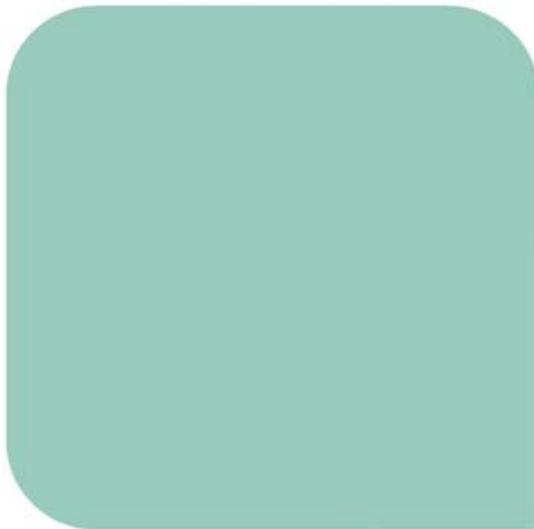


Supporting black and minority ethnic older people's mental wellbeing: accounts of social care practice



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Summary

Aims and background

This report (originally practice enquiry) aimed to look at practitioners' accounts of their practice in promoting the wellbeing of older people from black and minority ethnic (BME) backgrounds in four parts of the United Kingdom (UK).

Although there is no single universally agreed definition of wellbeing, it is usually seen as including important aspects of people's lives, such as life satisfaction, a sense of achievement and purpose, and generally feeling that life is worthwhile. Although an absence of wellbeing is associated with depression, wellbeing is about more than not feeling depressed. Governments and policy makers are becoming increasingly interested in measuring the success of the services they provide by looking at how they can improve wellbeing but we know very little about how adult social care services seek to improve the wellbeing of the communities they serve.

Previous work by the Social Care Institute for Excellence (SCIE) (Sharif et al, 2008) has shown that little is known about the mental health of older people from BME groups and the role of social care practitioners in providing them with support. As the proportion of older people from minority groups living in the UK increases (Lievesley, 2010), we need to know more about how they experience mental wellbeing and common mental health problems in later life, excluding dementia, (See SCIE guide [Assessing the mental health needs of older people.](#))

Methods

The enquiry is based on interviews with over 80 participants who included practitioners, managers, volunteers, BME older people, and family carers. Participants came from a broad range of ethnic backgrounds, including people from Traveller backgrounds.

The practitioners included commissioners, social workers and care managers, care home managers, workers in the voluntary and community sector (VCS) and in housing schemes, community development workers and advocacy workers.

Most research into social care services for BME older people has taken place in areas where there is a long history of settlement by BME people and where their population density is comparatively high. However, as the UK's BME population becomes more geographically dispersed (Wohland et al, 2010), we need to know how those parts of the country that have traditionally contained comparatively few BME older people, are developing their services. This enquiry deliberately chose to focus on four parts of the UK (three in England and one in Northern Ireland) where the BME population is currently comparatively small but projected to rise (Lievesley, 2010).

The study methodology means that the enquiry tells us more about current and emerging practice (Rutter, 2009) rather than defining good practice, although some examples of good practice are included here.

Key findings

- Practitioners identified that preventing isolation and loneliness played a key part in their role of promoting wellbeing among BME older people. BME older people may be at particular risk for loneliness and isolation if they live in areas where few people share their language and culture and where they have few members of their family and friends living nearby. At the same time, practitioners stressed that these feelings could also occur where BME older people lived with other members of their family and that it was important not to make assumptions about wellbeing simply on the basis of household living arrangements.
- As well as traditional services aimed at promoting social interaction, such as day centres and luncheon clubs, community centres – whether generic or mainly attended by older people from a specific ethnic group – offered an important source of support for BME older people.
- A wide range of ways of promoting wellbeing was described, including activities such as exercise classes, gardening, walking, healthy eating and cooking, and access to screening services, such as eye testing.
- Levels of fluency and literacy in English among this generation of older BME people varied. Translating and interpreting services were a key resource for this group in terms of being able to contact 'bureaucracies' such as health and social care organisations, housing services, and utility companies. However, access to these services was variable.
- The presence of migrant workers speaking the same language as BME older people was seen to be an advantage. Imaginative ways of tapping into this workforce included an example where a local authority emailed the providers with whom they had contracts to see if anyone spoke a particular language.
- Family carers and BME older people highlighted the importance of being able to talk to people from a similar culture to themselves and who were familiar with their customs. Access to satellite television stations broadcasting in different languages was offered as a way in which technology could help BME people's wellbeing by helping them connect to people from a similar background and watch broadcasts in their first language but this was not a substitute for face-to-face contact.
- Practitioners in social care may lack confidence in working with BME older people if they work in areas where BME older people are not regular users of services. However, BME practitioners commented that some BME organisations lacked expertise in working with BME older people who had mental health problems. Consideration should be given to finding ways in which different organisations could mutually benefit from each other's expertise.

- Practitioners recognised their need to provide more culturally sensitive services that allowed BME older people with a religious faith to practise their religion and to eat the sort of food that they enjoyed. They identified regulators and the internet as resources that would help them improve their knowledge in this area. However, it seemed as if there was potential for social care organisations to develop learning resources for staff based on consultations with BME older people and family carers and for organisations working on knowledge transfer in this area to consider ways of publicising their work to this very diverse sector.
- Although food and faith are important factors contributing to wellbeing, there was scope to develop other forms of help. Across the study areas selected, just one example of a counselling organisation specialising in support for BME people was identified.
- Outside specialist provision based in areas of population density, BME older people moving to care homes, sheltered housing, extra care or other housing complexes are unlikely to be able to meet people from a similar background. Care plans and support plans need to identify what steps have been taken to ensure that BME people living in communal settings do not become isolated. These plans may also need to consider how to protect them if other residents, visitors or staff show racist behaviour, given the links between the experience of racism and mental wellbeing (Karlsen, 2007).
- BME older people can be the providers, as well as the recipients, of services to promote wellbeing and play a key role in many community organisations. There are opportunities to develop the role of older BME volunteers in all types of setting, especially those that could offer peer support to older BME people with depression or mental health problems.
- The advent of personalisation and the changes to funding that have occurred since this practice enquiry was undertaken offered some opportunities and challenges to services promoting BME older people's wellbeing. On the one hand, personal budgets and direct payments were seen as offering a wider range of choice to BME older people and more personalised ways of arranging services that could promote wellbeing. On the other, many BME older people meeting eligibility requirements for social care, especially those who are isolated and who do not speak English fluently, have limited knowledge of how to access services. Some practitioners were concerned that funding for some traditional services with a good track record of supporting BME older people would be threatened. Small local BME organisations may need support to enable them to take on new advocacy and brokerage roles if they are to continue to be financially sustainable.

Conclusions

- Practitioners were broadly familiar with ideas about wellbeing and its importance to maintain good mental health and promoting quality of life.

- They recognised the role of personal budgets and direct payments in enabling BME older people to choose ways in which they could arrange services that improved their sense of fulfilment and quality of life but were concerned about the numbers of BME older people who were 'under the radar' and who were at risk of isolation and loneliness.
- Practitioners working in settings where BME older people comprise a small section of the population may lack confidence in engaging with BME older people and their families. While most practitioners have had access to training about faith, dietary customs and what to do when someone dies, specific training in promoting wellbeing appeared to be less widespread.
- There is an established BME voluntary sector that offers leisure, health, social and cultural activities but has less expertise in supporting BME older people with mental health issues. Consideration needs to be given to how local authority and National Health Service (NHS) mental health services engage with this sector.
- BME older people often play their part in promoting their own mental health and that of others by acting as volunteers or being involved in peer activities. These activities could be further encouraged. There may be a need to change the emphasis to self-management and greater health promotion efforts.
- Being the only person from a particular ethnic group, especially if it is combined with differing expectations about family support, may make the process of moving into a care home or housing support setting more difficult for BME older people and family carers. Steps need to be taken to ensure that this is not translated into an increased risk of depression.

