59	Christian	North Somerset	Abbeygate-BS23 4BG	The home care is based on a Christian philosophy however, they are able to accommodate people who may have another religious belief or wish to follow a belief
60	Christian	North Somerset	Dewdown House-BS23 4BE	The home operates with a Christian ethos
61	Christian	North Somerset	Tower House Care Home-BS23 2RJ	The home will be run under Christian beliefs and standards
62	Christian	North Yorkshire	Priceholme-YO12 6LE	The home has a stated Christian ethos based on the Methodist denomination. This does not, however, exclude admission for service users with other, or no, religious beliefs
63	Christian	Northamptonshire	Bethany Homestea-NN2 7BP	The home is run by a broad of trustees and admits service users who are members of non-conformist churches in town.
64	Christian	Northamptonshire	Nazareth House- NN5 6AD	Catholic ethos
65	Christian	Northamptonshire	St Christopher's- NN2-3AD	St Christopher's is registered as a Church of England War Memorial Home
66	Christian	Northumberland	Harwood Court-NE23 6AZ	The home has a Christian based ethos and welcomes applications from people of all faiths
67	Christian	Nottinghamshire	Queenwood Care Home-NG9 4DP	Is a Methodist care home
68	Christian	Oldham	Frameland-OX12 9L	Offers care for older people who share a Protestant Evangelical Christian faith
69	Christian	Oxford shire	St John's Home- OX4 1QE	Anglican religious community

70	Christian	Plymouth	Bethany Christian home- PL4 8QE	The home is run by a Christian organization and there is a daily Christian worship. However, the admission policy for the home is not exclusive
71	Christian	Plymouth	The Mount Eventide Home- PL4 7PR	Provides residential and nursing homes following Christian principles
72	Christian	Redbridge	Homesdale- E11 2SH	Christian concern
73	Christian	Sefton	Nazareth House- L23 OQT	'The ethos of Nazareth house is rooted in Catholicism and there is an integral chapel with daily Mass for those who live there'
74	Christian	Sefton	Northern Countries- PR8 2LE	Service users with strong Christian faith'
75	Christian	Solihull	The Foundation of Lady Katherine Leveson- B93 0AL	Has a Christian ethos, and although they will consider non Christians, it is required that the service users are sympathetic to the Christian ethos
76	Christian	Somerset	Westerley- TA24 5JB	The home cares for people within a Christian community and accepts requests for assessment from all Christian denominations
77	Christian	Southend on Sea	Westerley- SS0 7QU	The home is managed and run on Christian faith, beliefs and values
78	Christian	Southwark	The Elms- SE22 OJR	We provide comfort and support in a Christian atmosphere '
79	Christian	Suffolk	Bethesda Eventide Homes- IP1 3SN	The home has a very clear Christian ethos based on the teachings of the Baptist Church
80	Christian	Suffolk	Finborough Court	We welcome applications from Protestant Evangelical Christians of any denomination'
81	Christian	Suffolk	Manor House Christian Rest home- IP14 4LJ	Providing residential accommodation for older people within a Christian community
82	Christian	Suffolk	Montana Residential Home- IP23 2RF	The Sisters follow the Rule of St Benedict. His Rule is Christ centered. Promote doctrines of the Roman Catholic Church but welcome to all
83	Christian	Suffolk	Ormond Home for the Elderly- IP4 2UT	Christian ethos
84	Christian	Sunderland	Little Sisters of the Poor- SR4 8QA	Strong Christian home
85	Christian	Surrey	Shottermill House- GU27 1NX	Provides care for elderly Protestant Christians who Subscribe to the Doctrinal Basis of faith
86	Christian	Sutton	Eothen-SM2 6PT	Service is underpinned by a low key but positively declared, Christian ethos. Eothen (from the Greek) means 'The Dawn' and is referenced into Paul's Epistle to the Romans

87	Christian	Thurrock	Cedar House- SS17 7AB	comfortable caring home in a Christian environment'
88	Christian	Thurrock	Oak House- SS17 OBA	comfortable caring home in a Christian environment'
89	Christian	Torbay	Walmer House- TQ1 3HZ	All of our centers are run on Christian principles
90	Christian	Trafford	Handsworth Methodist Home- WA14 2LA	"We continue our professional service for older people which are caring, Christian-based'
91	Christian	Warwickshire	Bilton House- CV22 7QH	home with a Christian ethos'
92	Christian	Warwickshire	Homewood- CV32 5TR	"We continue our professional service for older people which are caring, Christian-based'
93	Christian	West Sussex	Greenways- PO21 2UW	"We continue our professional service for older people which are caring, Christian-based'
94	Christian	West Sussex	Koininia- B11 4DJ	care for elderly Christians from churches linked with the Fellowship of Independent Evangelical Churches
95	Christian	West Sussex	St Anne's Convent- RH15 8EL	Christian ethos home
96	Christian	West Sussex	St Joseph's- PO21 1NJ	The home provides specific support for Roman Catholics to practice their religion, but have in the past supported people to practice other faiths
97	Christian	West Sussex	St Mary's Residential Care home- BN11 1RF	Following the teaching and example of Christ'
98	Christian	Wiltshire	Bethesda House- SN11 9NN	Residents must attend the Gospel Standard Chapel
99	Christian	Wiltshire	Leonara- SN15 3DY	All residents must be in full agreement with Pilgrim Homes doctrinal basis