

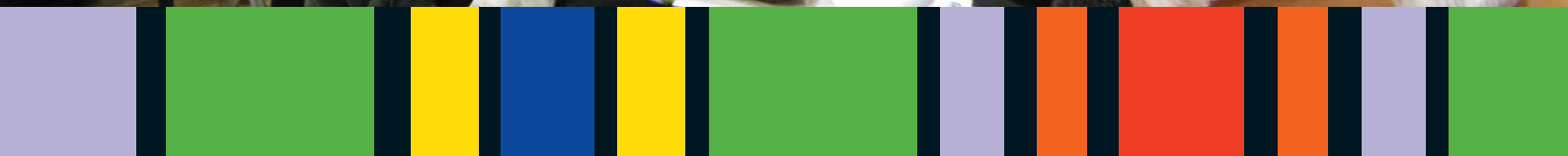


Managing Better Mental Health Care for BME Elders

Interim Report on National Seminars held for BME Elders

June 2009

Funded by the Department of Health



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About this report

This report summarises the outcomes from three regional seminars organised by the Policy Research Institute for Ageing and Ethnicity (PRIAE) for Black and minority ethnic (BME) elders and BME age organisations in the spring of 2009. The seminars were organised as part of a project funded by the Department of Health, the *Better Mental Health for BME Elders* project.



Background

Over the last three decades the number of elderly people (65+ years) from Black and minority ethnic (BME) population groups in the United Kingdom has increased. 8.2% of all BME people are classified as elderly: this amounts to more than 500,000 BME elders.

Depression and dementia are two of the most common disorders in old age. Depression accounts for about 10 -15% and dementia for around 5% of disorders in all those over 65 years of age. Both are as common in BME older people as in white British older people.

Demographic data pertaining to the elderly BME population in the 2001 census indicated an ageing BME population. Further analysis of this data to evaluate the implications for the future development and delivery of old age psychiatry services for BME elders suggests that in BME elders the absolute number of those with dementia and depression will increase.

Delivering Race Equality (DRE) in Mental Health Care (Department of Health, 2005) is a five year action plan launched by the Department of Health in 2005 to address inequalities in mental health care for BME communities. It is based on three building blocks:

- Better information.
- Community engagement.
- More responsive services.

The aim of DRE was to improve access to, experience of and outcome from mental health services for BME communities.

DRE was aimed at all BME communities and it acknowledged that there may be specific issues relating to equality for BME elders. In relation to dementia, for example, not only many BME dementia sufferers and their families who do not speak English face problems trying to get the care they need, but BME elders with dementia who have learned to speak English may lose the ability to do so as dementia sets in. In addition there may be cultural issues which mean that there is a risk that BME elders will see dementia as 'part of growing old', not recognising symptoms until later on. This may be compounded by the fact that for many BME communities there is considerable stigma attached to mental health, so it may be more comfortable to see someone's symptoms of dementia as a natural part of ageing, rather than as signs of mental ill health.

The complexity of the care system may be compounded for many BME families who are

unfamiliar with it and who may face language and cultural barriers and there may be structural inequalities that impact adversely upon BME elders with dementia. In many instances, voluntary organisations may be better placed to meet the needs of BME communities, but these are often dependent on short-term funding.

It is within this context that the *Better Mental Health for BME Elders* project was conceived by PRIAE.

PRIAE

Founded in 1998, PRIAE aims to improve quality of life for all Black and minority ethnic elders by: producing clear information; conducting focused studies with targeted policy and service developments; and engaging minority elders and organisations. As the only organisation specialising in helping Black and minority ethnic elders, PRIAE occupies a unique position and plays an essential role in policy, research, information and practice on:

- Employment and income;
- Health, social care and housing;
- Pensions; and
- Quality of life.

The Better Mental Health for BME Elders Project

The *Better Mental Health for BME Elders* project is funded by the Department of Health. It aims to:

- collate and co-ordinate examples of good practice, including mental health support developed with the BME age sector – particularly specific aspects of mental health issues and solutions
- train BME elders and workers to deliver appropriate support
- develop the capacity and confidence of the BME mental health and social care community, using well-developed and recognised models of community engagement.

The project builds on work carried out by PRIAE in 2007 which highlighted the key service gaps and concerns for BME elders accessing mental health services. This work demonstrated the need for statutory agencies in the health, social care and criminal justice sectors to receive training on cultural competence as well as the need for community-based groups to understand the referral pathways of mental health services.

In taking this work forward, PRIAE has:

- drafted two practice guides – one for BME elders and their carers about mental health and mental health services (utilising a patient journey to detail different diagnosis and treatment pathways) and one for clinicians which is designed to help them carry out high quality professional and appropriate assessments and appropriate care pathways;
- produced a video *Dementia Matters Ethnic Concerns*; and
- developed links with other organisations and bodies working on similar programmes.



The Regional Seminars

In March 2009 PRIAE organised three regional seminars for BME elders. The purpose of these seminars was to actively engage BME elders and BME age related organisations in the Better Mental Health for BME Elders project by:

- informing them about what was already going on in the field;
- sharing with them the work that PRIAE had done to date;
- gathering examples of good practice; and
- identifying BME elders who might become champions for the project in the future.