Limitations of this enquiry

The diversity of the BME older populations in the UK and the way that they are dispersed across the UK means that it is impossible to cover every aspect of wellbeing as it affects every ethnic group. This enquiry tried to look at the more numerous areas with comparatively small BME populations, as opposed to the less numerous areas in which BME older people are more commonly resident, but this is not the sort of enquiry that can produce generalisable findings.

Practice with BME older people may be more developed in those parts of the country such as London, the North West and the Midlands where there are longer-established and larger BME communities. However, the accounts presented may be more typical of the situations in which BME older people and family carers find themselves.

Sampling BME older people produces numerous practical and methodological challenges (Sin, 2004). The number of BME older people with mental health problems using services interviewed as part of this study was limited. Having said this, some of the study participants working as community workers or volunteers were themselves older and came from a minority ethnic group.

1 Background

This practice enquiry was commissioned following the production of the Social Care Institute for Excellence (SCIE) systematic map (Sharif et al, 2008), which identified a lack of research into social care services aimed at supporting older people with depression from black and minority ethnic (BME) groups.

Most older people have good mental health, but they are prone to risk factors for later-life depression, including physical disability and illness, and their resulting effects on daily functioning, as well as social isolation and loneliness, both of which may be a result of bereavement (Age Concern, 2007).

Depression is the most common mental disorder among older people (Livingston et al, 1990; McDougall et al, 2007) and has a profound impact on the quality of life and wellbeing of individuals.

As a way of avoiding the health focus that might arise from commissioning a piece of work looking solely at depression, it was decided that it would be more appropriate to take a broader perspective encompassing the promotion of mental wellbeing. This would allow for reporting on the extent to which social care services address mental wellbeing, while also including any services commissioned to treat and manage depression.

The Social Care Workforce Research Unit, based at King's College London, was commissioned to undertake a practice enquiry looking at how social care practitioners were supporting BME older people's mental wellbeing. Practice enquiries are designed to:

- see what is going on in a particular field of practice, although the view is only partial
- capture the range or characteristics of different practice and progress in relation to a specific topic area or research question
- consult with a range of stakeholders, or with one or more types of stakeholder (e.g. practitioners) on their experience and/or views of particular topic areas or research questions
- complement a literature review by:
 - focusing on gaps in what the literature describes
 - providing examples of practice which may not yet be written up
 - illustrate findings from the literature
- harvest self-reports of innovative, interesting or representative practice
- identify the presence – or absence – of particular services or interventions. It may then be part of a practice enquiry to follow these up with more detailed enquiry methods, such as case studies.

(Rutter, 2009, p 8)

The enquiry took the form of interviews with practitioners, managers, volunteers, people using services and family carers conducted by the Social Care Workforce Research Unit over the spring and summer of 2009. This report sets out some of the background to the enquiry, outlines the methods used and presents findings in seven chapters, each covering a separate topic. At the end of each of these chapters, brief summaries and reflections are presented in the form of main messages. These are distilled ideas taken from aspects of practice that participants identified as being of particular value. They are presented to help stimulate thinking rather than being firm conclusions, given the exploratory nature of this enquiry. A brief conclusion draws together some of the main messages.

Research to date

The focus of this enquiry is social care practice with BME older people, which aims to improve mental health and wellbeing. Relatively little research is available covering the broad spectrum of mental health within the older BME population in the United Kingdom (UK). Over a decade ago, reports such as the Audit Commission's (2000) *Forget me not* and the Department of Health's Social Services Inspectorate (SSI) audit report *They look after their own don't they?* (SSI, 1998) highlighted the challenges of commissioning and providing services for BME older people and the need to raise awareness of mental health needs and provide care through a person-centred approach. Despite this, progress in achieving good-quality culturally acceptable services has been uneven and strategies among the public sector remain underdeveloped (Manthorpe et al, 2008). Concerns have been expressed that progress in districts in which there are smaller proportions of older people from minority ethnic groups has been slower than in those areas where their populations are well established or growing rapidly (Manthorpe et al, 2009a).

This has also been reflected in the lack of research-based knowledge in social care on the topic. An under-representation in research, difficulties with access and lack of appropriate provision emerged in SCIE's map of research relevant to social care practice when supporting BME older people with depression (Sharif et al, 2008). This was not unexpected but confirmed the presence of gaps in the literature concerning BME older people and the lack of material relevant to social care practitioners. Some communities, such as African and Chinese people, have been, until recently, almost totally ignored within the literature, partly on account of their comparatively small numbers. However, the age profile of the BME population in the UK means that the numbers of almost all BME communities are set to increase and they are likely to become more dispersed across all parts of the UK (Lievesley, 2010; Wohland et al, 2010). Furthermore, the impact of world events on migration to the UK has meant that there are now new communities such as Afghans, Iraqis and Somalis among the older UK population with whom practitioners must engage (Butt, 2005).

Furthermore, there has been very little acknowledgement of older people's views in terms of the acceptability or accessibility of services to BME older

people, and very little indeed exploring the perspectives and experiences of practitioners working in social care settings. The map highlighted the great bias towards research into service provision within the National Health Service (NHS), a focus on dementia, and the difficulties of adequately describing the prevalence and management of depression in BME older people in the UK that might inform social care practice, education and training, commissioning and inspection. This does not suggest that health colleagues have all the answers; the conclusion of a report published by the Royal College of Psychiatrists (Shah et al, 2009) was that progress since the publication of its previous report (Ong, 2001) had been very slow and that there was an urgent need to identify further examples of good practice, including old age psychiatric services (OAPS) providing equitable access for BME older people relative to their white British counterparts. In addition, it concluded that more work was needed to develop appropriate services and to recruit a more diverse workforce that better reflected the communities it serves.

With the UK literature on depression and BME older people being dominated by health-focused materials, SCIE's map of the literature on depression (Sharif et al, 2008) was unable to provide a sense of the state of social care services and support for BME older people with depression or other mental health problems, apart from dementia. Indeed, it located only one study reporting on an intervention provided solely by social care services.

Consequently, as well as looking wider than depression and taking a mental wellbeing perspective, this practice enquiry focuses in particular on social care practice. This allows for reporting on the extent to which frontline practitioners, including social workers/care managers and social care workers in the statutory, voluntary and community sectors, seek to address mental wellbeing, alongside the work that they do in supporting people with depression.

Definitions

Mental wellbeing and mental health

There are various definitions for the terms 'mental wellbeing' and 'mental health'. Mental wellbeing may be ignored or interpreted in a number of ways but, like mental health, it is often used to refer to the opposite of mental illness and its related treatments. While there is no universally agreed definition of wellbeing (Scottish Executive Social Research, 2005):

There is a growing international recognition of the benefits of addressing mental wellbeing in a comprehensive approach to mental health ... mental wellbeing generally includes areas such as life satisfaction, optimism, self esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support. (NHS Health Scotland, 2010, unpaginated)

The Foresight Mental Capital and Wellbeing Project involved a wide-ranging group of experts commissioned by the previous UK government to advise it on how to achieve the best possible mental development and mental wellbeing for everyone in the UK. It concluded that wellbeing is:

A dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society. [Governments need] ... to nurture the mental capital and wellbeing in the wider population, so that everyone can flourish throughout their lives. (Government Office for Science, 2008, p 10)

Current definitions of wellbeing go beyond factors such as the absence of ill-health and poverty to incorporate feelings such as a sense of achievement, being satisfied and able to make decisions (Searle, 2008). Existing research has reported contradictory pictures in terms of ethnicity and wellbeing, with certain factors such as poverty and poorer health being more frequent among some minority ethnic groups but others, such as social support, being better, in some respects (Moriarty and Butt, 2004; Nazroo et al, 2004).