The seminars took place in Manchester, Birmingham and London on the 2nd, 3rd and 16th March 2009 respectively. The regions were selected in order to maximise the opportunity for BME elders from around the country to participate. BME elders were able to claim the cost of their expenses for attending.

Potential participants were invited via a promotional flyer (appendix 1) that was circulated to BME elders and BME age related organisations using PRIAE's databases. A number of partner organisations also circulated the flyer.

65 people, representing BME elders and BME age organisations, attended the three seminars. They described their ethnicity as below:

Ethnicity	Number	Rounded percentage
British Asian	26	40%
White British	13	20%
Black British	11	17%
British Chinese	4	6%
Black Caribbean	1	1.5%
Black African	1	1.5%
British Gypsy	1	1.5%
African Asian	1	1.5%
Mixed Heritage	1	1.5%
British Somali	1	1.5%
Irish	1	1.5%
Kurdish British	1	1.5%
British Burmese	1	1.5%
Chose not to answer	2	3%
Total	65	100%

Content of the days

The seminars were delivered in partnership with the International School for Communities Rights and Inclusion (ISCRI) at the University of Central Lancashire (uclan).

The full programme for days is set out in appendix 2. Professor Ajit Shah (Professor in Old Age Psychiatry and Consultant at the West London Mental Health NHS Trust) and Jez Buffin (Associate Head, ISCRI) both gave presentations in order to set the context for the day.

Professor Ajit Shah's presentation

Professor Ajit Shah outlined some of the demographic changes that have been occurring in the United Kingdom over the last three decades and pointing out the implications of this for BME communities and mental health service providers.

Depression and dementia are two of the most common disorders in old age. Depression accounts for about 10 -15% and dementia for around 5% of disorders in all those over 65 years of age. Both are as common in BME older people as in white British older people (Bhatnagar and Frank, 1997; Lindsey et al., 1997a,b; Shah et al., 1998; McCracken et al.,

1997; Livingston et al., 2001; Ebrahim et al., 1991; Silveira and Ebrahim, 1998a,b; Reeves et al., 2001)

Demographic data pertaining to the elderly BME population in the 2001 census indicated an ageing BME population. Over the last three decades the number of elderly people (65+ years) from Black and minority ethnic (BME) population groups in the United Kingdom has increased (OPCS, 1983; OPCS, 1993). 8.2% of all BME people are classified as elderly; this amounts to more than 500,000 BME elders (Shah et al 2005a; Shah, 2007).

Further analysis of this data to evaluate the implications for the future development and delivery of old age psychiatry services for BME elders suggests that in BME elders the absolute number of those with dementia and depression will increase.

Even though older people from most BME groups have high GP registration and consultation rates (related to depression and dementia) they are poorly represented in secondary care old age psychiatry services. There are many reasons for this including the family being unfamiliar with symptoms of mental disorder – i.e. being dismissed as 'being old'; not having the language / vocabulary to explain symptoms; a lack of awareness of services or poor experience of services - i.e. being culturally inappropriate; stigma; accepting it as fate; a preference to consult traditional / faith healers instead of asking for a referral etc (Marwaha and Livingston, 2002, George and Young, 1991, Wai Yin Chinese Women Society 2007, Bhatnagar 1997).



GPs themselves may lack clinical experience to diagnose depression / dementia amongst BME populations and issues such as language, lack of interpreters, poor experience of a service (e.g. being

ethnically insensitive) may also be contributing factors in poor diagnosis and referrals, as well as clinical bias and institutional racism (Shah et al 2005b).

Despite this, three different studies - one of Indian sub-continent elders living in Ealing and Hounslow, one of Polish elderly and one of mixed BME groups (Livingston et al, 2002) - have highlighted equity of access to health and social care services amongst these groups and these give some cause for optimism.

In addition the 2007 and 2008 Count Me in Census's of 65+ year old psychiatric patients found that most BME groups had either higher bed occupancy than or similar bed occupancy to the national average for England and Wales - the reasons for which were not absolutely clear (Commission for Healthcare Audit and Inspection, 2007).

Research has also highlighted that social, cultural and economic factors were impacting on BME family lifestyles and changing BME family structures. Therefore the popular perception that BME elders did not access services because they were being looked after by their extended family was in fact not accurate and a myth.

Jez Buffin's presentation

Jez Buffin set his presentation within the context of the Department of Health's five year action plan, Delivering Race Equality in Mental Health Care. As part of the Community Engagement strand of this ISCRI had been commissioned to support 80 Community Engagement Projects to undertake research in their own communities in relation to mental health issues. 14 of these (see appendix 3) had specifically focussed on BME older and mental health and Jez reported back on the key findings from these.

There had been some challenges in trying to collate the findings from the 14 projects. These included the fact all of the projects had used different methods and had focussed on different issues that were of most concern to them. In addition, many of the projects themselves had encountered problems in talking about mental health. In many communities considerable stigma surrounded the issue of mental health that had made the subject difficult to talk about. Many of the studies had been carried out in languages other than English and sometimes key words and concepts around mental health and well-being had not translated easily. Some communities, such as the Chinese, had their own cultural concepts of mental health such as Jing Shen, which is about the internal balance of body, mind and spirit.



On top of this, the participating projects had no agreed definition of 'older', with many communities seeing elders as being 40 plus. This perhaps reflects two things. First the general respect that is shown towards elders in many BME cultures as opposed to westernised ideals of youth; and second the impact of discrimination on premature ageing.

Despite this, it had been possible to pull out some key themes from the 14 reports relating to mental health care for BME elders. These included:

- Lack of recognition of diversity within different minority groups - there was a sense from the projects that service providers and commissioners tended to lump all BME groups together. They did not appreciate the heterogeneity of the groups, for example: different age and generational issues; different language and dialect issues; different faith issues; different gender issues; issues relating to differing countries of origin etc.
- Lack of recognition of histories - problems related to migration. There was a sense that service providers and commissioners tended not to understand the histories of the different BME populations of England.
- Stereo-typing – this lack of understanding could often result in BME elders feeling that they were being stereo-typed. For example, many Irish people immigrated to the UK after World War II. Their need for employment, due to limited opportunities in Ireland, meant Irish immigrants were able to provide a cheap and mobile workforce to the UK's labour market. This has resulted in them being seen as low skilled manual workers. Many migrated alone, so they have no family support. Labour mobility has often contributed to the problem of isolation.
- Understanding of the different experiences in UK and abroad – discrimination and social isolation vs. war and separation. Many BME elders faced very different challenges in the UK to those they may have faced before they came here. In the UK, is

sues such as social isolation and discrimination were likely to impact upon mental health. Often the issues that might have impacted upon mental health from the times before they came to the UK, such as war and separation, were very different. There was a sense that mental health service providers and commissioners did not understand these issues.

- Language and literacy – low levels of education (although there were variations). In many of the projects less than half of the elders could communicate fluently in English and less than a third could read English. Many could not read in their mother tongue. Many elders had not been educated beyond primary schooling in their countries of origin.
- Problems communicating and being understood – perhaps unsurprisingly given the above, many BME elders complained that they had problems making themselves understood or understanding what was being said to them and this undermined their confidence in mental health services.
- Not wanting to be a burden – many BME elders would not access services because they felt that they were a burden.
- Categorisation of mental health symptoms as something else – many BME elders did not recognise their mental illness symptoms as such – they tended to view symptoms as signs of something else, such as a physical illness, a normal part of ageing, black magic or punishment.
- Over-reliance on medication – many BME elders were critical of mental health services for their over-reliance on medication. They wanted to see more holistic responses including social activities to reduce isolation and promote more active ageing.
- Stigma – Many BME elders were fearful about the stigma associated with mental health and were fearful of implications of being seen as ‘mad’. Many worried not only about the impact upon themselves, but also about the impact upon their families (e.g. of reduced marriage prospects).
- Services not ‘for us’ – services were often seen as for white older people. Activities (e.g. reminiscence groups) were seen to focus on the memories and shared histories of white older people. Music groups tended to play European or North American music. There was little gender specific service provision. Dietary needs were often not met.
- Role of community organisations in promoting well-being and also as ‘sign-posters’. BME community organisations were often central to the well-being of BME elders (e.g. through the provision of luncheon clubs). These organisations

were seen as having a key role to play in promoting well-being and in being able to keep a watchful eye on BME elders. It was suggested that these organisations could play a key role in referring or sign-posting elders on to other services when appropriate.

- Awareness raising, education and information – elders felt there was a need to raise their own understanding and awareness of mental health and to promote mental health issues within their own communities so as to reduce stigma. They also felt that there was a need to raise the awareness of service providers and commissioners about their specific needs.
- Advocacy and interpretation – a key need that many BME elders had was for advocacy and interpretation. Many saw community organisations as having a key role to play in the provision of this.
- Mental health guides – outreach. Many BME elders saw the value of having people within their own community who were experts on mental health and who could help to guide them around the services they needed. Others saw the value in services working more pro-actively within their own communities, perhaps via outreach services.
- Integration of faith into mainstream services. Many of the BME elders practiced a faith and faith was a major aspect of their well-being. For many, faith was what gave them a sense of purpose in the world and faith was what sustained them at times of difficulty. Many BME elders complained about the lack of services that integrated faith with mental health issues.

Issues raised by participants following the presentations

This section lists issues and points made by participants immediately after the presentations. As these were similar in all three sessions they have been collated and are not listed in any priority order.

- Although there were many community based mental health services for BME elders very few dealt or specialised in dementia mainly because this was seen as the domain of psychiatry and treated as one of a number of mental illnesses. Previously, dementia services have struggled for dedicated funding but the launch of the national Dementia Strategy offers opportunities for more focussed interventions.
- Depression rate amongst BME population groups was far higher than other groups. Within older age groups suicide rates have increased in Asian women over the last decade and there is

unpublished evidence of suicide rates increasing with age in Indian men and Chinese and African women. However, there is little mention of BME groups in the National Suicide Prevention Strategy for England.

- In the Chinese community there was a lot of stigma attached to mental health. The children were reluctant to use interpreters and external agencies. As a result Chinese elders remained invisible (in the system) and were suffering. Furthermore, services were not culturally appropriate for Chinese elders. It was a challenge to get Chinese community / elders to access (dementia) services and equally challenging to get services to be more open, accessible and culturally appropriate.
- Structural changes were taking place in Asian (Indian) families which were having an adverse affect on elders, most of whom were at home, alone and feeling very isolated.