The promotion of mental wellbeing is not confined to any one particular area of service provision nor is it the province of social care alone. It includes: housing; NHS primary care; specialist NHS mental health services; and acute hospitals (Age Concern, 2007). To this list could be added transport, leisure and environment, community development approaches and so on. However, this practice enquiry focuses on provision that is funded, provided, organised, inspected, regulated or commissioned by social care agencies or involves the social care workforce. Of course, this provision covers a diverse range of services and support, all of which need to reflect the needs of diverse populations. In order to give a sense of the extent and variety of the services that need to be considered, these include:

- direct payments and personal budgets, whereby people may choose elements of their own care and support (subject to a means test and reaching eligibility criteria), including assistance with participating in leisure and social activities
- home care, including personal care, domestic assistance, medication management, rehabilitation (reablement) and intermediate care – paid for by public funds or by individuals themselves
- day-time services, including lunch clubs, drop-in centres, befriending schemes, social groups for older people with mental health problems, information and advocacy
- short-break services or respite care – family placement schemes, 'sitting' services, befriending schemes, day care, a short stay in a care home setting

- care homes and housing with care services (such as extra-care housing) possibly providing a home for life.

With the moves towards more integrated services, the practice enquiry highlights the potential for partnership working between social care and other public services, including health services but also leisure and cultural services. It also discusses some emergent practice associated with the transformation of social care through the policy of personalisation and its effects on roles and relationships. SCIE has produced many guides to personalisation that cover this subject (e.g. Carr and Robbins, 2009; Carr, 2010) and this practice enquiry took place at a time when there was considerable discussion about the potential effects of personalisation but little evidence of changes. This is in the context of existing concerns that people from BME groups (Stuart, 2006) and older people in general (Glendinning et al, 2008) face additional barriers in terms of accessing more flexible forms of support. Although this is an issue outside the scope of this practice enquiry, this risk is one that will need to be monitored, and was certainly a concern among participants in this study.

Black and minority ethnic groups

Ethnicity is a complex subject and intersects with other ways of defining one's identity such as religion or language (Nazroo, 2001; Burton et al, 2008). In this enquiry we have taken a broad approach to the definition of 'black and minority ethnic groups' and have included experiences of groups defining themselves on the basis of their religion, such as Jewish people and Jewish care providers, and umbrella terms encompassing a range of cultural identities, such as Traveller communities.

Practitioner to practitioner

This enquiry brings experiences from practitioners to their colleagues in the social care practice community. The aim of this enquiry is to enable practitioners to reflect on and hopefully improve their practice by considering accounts of a range of practitioners' own experiences and learning. The material is drawn from a survey that took the form of in-depth interviews with practitioners in four different local authority areas (three in England and one in Northern Ireland), which we have anonymised as High Town, Pier Town, Fen Town and Field Town. Full details of the study methods and the settings in which we undertook the study are presented in Appendices 1 and 2 respectively.

The practitioners interviewed worked in many different areas of social care, ranging from care homes to community development. They told us about their work with older people, their efforts to promote mental wellbeing, and their engagement with older people and carers from BME communities. We found no other account of practice in the UK that combined these interests. Notably, the areas that took part in this study were not parts of the UK with high BME populations. They were fairly typical of parts of the UK that do not have such population profiles, being counties, cities, towns and suburbs, many with surrounding rural areas. In other words, this enquiry does not draw on the experiences of people working in places where substantial populations are from BME backgrounds. The latter are often the areas where research is concentrated, with the result that we have less of a sense of the experiences of older people from BME groups living in areas where the population of people from BME groups is smaller and more geographically dispersed.

In each of the four parts of the UK included in this enquiry, we also talked to people about their experiences of using social care services, in the main BME older people and their families, to gain a picture of what they might want for a later life characterised by wellbeing and a sense of coherence rather than depression, sadness or a feeling of worthlessness. Some of the older people interviewed spoke about their experiences as users of social care services, living in care homes for example, but others were involved in community and faith groups in the wider sense of social care, or spoke on behalf of their members on behalf of their family. We hope that this enquiry presents an authentic picture of the potential of social care practice to enhance the mental wellbeing of BME older people.

2 Promoting wellbeing: addressing risk and encouraging social interaction through preventive approaches

Fundamental to approaches designed to enhance mental wellbeing and people's psychological resilience is attention to prevention and early intervention. Following a brief section that indicates participants' understanding of the importance of identifying isolation and loneliness and doing something to lessen these risks, this chapter sets out participants' views and experiences of preventive approaches.

Importance of identifying isolation and loneliness

Isolation and loneliness were identified as important signs to notice as potentially placing people at risk of depression. It was pointed out that these experiences could occur even when individuals were members of an established social network. For example, Magda, working in a specialist counselling organisation in Pier Town, had experience of some older people becoming cut off from social contacts, or experiencing their social network as becoming relatively weak, even if living within their immediate family:

'Older people, I mean our older people, are getting isolated. And even when some of these older people appear to have family around them, they actually feel very isolated, because if they were at home they'd have had a huge extended family around, immediately around them. So, even though they've got a wife, and two or three children, for him [that individual] that is very isolated.' (Magda – counselling organisation worker)

Magda also noted that some BME older women could be very isolated in those families where it was not customary for a woman to leave the home unaccompanied by a male relative: 'She is stuck in the house with the children or older children coming in from work and that, with their children. She is really, I think, she's invisible to the world'. Magda had not come across many such cases, but she had come across some. In these instances, she felt that it was hard to assess and monitor these women's wellbeing as their husbands took them to the doctor and acted as their interpreters.

The risks of depression were also widely recognised and some people associated them with multiple losses, which places more emphasis on the need for early intervention and prevention. Tina (a housing scheme manager in Fen Town), for example, spoke of the balance between people wanting to be independent and yet at risk of increasing loneliness. In her experience, tenants who had made the move to housing with care services were often in declining health and mood:

'People get to a stage where they think, well my sight has gone, my hearing has gone, and this and that have gone, and therefore I can't do any more, I might as well give up. When they do realise that there are things out there that can help them and then when you do manage to get one side of a person's life moving up a little bit then often other areas follow, because people get very insular within their own problems.' (Tina – housing scheme manager)

Tina felt that some of these risks were compounded if older people were from BME backgrounds:

'Sometimes people when they move into a different culture and country then they are very worried and frightened and don't want to step on people's toes and say the wrong thing, so it is very important to get to know them and get to understand them so they feel safe and able in their environment to talk and say when they need and what they want.' (Tina – housing scheme manager)

Views and experiences of preventive approaches

Early intervention and prevention, particularly when they were focused on identifying and reducing isolation and loneliness, were important parts of Tina's practice and that of other practitioners. A housing support worker in the same area as Tina, Trudy, spoke of the ways in which regular contact with people living in sheltered housing schemes meant that workers could notice any deterioration. Such regular contact fostered trust not only with older tenants but also with members of their family. Specific approaches to prevention based around housing and social care services working closely together were reported from mainstream organisations, such as the local authority where Tina and Trudy worked (Fen Town), as well as more specialist care services from different sectors in other areas.

Other practitioners working in specialist services and groups reported undertaking preventive as well as responsive practice. A voluntary mental health group, for instance, offered 'mental health first aid' across different communities and workplaces, which they felt reduced the stigma associated with mental health issues and which they thought could pick up on early indications of depression among older people from BME groups. Another voluntary group offered 'walking therapy' for people with enduring mental health problems, along the lines of the Shrewsbury 'Walk and Talk' service, which has received recent media coverage (South Staffs and Shropshire Healthcare NHS Foundation Trust, 2010). In a further example, in one housing support scheme in Fen Town, staff had access to the housing scheme's records for each tenant, that covered the person's likes and dislikes, small amounts of biographical detail and their support plan. In some schemes, these seemed very 'living' documents and were referred to often. If a tenant had raised a worry with one member of staff, then this was recorded to inform

others or to inform a new worker. Such an approach was valuable in helping with early identification of problems.