- BME elders preferred their families to care for them but under the current Direct Payment system they could not pay a family member to look after them. Individual Budgets will be a helpful move in alleviating this problem.
- General consensus that services were not culturally appropriate and remained Eurocentric. Most didn't really understand what was meant by 'being culturally appropriate' and were therefore not meeting the needs of BME elders. For example, there was a paucity of culturally appropriate residential homes for BME groups which was a barrier in terms of uptake of such services.
- Commissioners had difficulty commissioning services that met the diverse needs of their communities because they didn't have comprehensive information on what existed and what the gaps in service provision were. So even with an evidence base there were very few models of good practise.
- BME voluntary groups should look at commissioning procurement guidelines to help prepare their bids.

- Professionals needed to have an awareness and understanding of the family culture and dynamics and should take this into account when making assessments. For example, in Asian families - the carer was usually likely to be either the wife, daughter-in-law or daughter but yet they were often not consulted when it came to making key decisions about care packages.
- Diversity and cultural awareness training for professionals should be made mandatory.
- The social context was very important to the recovery process. Day centres, luncheon clubs and other such social activities were very important in helping BME elders to socialise, reduce loneliness and isolation.
- Most community based services were started by community champions and were not sustainable as they were either personality led or people burnt out.
- There was very little support (from the NHS) for alternative therapies such as Ayurvedic/ Chinese treatments. Homeopathic medicines were being prescribed by some GPs.
- Services should be aware that some BME groups wanted to consult faith healers and should be enabled to do so as well as them accessing statutory services. There was evidence of discriminatory practises by some services where patients had used a faith healer and had been made to wait five months or more for an appointment.
- Faith healers should be regulated to protect people from 'cowboys'. There should be a code of conduct and practise.
- More joint work needed to take place between services. For example, between faith groups and older people's services.
- There was concern about the lack of information and support given to carer's (and the family) once a BME elder had been diagnosed with dementia. They were left to cope on their own.
- Language was another critical factor especially if English was not spoken by the main carer/s. Women carers tended to get overlooked and discriminated against.
- In some areas GPs were only able to provide a five minute appointment slot which was inadequate for a proper consultation since a full assessment (with an interpreter) takes longer. As a result BME elders were either not being diagnosed with dementia or being misdiagnosed with another mental illness.
- More trained interpreters with mental health

background and specialist knowledge of dementia were required to interpret technical and complex issues to the patient and their families. This would greatly improve service provision.

- Other issues around the use of interpreters included more training, use of language and gender specific interpreters.
- Depression amongst BME elders was a big issue. There was some concern that with the launch of the National Dementia Strategy the focus (and resources) would shift away from depression and towards dementia.
- Services should take on board that issues pertaining to longer established BME population groups (and BME elders) differed to newly arrived BME communities. For example, those coming from war or conflict areas; those with immigration issues; had special needs and required specialised services. It was important that less established groups learn from more established ones.
- More should be done to target BME elders and ensure they were diagnosed (with dementia) early on as this could help to slow down the condition and improve their quality of life.

Afternoon Discussions

The workshops focussed on identifying opportunities for increasing the role of BME elders and BME age related organisations in the promotion of better mental health for BME elders and in the collation of examples of good practice in the care of BME elders. Participants were specifically encouraged to identify projects that:

- promoted well-being and mental health.
- promoted an understanding and awareness of mental health.
- reduced stigma.
- provided good information.
- assisted access to services.
- enhanced good experiences.
- supported recovery.
- supported carers.

Opportunities for increasing the role that BME communities could play in the promotion of mental health

Participants identified four key areas in which they thought BME elders and BME communities could

make a significant contribution to the promotion of better mental health. These included:

- BME older/elderly people could raise awareness within their own communities through peer education; by helping to develop communication resources; sharing good practice and becoming mental health advocates.
- Destigmatise mental health – recruitment of BME ambassadors - people who were well known and well respected from within the community to act as role models.



- More involvement of service users – BME elders and carers could be encouraged and supported to take on a greater role.
- BME communities could run or facilitate health education and/or health promotion initiatives in social and faith settings to enable communities to help themselves.

Points raised in Workshop Discussions:

The following points were raised in workshop discussions.

- Services did not meet diverse needs of communities e.g. communication, food, personal services, faith needs were not being met. Poor communication and terminology also created barriers.
- Services needed to join up and work together to appropriately cater for the needs of BME elders. More outreach was needed to promote mental health amongst BME communities.
- Religion, faith and spirituality were important

factors for some BME communities and the use of Imams and scholars was an important aspect of their recovery. Faith leaders should be engaged and involved in raising awareness about the needs of mental health issues and older people. Places frequented by elderly people such as luncheon clubs, faith buildings and community centres should be used to raise awareness.

- National and local road shows to highlight and raise awareness.
- BME elders suffering with depression and stress related disorders had fewer friends and less social support. They found out about services 'by chance.'
- Families were experiencing difficulties due to incorrect diagnoses of dementia by GPs and inadequate support for carers.
- Carers groups were helpful enabling carers to come together providing practical advice, information and support to each other.
- There was genuine anxiety amongst professionals to openly ask questions on diversity related issues in case they got things wrong.
- People could not communicate their difficulties – language barriers.
- BME families preferred to use voluntary sector organisations. The BME voluntary sector should be supported more. Many BME voluntary groups were more vulnerable when it came to funding cuts. Loss of grants results in loss of services putting more strain on statutory front line services.
- More cultural awareness training for staff.
- More engagement of service users in policy initiatives.
- Information should be available in different mediums not just written format.
- Commissioners needed to change their mind set and become more innovative in their approaches. They need to work with and support the voluntary sector. Even though national policy drivers were moving in this direction Commissioners needed to change their approach and working practises. Three year contracts would give scope for voluntary sector services to develop.
- The media could play a powerful role to educate people. More use of ethnic media.
- The Dementia Strategy provided a good opportunity for workforce development. Having a representative workforce was very important. Development of BME Counsellors.
- Government policy for example, the National Framework Policy, Everybody's Business and the

National Dementia Strategy all mention 'culturally sensitive' services but there was very little specific guidance on what this meant and HOW services should implement this. The DRE document tried to provide a framework but again its' focus was largely on young people.

- CSIP's National Older People's Programme high lighted depression as a main factor within BME populations and the Dementia Strategy needed to look at wider adult services as part of its delivery remit.
- CDWs needed to be proactively taking forward community issues and recommendations enabling communities to voice their concerns at decision making levels. They should be pushing for change in policy and practise.
- Carers were integral but often missed out when it came to making important decisions. This can create additional stress, illness, depression and actual hospitalisation of carers.
- A representative and diverse workforce and workforce development was very important.
- There was too much variation in the UCLAN CE projects. Whilst some groups focussed on established communities, some concentrated on new arrivals and others looked at asylum seekers and refugees. It would have been good to draw out common factors for all communities; lessons learnt from more established communities and examples of good practise. There were no African Caribbean Community Engagement projects – this was a missed opportunity.
- Working with community champions, community organisations and ethnic media can help to reduce stigma.
- A new Mental Health Unit was being set up in the Department of Health that would focus on a broader equality and human rights agenda driven at a regional and local level. This would provide opportunities for BME voluntary groups to engage with Commissioners and work with them to respond to this emerging agenda.
- Locally, Commissioners were struggling to commission services that were meeting the diverse needs of their population groups. They needed to work more closely with BME voluntary sector groups to meet gaps.
- World Class Commissioning. BME voluntary groups needed to strengthen their ties with Commissioners and present them with ideas on how services could be designed to meet local needs.
- It was imperative that services found out more about the needs and circumstances of the people and communities they were serving.

- More dementia advocates were needed.
- Resources were too often focussed on healthcare rather than broader social care support and facilities which often underpin health outcomes.
- Educate young people in schools in order to alter their attitudes towards mental health.
- Funding should go to communities to buy what they want from the experts and not for experts to buy what they think communities want. Service users should be on NHS Boards and decide how the money is spent.
- There were links between social exclusion and mental health.
- Voluntary sector should build links with newly set up Local Involvement Networks (LINKs).
- Stigma from within one's own community leads to disengagement.
- More community engagement and work in schools was needed to raise awareness.
- **Sharing Voices, Bradford:-** Projects raise awareness of and build relationships between statutory services and service users. For example, advocacy, signposting, information, visiting hospital wards. User-led focus group facilitated by CDW which links into service providers and commissioners.
- **Bradford:-** Well being cafes empowering minority communities and individuals in groups to become more pro-active, raise questions about care services and challenge.
- **Walsall:-** DVDs in Hindi on post natal depression; older people and depression.
- **Manchester:-** CDWs working in schools to raise awareness of mental health issues.
- **Time to change campaign**
<http://www.time-to-change.org.uk/>
- **Independent Mental Capacity Advocates:-** for people with brain injuries or dementia:-
<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/IMCA/index.htm>
- www.dca.gov.uk/legal-policy/mental-capacity/mibooklets/booklet06.pdf

Examples of good practice identified in the care of BME elders

The following were examples of good practice raised by BME elders and BME age related organisations.

- **Pakistan Resource Centre:-** Great Marlborough Road, Manchester. Established for 40 years providing services to South Asian community.
- **Carer's Project, Manchester:-** Works with carers. Provides drop-in service and trips for carers. A well used and recognised project.
- **Mental Health Project, Manchester:-** Provides culturally appropriate and gender specific services; home visits and drop-in services. GP referrals.
- **Sheffield Rethink:-** Provides support to Somali women who are carers. Provides training in mental health and caring to carers.
- **Wai Yin, Manchester:-** Supports the Chinese community to identify barriers and provides training to statutory services to meet barriers. Funded by Local Authority.
- **Liverpool:-** CDW team works with PCTs to implement recommendations from UCLAN's Community Engagement project (Chinese, Irish and Asylum Seekers).
- **Blackburn:-** Provides culturally appropriate family mediation service; signposting to statutory services.
- **Rethink, Birmingham:-** Faith project using Imams who are trained in mental health issues and who work out in the community to raise awareness about mental health services.
- **Improving Access to Psychological Therapies (IAPT) –** Low referrals for over 60's. New guidance for older people: www.iapt.nhs.uk/wp-content/uploads/2009/02/83077-nhs-iapt-older-people.pdf
- **BME counsellors:-** Do exist but difficult to find as most work in BME voluntary groups and are not always listed in statutory provision.
- **Hikmat, Devon:-** Sahara project (funded through POPPs funding) has 5 centres in the community each with crèche - run sports and health activities, keep fit, Wi – League (intergenerational activity); 'Bus Pass Group' - older men's lunch club; confidence building; participation in forums and networks; training and accredited qualifications leading to employment. Helps build bridges, make friendships, reduces isolation and loneliness, improving mental health.
- **Hikmat, Devon:-** Drop in centre (called 45 plus) for different minority communities; used the UCLAN CEP model to effectively engage with BME groups; providing culturally sensitive and appropriate advocacy work. Develop community Ambassadors.
- **My Time, Birmingham:-** Runs Bollywood dance classes; confidence building initiatives; counselling in community languages (gender specific) - a successful strategy is to ensure counsellors and clients are from the same background.