Resource centres for BME groups

In those areas of the enquiry where several BME communities had been living for some time but not in large numbers, we visited resource centres that were used by several groups and many generations. In High Town, for example, a Caribbean Centre was established 20 years ago and was now attended by African, Arab and Chinese families with different cultures and religions, including Christianity, Buddhism and Islam. When we visited there was an 'elderly project' running at the Centre, with exercise sessions and 'healthy eating' food preparation and snacks. Trips or outings for the older members were arranged by the Centre's paid staff and management committee, and a small number of volunteers visited housebound older people, generally those without nearby family. Staff sometimes accompanied people to hospital appointments or contacted 'officialdom' on their behalf. When asked about links with social services, Mr Carpenter, the spokesperson (in his seventies) and one of the Centre's founder members, said that there were not any, at the moment, which seemed surprising for such a resource, even one that was an open access resource. From our enquiries, it appeared that the funding for the Centre was a complex mix of community development/project funding, council-subsidised premises, charitable grants, donations and fundraising, meaning that social services were involved at the level of local commissioning and in partnership with other bodies but that some members of the Centre did not see that social services were helping by funding their running costs and thus providing support. It may be that the advent of personal budgets will mean that centres such as this are able to offer the kinds of support that individuals will pay for out of their budget if they are confident that the service will meet their needs. At the end of this chapter we outline further potential developments around personalisation and our indicative findings are further described in Chapter 4.

Mainstream older people's groups

However, mainstream older people's groups (meaning groups that are not specifically working with BME groups) also work in the area of prevention; indeed, many see this as central to their role. Brenda, the manager of an older people's centre in High Town run by Age UK, described its focus on health and wellbeing, with physical activities taking place at the centre that were designed to enhance social participation and foster mental health generally. Activities such as Tai Chi, and more recently Chinese fan dancing, were attractive to local Chinese older people. Other BME individuals used the group's facilities, notably its charity shop and lunch clubs, and Brenda thought that this helped improve their familiarity with the building, enhanced their confidence with the staff and volunteers, and increased knowledge of what was on offer. In other words, she outlined ways in which the organisation was making efforts to improve access and acceptability. Nonetheless, Brenda

thought that prevention in the area of mental health was not always taken sufficiently seriously by statutory services:

'For example, if someone is lonely and isolated and depressed, if some small prevention measures are put in place, you can maybe get round the mental health issues. There are low [level] prevention measures that can be put in place ... but with older people they have to be 'acute or crisis' before they get intervention [from statutory services] ...' (Brenda – manager of VCS organisation)

Specialist settings

A similarly large range of activities, but in a specialist setting, was evident in the Chinese Community Centre in Pier Town. Linked to a lunch club, were activities such as Chinese games and television programmes, exercises and eye tests. The Centre staff offered advice and support with accessing health services. Their services were increasingly needed now that many of the local older Chinese community were living alone, because their families had either died or moved away. Few of the Centre's members spoke English or were confident in using it. Some had limited literacy. The Centre provided a service to local care homes if they had Chinese residents – either by offering volunteer visitors or volunteers to act as translators, or by enabling care home residents to attend the Centre if transport could be arranged. Such arrangements seemed to be of the sort that might be incorporated in a personalised support plan by older people, their support brokers or care managers.

Mainstream community-based resources

Community-based facilities with a preventive role could also be part of mainstream resources. In Fen Town, a community cafe that was linked to mental health services attracted a wide range of customers, including BME older people, to a venue that looked like an ordinary coffee shop. However, Kathy, a local occupational therapist, was aware that some BME groups did not seem to see this as necessarily part of "normal life" and was worried about South Asian women who appeared to her to be less able or willing to access such resources. In her view, some women were not able to go out in to the wider world and her contacts with them were always mediated by family members, who did not seek support until late in the day: "you can improve their home life, but you can't do a lot to improve their social life or get them out meeting people". In some instances, family members' views might override what she saw as the rights of older people to preventative help:

'Occasionally the family controls what we do and they are not always keen to have ... there was a case recently where the family said no, they didn't like the look of the grab rails so they won't have them put up. You end up literally marooning somebody in a room. It's very difficult. It's difficult to know what you do from there if other people have control over the environment.' (Kathy – occupational therapist)

Respite and short breaks

This account, and others like them, exposed an issue for social care practitioners. Practitioners perceived that some BME older people who are living with families may be isolated and at risk of lack of stimulation, choice and social participation. They saw it as important for older people to be able to "get away from their families" at times. Many of these concerns were perceived as relating to gender equality and gendered ideas about duty or obligations to care, and the stigma of accepting outside help. They saw this as potentially giving rise to strain and depression.

This idea is not confined to BME older people, and for people with high support needs the idea is often referred to as 'respite' – implying that both parties may need a break. However, some practitioners, including those from BME groups such as Zia (working with a health development group in Pier Town) voiced this issue in respect of BME older people without high support needs. This perspective suggests that assessment of mental wellbeing therefore needs to include dimensions of social participation that do not assume that people living with family members are not at risk of feeling lonely or isolated. Such assessments need also to ask about the quality of relationships and not presume that they are stress free.

Recruitment of volunteers from BME groups

Other approaches included the recruitment of volunteers from BME groups into more general services, such as befriending schemes. This could take time in some areas; one scheme had run for almost seven years before being able to recruit a diverse volunteer cohort. Research has shown that this is not uncommon; while BME people are under-represented in formal volunteering settings, they are actually more likely than their white counterparts to be involved in informal volunteering settings. This is sometimes through choice but sometimes reflects how committed different organisations are to increasing diversity (Institute for Volunteering Research, 2004). However, once achieved, it was thought that this helped overall in demonstrating that the service was open to all and that the service could respond when specific requests were made. Lorna, a BME group organiser in Field Town, recalled:

'We had a South Asian lady who had recently lost her husband and although she speaks very good English she desperately needed somebody to talk to in her own language. That was a real worry but we

managed to find a lady, not from her own country, but she can speak her language, and we've linked them together and it's working wonderfully well. This lady [the widow] has gained enormous confidence and she's got somebody that she can ring back if she's a little worried about things or she feels that she doesn't fully understand something.' (Lorna – BME group organiser)

Mental health awareness

While many statutory professionals, such as social workers and managers, were familiar with terms such as 'mental wellbeing', other people working or volunteering in BME community or faith groups were less accustomed to such terms. This is consistent with existing research on lower levels of awareness of mental health issues among some BME communities (Adamson, 2001; Bowes and Wilkinson, 2003). Ayasha, for example, a coordinator for a BME infrastructure/umbrella group (a group that coordinated other smaller groups and offered them organisational and practical support) in Pier Town, said that there was little general knowledge about mental health or mental wellbeing among the groups she supported. The groups had experience of community development approaches but it was rare for them to be able to combine these with expertise in mental health. Zia, the health outreach worker mentioned earlier who was particularly working with women from the Indian subcontinent in Pier Town, also spoke of the general lack of knowledge of mental wellbeing and described how they were addressing this through their network's newsletter which now included mental health information but tended to avoid the words 'mental health', using other terms such as 'wellbeing' – "to make it less scary". A recent newsletter had included an easy 'test' with examples and stories to help people recognise symptoms of depression. The benefits of physical exercise were often couched as improving mental wellbeing. Similarly, a voluntary sector group in Fen Town, running a gardening scheme at local allotment sites for the neighbourhood, was building up links with more mainstream mental health providers to emphasise the value of outdoor activity and exercise for mental wellbeing.