- **Khidmat, Birmingham:-** provides confidence building initiatives; training courses; Older peoples lobbying group. www.shcfltd.com/reports/annual_rpt_07-08.pdf
- **Meri Yaadein, Bradford:-** Highlights good practice and care for older people; peer education.
- **BME CPN Wolverhampton:-** Works with BME communities raising awareness of and signposting to services; aftercare; Produced audio tape in Punjabi re health services in Wolverhampton which different communities use. Staff and individuals are key to delivering good services.



- **Derbyshire Gypsy Liaison Group:-** The Gypsy Travelling community are very proud people and but they get stereotyped and misrepresented causing them a lot of distress. Diversity training should be made mandatory.
- **Midland Art, Sandwell:-** Empathetic, caring and experienced BME staff are key to running successful and integrated services for BME residents in sheltered housing. The scheme offers BME specific services for BME residents. Joined up working is important to give clients the best information, advice and support.
- GP Practice based commissioning.
- The 'Lets Respect' campaign focussing on African Caribbean elders. www.olderpeoplesmentalhealth.csip.org.uk/lets-respect.html
- CSIP BME older persons programme: <http://www.olderpeoplesmentalhealth.csip.org.uk/mental-health-and-well-being-of-black-and-minority-ethnic-elders.html>
- Twice a child project – research in Wolverhampton with African Caribbean community. <http://www.rcpsych.ac.uk/pressparliament/pressreleasearchive/pr296.aspx>
- **Harrow, Brent and Harlesden:-** Provides day care services, luncheon clubs, advocacy, information, outreach, signposting, trips, social clubs; support to carers.
- **Harrow Mind:-** 'Open Up' project working to reduce stigma and discrimination and build up trust. Produced Tool kits:
 - 'Man Ki Baat' – CD which is used to help participants open up and talk.
 - 'Dil Ki Baat' – Matters of the heart – helps participants to talk about physical and mental health issues.
 - 'Nutrition Plate' – visual DVD about food, diet and nutrition. Afterwards participants are taken on picnic as a treat.
 - 'People like Us' - BME mental health promotion project. Looks at faith, spirituality and mental health issues. Produced a booklet / Directory of information.
 - 'Time to Change' - national 4 year programme in partnership with MIND, Rethink and Mental Health Media to tackle stigma in mental health.
 - 'Call for Drama' – interaction through drama - in BME communities visual projects have a greater impact as they can relate to the information.
 - 'Open Secrets' - a 17 minute film based on mental health issues screened in Harrow.
- Befriending / Buddying scheme specifically for Asian community. Referrals to the scheme come from older Asian people themselves.
- **Barnet:-** a culturally specific service (gender specific) mental health specialist who runs a monthly, one to one, surgery session. People can discuss their mental health problems.
- **Barnet, Art therapies:-** People can participate and socialise. The work was displayed at the Diwali festival.
- Three CDWs in Barnet collecting info on needs and gaps in services.
- **Healing Waters, Croydon:-** African Caribbean people are 'afraid' to talk about mental health issues. Healing Waters Alzheimer's group runs photography, gardening, allotment, cooking / about foods, and drama projects / therapies. The activities help to 'normalise' things and help facilitate discussion. A family environment is created. People engage with each other.
- **Bristol:-** Bristol City Council has linked up with other European partners to run a preventative campaign on health care of elderly. Exchange ideas on what is happening Europe wide. Chinese migrant workers are ageing and are isolated – set up 3 Linkage Centres to run exercise, drama, nutrition with the focus being on prevention.

- **Bristol, Local Area Agreements:-** Focussing on health and social care. 7 CDWs in Bristol of which one is seconded to the organisation and supporting them to develop dementia services.
- **'Eye to Eye'** focussing on welfare and well being of BME elderly.
- **Memory cafes.**
- **EKTA Group:-** User led forum.
- **MIND in Harrow, User-led Employment Programme:-** Users go to meetings but motivation needs to be sustained.
- **Use of faith establishments:-** especially as the older population tends to prefer accessing faith establishments - for example, presentations in mosques and at religious events.

Conclusion and next steps

The seminars highlighted many examples of good practice, for example:

- older people's mental health programmes.
- bilingual workers.
- availability of interpreters.
- geographical location of services.
- ethnicity of staff.
- collaboration with voluntary sector organisations.
- translated information sheets (CDS and audio tapes are being used).
- glossary of common terms.
- talking therapies in different languages.
- education videos for carers and patients.
- community specific training.

During the next phase of this project these will be explored more thoroughly so that they can be written up in ways that allow them to be easily understood and replicated.

BME elders will be actively engaged in this process.

The seminars also pointed out many gaps in service provision. One of the main reasons why most BME elders (and their families) did not access statutory services was their inability to cater for their cultural, ethnic, language and faith requirements. For most BME elders their preferred choice for care, support, and information was either their family, BME voluntary groups and/or faith based institutions.