In a further example of an innovative project that aimed to identify mental health needs at an early stage and therefore prevent more serious problems, one Age UK group was running a prison service supporting long-term older prisoners, with a whole range of health and social care needs. Some of this work was around risk and resettlement; other aspects were around prisoners who were serving very long sentences. Group work, stimulation, assessments and befriending were examples of this project's activities that were available to this highly excluded group who were from all faiths and ethnicities.

However, as Chapter 4 shows, some participants were concerned about the potential for personalisation to impact on some of these more traditional forms of provision and the challenges of maintaining a balance across different types of service.

Main messages about promoting wellbeing and addressing risk through social interaction and preventive approaches

- Drawing on existing local community development organisations seems to be a key way of developing good, responsive services and support networks.
- Practitioners recognised the need for preventative work to identify isolated BME older people at risk of depression. While the role of community groups in acting as a link between individual BME older people and statutory services was thought to be key, there were concerns about the variability among these groups in their capacity to recognise depression and intervene accordingly.
- Universal local authority services such as leisure, education, housing, and transport are clearly part of the prevention of ill-being, alongside social care services. Those responsible for social care transformation need to ensure that local voluntary and community groups are fully engaged in the process of making decisions about local services.
- BME groups and centres may need to be specifically included in developments, such as third sector support for micro-commissioning, to ensure that they are able to offer older people support, arrange contracts and finances, and are confident in this role. This applies equally to groups supporting older people who are eligible for personal budgets as well as self-funders.
- Volunteering offers opportunities for promoting self-esteem. Being a volunteer in a BME group or elsewhere may be a way for some BME older people to maintain wellbeing and reduce isolation.
- Many community organisations are intergenerational and this can be beneficial in terms of recruiting volunteers and arranging family-type meals or outings. These seem to have potential for reducing the risks of depression (see SCIE, 2009). Finding ways to support people find social outlets may be an important task for support brokers in the era of personalisation but it can also be part of the work of mainstream practitioners in social care or in social housing services. Care or case managers need to think more widely than existing conventional older people's groups when arranging services.
- Personalisation offers a fresh opportunity to present prevention work as coherent and consistent, by including it in people's support plans and by stimulating community support.
- Personal budgets (however they are arranged or deployed) also provide the opportunity to mix and match support packages, with greater opportunities for social inclusion, reducing social isolation, loneliness and possibly enhancing self-esteem as an alternative to

'traditional' models of service provision such as day care or home care.

- Offering services in social or community settings, such as cafes or shops, brings mixed benefits; while this may not be appropriate or accessible for certain individuals or groups, it can be highly effective in promoting accessibility. Finding ways to offer opportunities that are acceptable to individuals and families in certain cultures may necessitate enquiry and the avoidance of stereotypes. For example, developing women-only groups may be more acceptable for people from certain cultural groups but not everyone may find this helpful or it may not be what they want.
- Many BME older people's organisations have been run very informally. Where they choose to expand into supporting BME older people with mental health issues on using personal budgets, they need to be prepared to take over the responsibilities of monitoring and dealing with the administrative arrangements for personal budgets. This is especially important where they are supporting individuals with limited fluency in spoken or written English.
- Stigma about mental health continues to be an issue across society, but may be greater in some BME communities. Raising awareness about the availability of services aimed at improving or maintaining mental health and wellbeing requires careful use of language to avoid alarming people and putting them off using particular services.
- Practitioners need to be aware of the need not to have stereotyped ideas about the relationship between household living arrangements and wellbeing; some older people living in intergenerational households may still experience loneliness.

3 Mental wellbeing in care homes

In this chapter, we focus on one of the major parts of the social care sector, and one where ideas of mental wellbeing have often been less quick to develop. While only a small minority of older people live in care homes, they are a group with high level needs and can be at great risk of depression (SCIE, 2006). There is a long history in the UK of care homes being set up by the voluntary sector to reflect the faith or ethnic backgrounds of residents and we interviewed some practitioners in such settings as well as social workers who had experience of arranging the moves of older people to such homes. We listened to the views of several people living in care homes and those of their carers; some living in homes that had a specific faith or ethnicity focus; others living in care homes that were mixed and open to all. Their accounts offered different pictures of the ways in which social care workers could make the lives of BME older people and end of life, in particular, individually meaningful and enhance their wellbeing.

Faith and ethnicity

There were many examples of supportive social care practice being carried out by all staff in a care home; not just direct care workers. Mr Myers, aged over 90, for example, spoke of the ways in which he was supported to practise his faith and to be part of 'his community' by staff at the Jewish care home in High Town where he lived:

'I go to synagogue on a Saturday and my in-laws, they pick me up ... they bring me back here and invariably I'm late of course. The cooks put something aside for me and heat it up in the microwave and it's perfectly fine ... I'm just starving ... they are very good.' (Mr Myers – care home resident)

Such inclusiveness might also help staff with managing different customs. Finulla, a voluntary sector liaison worker for Gypsies and Travellers (a post funded by the local authority in High Town), spoke of the ways in which she felt staff in hospitals and care homes were often unprepared for the visiting practices of large Travelling families, such as "a lot of people turning up and not just at visiting times". After a death, families might want to take the body back to their Traveller site before the funeral. In the rare instances, in her experience, of an older Traveller moving to a care home, the family might want to be involved to a large extent. In a recent example of this, Finulla talked of how a wife had taken her husband's meals to him every day and wouldn't allow anyone else to provide personal care for him:

'They struggled to give somebody else the responsibility of care, because within the family, within their culture, their family care is a big thing and they don't believe in outsiders coming in to do that responsibility, when it's their own.' (Finulla – Gypsies and Travellers' Liaison Worker)

Language and communication

Only a comparatively small number of care homes in the study sites, as elsewhere in the UK, were designed for one particular faith or ethnic group. More commonly, residents from BME backgrounds were living in homes in which they are in a tiny minority. Research has shown that English language proficiency varies across different ethnic groups (Shields and Price, 2002; Dustmann and Fabbri, 2003). For example, one estimate suggests that between 70 and 80 per cent of first-generation Chinese people do not speak English (Mind, 2010) and staff in the present study working in homes with residents who did not speak English could find that language barriers were substantial challenges to providing person-centred care but noted that this might be equally applicable in other circumstances such as hospital stays. Indeed, in Field Town, Felicity, a policy and quality assurance manager, had specifically raised the concerns of an Indian community group about the lack of cultural understanding in the local hospital where, for example, Indian vegetarian older people had been offered eggs, which contravened their dietary rules.

Inability to communicate because no one speaks your language or can understand what you are saying is an example of a comparatively rare problem in numerical terms but one that is potentially devastating for the individuals concerned. This was acknowledged by practitioners and commissioners. Katherine, a local authority commissioner working across the whole of Fen Town, spoke of the problem of commissioning a care home service for one Chinese older person who spoke a minority language and was not able to read or write in any language. She felt that this person's needs were being met in as far as the care home could provide an individualised service.

In the same town, Seema, a care home manager from a black African background, reported commissioners making email enquiries of all local care homes to see if they had Italian-speaking staff for the benefit of a person needing respite urgently. Seema felt that this was a sign of positive practice and thought that the greater diversity of staff, through the employment of migrant workers, was likely to broaden care homes' responsiveness.

However, language problems remained for many older people. In Pier Town, Zia, a health development worker, spoke of a woman living in a care home who attended a local lunch club once a week as part of her support plan: "it's the only day of the week that she can speak her own language and have her own food and everything". Care managers were aware of the negative effects

of such isolation and, like Susan, working in Fen Town, some described strategies for trying to ensure that a particular BME older person who had moved to a care home might be assisted:

'She could not communicate, her carers [care workers] could not communicate with her; she could not communicate with them. They had certain things written in English and her language but she could not read her own language. I got a picture book made up for her and the library was looking at getting some music CDs and some websites for us to download for her. The home itself has got satellite TV so she could watch TV and listen to programmes in her own language.' (Susan – care manager)

Isolation

Stories of isolation in care homes were often cited and often seemed to be the only news of this sector that reached BME groups, apart from alleged mistreatment. Mrs Ho, one of the founders of a Chinese housing support service in High Town, recounted:

'I've met a few who have had to go into homes and they've been very upset about it, because obviously they are very isolated and have nobody to talk to. They just sit around there all the time. If they need anything at all, they are unable to communicate that. So it's like shutting them away in a prison and throwing away the key. It's no life at all, once they are in a home.' (Mrs Ho – older person)

Mrs Ho's concerns were shared by Fang, a Chinese carer living in High Town. She explained that she had been caring for her mother at home for some years but her brother had moved her mother to a care home near him in another part of the country out of a sense of filial piety. Her mother's care costs were met by her brother. Fang pointed out the multiple elements that comprise wellbeing. She recognised that her mother was pleased that her son had demonstrated his sense of obligation for her welfare. At the same time, her mother was the only person of Chinese origin in the home, and she and Fang now saw each other much less often than in the past.

The role of interpreters

In Fen Town, Freda, a BME older woman who volunteered at a horticultural social centre, felt that interpreters needed to be familiar with settings such as care homes so that they were better able to provide accurate and empathic advice to BME older people needing to move to a care home. Heather, a care home manager in the same area, shared Freda's views about the importance of interpreters in ensuring that 'the older person was heard' so that practitioners did not just rely on the opinions or wishes of family members. She argued that interpreters needed to be able to understand older people

and the ways in which mental health needs might influence a person's communication style. While care staff might be able to assist, a professional interpreter was important at times such as making the decision to move to a care home, because care home staff, for instance, could become very focused on personal care and they might "miss things that we'd need to know about".

The role of volunteers

In addition to the role of interpreters, participants identified a role for volunteers. Mrs Verny described the situation of her mother who was now living in a nursing home. Her mother's poor health meant that trips in a taxi to the local Pentecostal church were no longer possible and her mother also seemed to have given up interest in such activities. Mrs Verny was conscious that her mother's African-Caribbean background was different to that of the other residents and she worried about care staff feeling that her mother was not sufficiently polite or that the 'West Indian way of coming over might be misconstrued for other things'. Her mother's distress and frustration at times caused her daughter to fear that staff would perceive her mother as constantly complaining. Mrs Verny would have greatly appreciated a volunteer from her mother's background to come and chat with her, to joke and to talk about old times. If her mother was still living at home, Mrs Verny envisaged that personal budgets might have been helpful to the family in possibly arranging more individualised care. At the moment she suspected that her mother was depressed and almost 'bereaved' from the losses of her home, her declining health and the impact of her disabilities on her self-esteem. Her mother had been depressed previously and was now 'very low'.

Approaches to provision for BME residents

According to some care home managers, no one from a BME group had ever been resident in their care homes. This was not untypical in some areas. Linda, a manager of a small care home in the rural area of Field Town, said that if someone from a BME group was moving in then her first port of call would be the social care regulator. She thought that its staff would know what to do and be a source of information. This home had never had any training on diversity and had no policies on the subject.

In contrast, and not very far away geographically, another care home manager, Bryony, described imminent staff training on diversity, in partnership with the statutory sector. While she envisaged that the home might struggle with language proficiency, she was aware that the new migrant working populations in rural areas were a potential employment pool for staff in her home. However, this did not offer any guarantees that the languages spoken by migrant workers matched those of residents.

Nearby, Iain, manager of a medium-sized care home, spoke of the ways in which, if a person from a BME background were to become a resident, their needs would be identified by staff who would record them and try to meet them through the building up of a care plan. He gave as an example of possible different needs, social care practice around end-of-life care and treatment of the body after death. Equally, he spoke of the needs among residents for stimulation, and the ways in which activities should be tailored to each individual resident. He was fairly confident that training would equip staff in the home to work with people from different cultures but not so sure that other residents would be 'comfortable' with people from a different culture:

'My understanding is that even though it may be a challenge, it is an opportunity. It is good for people to learn other things. They may see this from a TV and form an assumption and then they meet someone from another background and they see that they are not like that. It's good for people to learn.' (Iain – care home manager)

As with another manager, Linda, he would seek advice and information from the care home inspectorate. Importantly, however, Iain said he would ask the potential resident and their family to explain what their needs were and how to meet them in a care home setting.

However, in the same area, Field Town, Kim, a care home owner, had once had a resident a few years previously from a South Asian background. She had sat with her to talk about food preferences – discovering her love for very hot curry – and explored her religious needs – although the new resident said that she was not practising her original faith. Kim perceived no problems in providing any new resident with the same high level of care as her other residents and said she would draw on support if needed from social workers who provided an annual review for residents.

Not far away in the more urban part of the Field Town area, Nigel, the manager of a large care home with a day care centre attached, had both a diverse staff team (the majority of his non-UK staff being from new accession European Union countries – Eastern Europe in particular) and a history of a minority of residents being from diverse ethnic backgrounds, including Jewish people and Travellers. He was confident in outlining general provision for BME residents as individuals and in explaining the service's input into mental wellbeing, such as reminiscence work. Interestingly, this home had a shared care philosophy through which, as far as possible, care activities, including personal care, were shared by relatives or friends and the staff of the home. In the same area, Enid, the manager of a medium-sized care home, knew of two former residents who had come from Chinese and Jewish backgrounds respectively, but there were no BME residents in this home at the time of the study. Arising from her own interest, she had drawn up a leaflet for the direct care workers on different religious practices around death when developing the home's diversity policy, as diversity had become a bit of a 'buzz word'. She did not envisage any 'attitude' problems with staff if the home was to have BME residents since the ethos of the home was around the core values of dignity, freedom, choice and promoting fulfilment.

Residents with mental health problems

Care home managers were alert to the potential of care homes to support people with mental health problems, not just dementia. In Fen Town, Heather, manager of a local authority care home with experience of talking to other providers, spoke of the current emphasis on dementia in commissioning and in the media and regretted that there was not the same focus on older people with functional mental illness, who may have had a lifetime of a depressive illness, for example. She also highlighted that people with mental health problems when they reached the age for 'older people's services' were at risk of 'dropping off the end of services', adding that 'suddenly, it's just an older person being a bit odd, when their needs don't go away do they?' In her experience this risk occurred when such individuals had been living in a rather protective arrangement at home until family members died, at which point they could become 'totally lost'. They were vulnerable if they moved into services where there were younger people, for example, in hostel settings, but if they moved to an older people's home they could be much younger than the majority of residents. Heather's approach was one of seeking to make the move positive and meaningful for such individuals, notably by trying to get these older people involved in providing support and 'helping out' with residents who were more frail.