The seminars highlighted that statutory services needed to:

- Develop more effective engagement strategies with BME elders, their carers and families.
- Involve BME elders in developing mental health policy.
- Design services in collaboration with BME elders, their families, the BME voluntary and community sector and faith organisations.

APPENDIX 1

New National Workshop Series:

Exploring and promoting better mental health care for BME elders

The Policy Research Institute on Ageing and Ethnicity (PRIAE) and the International School for Communities, Rights and Inclusion (ISCRI, formerly known as the Centre for Ethnicity and Health) at the University of Central Lancashire are proud to invite you to a series of inter-active workshops designed to help us explore and promote better mental health care for BME elders.

UCLan have recently concluded a study involving 80 Community Engagement Projects across England delivered as part of the Delivering Race Equality Programme. Many of these studies looked at BME elders and a key finding was the lack of awareness of mental health and mental health services. These workshops will give you the opportunity to hear about these projects in more detail and contribute your ideas about the needs, strengths, strategies used and opportunities within BME communities to offer mental health awareness, support and mentoring to BME elders. As an outcome of the event we want to prepare a small number of case studies that illustrate best practice and that might be used by PRIAE as the basis of an advocacy and training programme.

We are anticipating a high demand for places, so please register your interest early using the form below. There is no charge for attending the event, but a charge of £40 will be made for no shows on the day as we do not believe it is fair to deprive someone else of a place that you do not take up.

These workshops are specifically aimed at those who are working with or concerned about mental health and BME elders, including BME elders and their carers, service providers, service commissioners, and policy makers. We are particularly keen to get a good representation at these events from BME elders themselves. To this end we would really like to encourage service providers, commissioners and policy makers who wish to attend to think about whether they know of BME elders who they could encourage to attend with them. We will also pay the travel expenses of BME elders who wish to attend the event.

The workshops will take place as below:

Date	Venue	Time
2nd March 2009	Manchester	11.00 – 16.00
3rd March 2009	Birmingham	11.00 – 16.00
16th March 2009	London	11.00 – 16.00

Key speakers at each event will include:

Professor Ajit Shah – Professor in Old Age Psychiatry and Consultant at the West London Mental Health NHS Trust

Jez Buffin – Associate Head, ISCRI, Director of the UCLan Community Engagement Programme

Representatives from groups who took part in the CE programme

A buffet lunch will be provided.

If you would like to attend one of these events, please book your place by completing the reply slip below.

Note: This is only one of three exciting new projects that PRIAE and ISCRI are working together on. The others are about increasing organ donation from BME communities and increasing policy literacy of BME elders so that they can become actively involved in campaigning on the issues that affect them. You will find a flier about the organ donation project included for your information. We will write to you about the other project shortly.

New National Workshop Series:

Exploring and promoting better mental health care for BME elders

Reply Slip:

Name: _____

Address: _____

Phone Number: _____ Email: _____

Please reserve me _____ (insert number of places) places on the following workshop (tick preference)

Date	Venue	Time	Tick
2nd March 2009	Manchester	11.00 – 16.00	<input type="checkbox"/>
3rd March 2009	Birmingham	11.00 – 16.00	<input type="checkbox"/>
16th March 2009	London	11.00 – 16.00	<input type="checkbox"/>

The names of the people who will be attending are:

Name	Contact Address	Contact Phone Number	Contact Email Address	Please indicate if this person is a BME elder who will want to claim travel expenses
				Yes/No
				Yes/No
				Yes/No
				Yes/No
				Yes/No

I have explained to the people named above that there is no charge for attending this event but that any person who is allocated a place and then fails to turn up on the day without cancelling it will be liable to pay a £40 charge. I and they understand and accept this. I and they understand that places can be cancelled without incurring any charge up to 48 hours in advance by e-mailing **KAPatel@uclan.ac.uk**

Signed: _____ Date: _____

Please tell us if any of the people above have any special or specific needs (e.g. diet, disability, and language) that we need to be aware of in order to allow us to help you and them to get the maximum benefit out of the day.

Please return to **KAPatel@uclan.ac.uk** by Friday 13th February 2009.

Khalil Patel, International School for Communities, Rights and Inclusion, Harrington Building, University of Central Lancashire, Preston, PR1 2HE

Tel: **01772 892870** Fax: **01772 892964**

APPENDIX 2

Managing Better Mental Health Care for BME Elders

11.00 – 11.15 Welcome, registration and housekeeping

11.15 – 11.30 Introduction to the day

11.30 – 12.00 Ajit Shah presentation

Setting the context. What are the main issues and challenges faced in providing appropriate mental health care to BME elders? What do we already know about good practice?

12.00 – 12.10 Questions

12.10 – 12.40 Jez Buffin presentation

What did the 14 NIMHE CEP reports that focussed on older people tell us?

12.40 – 12.45 Questions

12.45 – 1.30 Lunch

1.30 – 1.45 Preparation for the afternoon discussion

1.45 – 3.00 Small discussion groups facilitated and recorded by UCLan staff

***Purpose** - To collate examples of good practice in the care of BME elders – projects that promote well-being and mental health – projects that promote understanding and awareness and reduce stigma – projects that provide good information – projects that assist access to services – projects that provide and/or enhance good experiences – projects that support recovery – projects that support carers.*

Identification of champions.