Heather also had experience of the positive outcomes for older people with anxiety and depression of a move to a care home. She talked of the ways in which it was important to recognise that anxiety could be highly disabling if an older person is living on their own and their quality of life could be much improved by the reassurance of care home support. Similarly, she spoke of the importance for social care practitioners of enabling the tenets of personalisation, choice and control, in a care home setting:

'Just because somebody has always liked something, if they say 'don't' we are not to be disappointed, even if we have put so much effort in providing it for them. It's the same really with people from different cultures, isn't it, because some people want to retain their culture and I think that's absolutely brilliant, and they try to impress it on their children and their grandchildren who sometimes rebel against it or sometimes embrace it.' (Heather – care home manager)

Provision of culturally appropriate food and support to practise faith

In order to address some of the criticisms of the care home sector that culturally appropriate food and supporting older people to practise their faith are not always embedded in services, in High Town, Denise, a social services commissioner was building related standards into its contracts with care homes. This had initially been a matter of 'ticking the box' but she had now

developed a more detailed approach to seeing what happened in each home through monitoring and review of the contract. Denise gave examples where discussions about some BME older people in her area had generally seemed to be around food but were perhaps “not well-disguised racism” from some members of staff. She gave the further example of an older man from a BME community who was bringing his wife the food she liked while she was staying in a local care home, but staff attitudes to this were not positive. Following the involvement of social services, she felt that the improvements had been made but still were perhaps only tokenistic.

Main messages about mental wellbeing in care homes

- In promoting wellbeing and inclusiveness, care homes need to include all staff as part of their service. Cooks, cleaners, gardeners and so on may be the ones who, in their day-to-day practice, make the difference to a person. In their action or inactions, they can affirm or deny the personhood of an older person.
- Mental wellbeing needs to be explicitly identified as part of everyone's work. This too is part of prevention and may also help to reduce the stigma of mental health problems.
- Inability to communicate with practitioners and other older people can be detrimental to the wellbeing of BME older service users. Care home practitioners need to find positive ways of supporting such individuals.
- Family members should not be relied on to act as interpreters although family members will often take on this role. Interpreters, whether professional or family members, need to have a good understanding of care home environments and arrangements in order that they are able to provide accurate and empathetic advice to BME older people whose mental health problems may make communication particularly difficult.
- Anxiety and depression are commonplace among care home residents and older people of all backgrounds may need plenty of reassurance and support.
- Volunteers can have an important support role, especially where a BME older person is the only person of a different cultural, ethnic or religious background to that of other care home residents.
- Care homes may be regarded by some BME older people and other age groups as isolating and not able to provide culturally sensitive services and support. Community outreach by care homes may help to dispel some of these generalisations. Commissioners need to build person-centred standards into their contracts with care homes, which should be regularly monitored and reviewed.

- Care home practitioners need to be sensitive to the particular cultural needs of BME older people (and, of course, those of all residents), around, for example, end-of-life care practice and the treatment of the body after death.
- Care home staff should draw on support from each other and local community resources and integrate cultural and equalities issues into basic training to enable them to provide person-centred care and support for new residents. They may also have expertise that could be shared.
- There may be a potential role for migrant care workers in terms of broadening the responsiveness and cultural competence of care homes, but there is of course no guarantee that the languages spoken by migrant care workers or other staff will match those of BME residents.
- Person-centred approaches in care homes offer new opportunities to provide a high level of support to meet mental health needs beyond those relating to symptoms of dementia.

4 Personalised approaches to promoting wellbeing and supporting people with depression

Personalisation of social care services relates to models of working that enhance choice and control for people needing support and continues to be a major central government policy focus. This chapter focuses on how practitioners, commissioners and BME older people perceived various aspects of personalisation in relation to providing social care to best promote mental wellbeing among older people from BME groups.

Assessment

The value of personalised approaches to supporting older people from BME groups with depression was identified by several participants working in or managing different kinds of services. For example, changes associated with personalisation included requirements to address mental wellbeing in assessment sections of computerised forms determining eligibility for publicly funded social care and other paper-based tools. In High Town these new local authority systems were seen by social workers as replacing a deficit model of mental health problems or illnesses, by encouraging social workers to identify mental health outcomes. These additions further included 'leisure' and similar areas so that assessments would be a better record of a person's choices and wishes. Commissioners and social workers in this area, such as Denise, Peter and Diana, were largely positive about these new developments, although Diana, a commissioner and manager, thought that the term 'wellbeing' was being used more to differentiate provision for older people with mental health problems from dementia care services. Social worker Denise thought instead that the term 'mental wellbeing' was being used to counter notions of mental illness as being highly 'medicalised' and as something only affecting a small minority of older people. She argued that mental wellbeing was for everyone, and 'immediately applicable to all' although she thought that social workers would often have to 'tease it out'.

Personal budgets and direct payments

Closer to frontline services, Fred, a carers' link worker, described how a specialist carers' service (jointly funded on a short-term basis by the local authority and the NHS) could highlight the needs of carers who both supported people with depression and were at risk of depression themselves. In common with many such resources in the areas studied, this was not a BME-specific service. Fred predicted that personal budgets in the form of direct payments might be very attractive to older BME people if they could use them to employ their relatives or family carers to provide care. Making use of older volunteers, an Age UK group envisaged personal budgets as being ideally suited to personalising care for isolated or anxious older hospital

inpatients by offering help with eating or personal care (although this is not permitted under personal budgets at the moment in NHS settings). Such activity could benefit older volunteers by building up their self-esteem and feelings of self-worth. Working within social services, Nick, a social worker in Fen Town, added that when devising the support plan for personal budgets, social workers often needed to be imaginative since people might have low aspirations if they were depressed or similar.

One of the most enthusiastic proponents of elements of personalisation in the form of direct payments was Finulla, a liaison worker with Gypsies and Travellers:

'Why pay an outsider that needs to learn everything about that kind of cultural traditions? Why not pay the community members to do that job? They [older people] are going to trust their own family.' (Finulla – liaison worker with Gypsies and Travellers)

Likewise, Linda, the wife of an older man with multiple health problems in High Town who had migrated to the UK in the 1960s from the Caribbean, envisaged that if her husband were to need more personal care then he might welcome someone from his background, because he might 'respond better' and would have 'something in common with them', being able to 'open up more to someone from his own culture and country'. Drawing on actual practice, some practitioners interviewed had positive experiences of direct payments and how these might benefit BME older people. Kathy, an occupational therapist in Fen Town, spoke of an older BME woman whose disabilities fluctuated in their severity. With a standard care package, she was not able to get sufficient help at some times, while at other times she had more help than she wanted: 'everything sort of got all wrong and she cancelled it in the end'. In contrast, direct payments, when explained and established, worked wonderfully for her by enabling her to have greater flexibility.

In High Town, Denise, a senior social worker, described experiences of using direct payments to pay for members of an extended family to provide care for their mother, a Muslim, who did not want strangers in her house. She had gained the permission of managers for what was then an exceptional case in that relatives were being paid, but envisaged that this would be more the norm in personalisation. She contrasted this to some of the inflexibilities of in-house home care, where care workers, for example, saw being requested to remove their shoes inside a person's own home as a 'health and safety matter'. In the same area, local authority commissioner Diana saw that personal budgets in the form of direct payments would be very attractive because it was far cheaper to pay family members and neighbours than care workers. This might benefit older people who are isolated as their relatives might be willing to take them out and include them in social activities. However, there are some older people who would need care packages that are able to cope with high levels of need and risk; she gave as an example an older person taking medication for depression who either took too much or forgot to take it if he was drunk.

Crises developed fairly regularly, and the care packages often had to be revised.

There was a difference in view at senior level within local authorities of the use of direct payments when used to pay for relatives to provide care for BME older people in particular. One commissioner, Harriet, who had led the development of personalisation in her local authority, wondered if paying a relative to provide care or support would be sustainable and if relatives might be left without a break. She was not aware of any ways in which local care businesses were being encouraged to develop the market by publicising if their staff could speak languages other than English. However, she recognised that it was early days:

'One of the things that personalisation teaches [is] you can't second guess what's going to be – in the past we've tended to think what people need and provide it and then discover whether or not they need it or not ... as long as you have a system that retains the ability to be as tailored as possible then things will emerge. I say to providers, we are in a different world now. What we want you to do is to ask the people who use your services what it is that they would like.' (Harriet – commissioner in High Town)

In Harriet's view, one of the problems that personalisation was trying to address was that contracts, such as Service Level Agreements and so on, could never be detailed enough to cover all individual choices and needs. Likewise, in High Town, although no BME older people had made the move to personal budgets at the time Harriet was interviewed, personal budgets were already being used to support older people with long-term mental health problems to move from a care home back to their own home, albeit with substantial support. In Harriet's view, living back in their own home could do a great deal for their mental wellbeing. The potential anxiety that might be caused by managing a direct payment was lessened in her area, she thought, by the local authority's funding of an independent user organisation to help manage financial arrangements and employment relationships.