3.00 – 3.15 Tea/Coffee

3.15 – Plenary and Close

APPENDIX 3

Name of group	Main Focus	Region	Sample size
Northamptonshire Irish Support Group	Irish	Northamptonshire	27
Irish Welfare Information Centre	Irish	Birmingham	27
Hikmat	BME – mainly Chinese	Exeter	42
Wai Yin	Chinese - dementia	Manchester	72
Chinese Mental Health Association	Chinese	London	68
Chinese National Healthy Living Centre	Chinese	London	29
Subco	South Asian	London	50
SHIFA	South Asian and Chinese	Surrey	85
PRENO	Chinese, Vietnamese, Sikh	Portsmouth	59
BAND	South Asian	Bolton	100
Future Health and Social Care	Mainly South Asian – dementia - carers	Birmingham	78
Age Concern	Chinese and South Asian	Herefordshire and Worcestershire	40
Oldham PCT	Mainly South Asian	Oldham	40
MIND	Gujurati	Harrow	50

References

- Bhatnagar KS (1997). Depression in South Asian elders. *Geriatric Medicine*. February, 55-56.
- Bhatnagar KS, Frank J. (1997) Psychiatric disorders in elderly from the Indian subcontinent living in Bradford. *International Journal of Geriatric Psychiatry*, 12, 907-912.
- Commission for Healthcare Audit and Inspection (2007) *Count Me In 2007. Results of the 2007 national census of inpatients in mental health and learning disability services in England and Wales.* www.healthcarecommission.org.uk/_db/_documents/Count_me_in2007.pdf
- Department of Health (2005). Delivering race equality in mental health care. An action plan for reform inside and outside services and the Government's response to the independent inquiry into the death of David Bennett. Department of Health, London.
- Ebrahim S, Patel N, Coats M, Greig C, Gilley J, Bangham C, Stacy S (1991) Prevalence and severity of morbidity among Gujarati Asian elders: a controlled comparison. *Family Practice*, 8, 57-62.
- George J, Young J (1991). *The Physician In Multicultural Health Care and Rehabilitation of Older People.* (ed. A.J. Squires) London: Edward Arnold.
- Lindesay J, Jagger C, Mlynik-Szmid et al. (1997a) The mini-mental state examination (MMSE) in an elderly immigrant Gujarati population in the United Kingdom. *International Journal of Geriatric Psychiatry*, 12, 1155-1167.
- Lindesay J, Jagger C, Hibbert MJ, Peet SM, Moledina F. (1997b) Knowledge, uptake and availability of health and social services among Asian Gujarati and white elders. *Ethnicity & Health*, 2, 59-69.
- Livingston G, Leavey G, Kitchen G, et al (2001) Mental health of migrant elders - the Islington study. *British Journal of Psychiatry*, 179, 361-366.
- Livingston G, Leavey G, Kitchen G et al (2002) Accessibility of health and social services to immigrant elders: the Islington study. *British Journal of Psychiatry*, 180, 369-374.
- Marwaha S, Livingston G (2002) Stigma, racism or choice. Why do depressed ethnic elders avoid psychiatrists. *Journal of affective Disorders*, 72, 257-265.
- McCracken CFM, Boneham MA, Copeland JRM et al. (1997) Prevalence of dementia and depression among elderly people in black and ethnic groups. *British Journal of Psychiatry*, 171, 269-273.
- OPCS, 1983; Office of Population Censuses & Surveys (1983) 1981 Census: country of birth. Great Britain. HMSO, London.
- OPCS, 1993; Office of Population Censuses & Surveys (1993) 1991 Census: Ethnic Group and Country of Birth Great Britain London: Office of Population Censuses and Surveys.
- Reeves, S.J., Sauer, J., Stewart, R., Granger, A., Howard, R. (2001) Increased first contact rates for very late onset schizophrenia-like psychosis in African and Caribbean born elders. *British Journal of Psychiatry*, 179, 172-174.
- Shah AK, Oommen G, Wuntakal B (2005a) Cultural aspects of dementia. *Psychiatry*, 4, 103-106.
- Shah AK, Lindesay J, Nnatu I (2005b) Cross-cultural issues in the assessment of cognitive impairment. In: *Dementia* (Eds. Burns A, O'Brien J, Ames D). Pgs 147-164.
- Shah AK. (2007) Demographic changes among ethnic minority elders in England and Wales. Implications for development and delivery of old age psychiatry services. *International Journal of Migration, Health and Social Care*, 3, 22-32.
- Shah AK, Lindesay J, Jagger C (1998) Is the diagnosis of dementia stable over time among elderly immigrant Gujaratis in the united kingdom (Leicester)? *International Journal of Geriatric Psychiatry*, 13, 440-444.
- Silveira ERT, Ebrahim S (1998a) A comparison of mental health among minority ethnic elders and whites in east and north London. *Age & Ageing*, 27, 375-383.
- Silveira ERT, Ebrahim S (1998b) Social determinants of psychiatric morbidity and well-being in immigrant elders and whites in east London. *International Journal of Geriatric Psychiatry*, 13, 801-812.
- Wai Yin Chinese Women Society (2007) Report of the Community led research project focussing on: The needs of Chinese older people with dementia and their carers. University of Central Lancashire, Preston.

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