Kirsten, another commissioner, gave another example of how personal budgets could be used to provide new forms of support. She explained that one BME older person had decided to spend their money on a subscription to television programmes rather than attending a day centre. Like other senior managers, she was aware of the need to promote safeguarding when using personal budgets. She also thought that they might result in greater equality of resources for older people.

Support brokerage

Some older people's organisations were responding to the expansion of personalisation by making plans to develop their activities to include support brokerage, such as the Age UK group mentioned above whose director was thinking of volunteers' roles and contributions to this activity.

Another community-based organisation in Fen Town operated a benefits advice service for older people. The director of this organisation outlined ways in which it had access to the myriad of groups working to support younger people who were working in local industries, such as agriculture and food processing, in its area. However, its use of a local interpreting group was limited, for the reason that it "cost an absolute fortune. We, as a charity can't do that. We are not in a position to be able to provide interpreters".

In contrast, the coordinator of this local interpreting group, reported excellent links with local social workers and saw that would work as an advantage in getting involved in personalisation:

'All the social workers know us. I give talks to the social workers; they know how to access us.' (Bernadetta, interpreting group coordinator)

Bernadetta highlighted the potential for the group to get involved in support brokerage since it was used to working with a wide variety of older people. She felt that the group's workers had an advantage as they were very aware of people's customs and preferences and she could match interpreters to the people they saw.

Other service providers were also confident that their track record would enable them to continue. Liz, the manager of a mental health day centre, was confident that personalisation was not a threat as she thought that the centre already provided a highly personalised service to a wide range of older people from diverse backgrounds. She was optimistic that the service users would opt to continue attending the day centre because they felt safe there.

Alongside these positive comments about the potential for personal budgets to offer greater choice and control for BME older people, more cautious comments were also made. These reflected wider concerns about the tensions between developing individualised responses and maintaining the infrastructure of existing services, especially in the context of reduced resources (Stevens et al, in press).

Concerns about personalisation

Personalisation and safeguarding

The first set of comments reflects wider concerns about the link between personalisation and safeguarding (Manthorpe et al, 2009b). Nick, a social worker, was concerned about the risk of exploitation. He gave an example of an older woman he had worked with who was from a Travelling background who was receiving home care services but was being harassed by members of her extended family. Attempts to safeguard her were eventually to no avail and her declining health necessitated a move to a care home. There were difficulties in adjustment, particularly around smoking in the bedroom and various fires, and her family eventually moved her out of the area: 'She became someone else's problem'.

People with mental health problems

A related set of concerns centred on the need to find ways of supporting people whose mental health issues may affect their ability to manage personal budgets independently. Kathy, an occupational therapist, could see the value of personal budgets, however she was not so convinced that they would work well with people whose ability to manage everyday matters was declining due to dementia or a similar condition.

This caution was echoed by Kirsty, manager of a sheltered housing scheme in Fen Town, who was concerned that people with depression who received personal budgets in the form of direct payments might 'not bother' if they were feeling apathetic or low in mood to take up their care. In her view there would not be sufficient monitoring to see that people were not falling by the wayside.

Housing and care

Within housing and care sectors, Kerry, a local authority housing support worker in Fen Town, reported that sheltered housing tenants varied in their ability and willingness to manage personal budgets and that the implications for housing with care had yet to be fully determined. She felt that a lot depended on the quality of the support plan, regardless of personal budgets or other forms of care packages. In her view, a well-developed support plan would contain details of people's habits and routines, for example when they might want to pray.

Effects on workers' future roles

These apprehensions could become entwined with anxieties about interviewees' own future roles. Ursula, a 'mobile' tenant support worker in Fen Town, worried that people with a personal budget (either as a direct payment or care-managed service) might think that they do not need to spend it on the type of support her service currently guaranteed. She was fearful that if personal budgets became the norm then services such as hers would no longer be viable if not enough people wanted to pay for them. While this might be the majority choice, it would leave the minority disadvantaged and at risk of becoming isolated.

Decommissioning or closure of services

A small number of participants involved in different kinds of services at different levels raised concerns about the potential for personalisation to result in the decommissioning or closure of services that they considered were fulfilling a valuable function, particularly for minority groups, such as BME older people. Here, the main worries centred on the potential closures of services providing day opportunities such as day centres, luncheon clubs and drop-in clubs. Traditionally, these services seem to have achieved better rates of uptake among older BME people than care homes or home care services and examples exist of successful services that have been developed either as integrated services attended by older people from all ethnicities or as specialist services (Moriarty, 2001). These opportunities are particularly appreciated by BME older people as a way of reducing loneliness and isolation (Buffin et al, 2009). One of the members of an Indian day centre who participated in this study had received hospital inpatient treatment for mental health problems and the day centre was providing her with a regular place to go where staff seemed to be able to help with her distress.

Funding

For the majority of BME organisations in the voluntary and community sector (VCS), funding has always been precarious (Butt and Mirza, 1996; Bowes, 2006) and some provider managers were concerned that this would be exacerbated as local authorities started to review their funding of voluntary groups. While groups like the Age UK organisation in High Town mentioned earlier were calculating the costs of items or services they supplied that might be bought as part of individual care packages, there was concern about infrastructure costs for voluntary sector groups not being met in the future. However, this group, which had multiple funding sources, had been discussing these developments for some time and was fairly confident that its budget processes would adjust, but its director, Brenda, predicted that other smaller voluntary groups and some care agencies would 'fall by the wayside'.

Main messages about personalised approaches to promoting wellbeing and supporting people with depression

- Depression may affect people's aspirations and motivations. Very active involvement in devising support plans was suggested as necessary with BME older people with depression in order to take full advantage of personalised services, which largely rely on individuals identifying and finding ways to reach their own goals and objectives.
- Local authorities should be clear about the processes required if relatives are to be paid from personal budgets so that they are perceived as fair to all parties and to avoid the risks of exploitation and mistreatment. Detailed risk assessments may be helpful when there is concern.
- Increased monitoring of personalised support plans may be required to ensure that support is being received and service users remain motivated to engage with support plans if they are at risk of mental health problems.
- Identifying people (both social care staff and family) from similar cultures to provide social care may be one way of ensuring that support is acceptable and appropriate. However, older people may have very individual preferences. Again, it is good practice to monitor such situations closely if there are concerns to ensure that support does not further isolate people from contact with the wider world and actually does meet their needs.
- There is potential in using older volunteers from different ethnic backgrounds. This may bring positive advantages to BME older service users and the volunteers may benefit in terms of enhanced self-esteem and meaningful occupation.
- Community and voluntary organisations' links with social workers and other social care managers and practitioners should be nurtured as they provide an excellent opportunity for people to learn and increase their understanding about the care and support needs of BME older people.
- While traditional services such as day centres are at threat of being decommissioned, it is not yet clear whether and how their role in preventing social isolation is being replaced. Managing their loss may fall to voluntary and community groups.
- Many BME voluntary and community organisations have traditionally relied on funding through block grants. As these are reduced or withdrawn, local organisations need to be encouraged to develop the market through, for example, new roles in helping to manage direct payments for older people and support brokerage.

5 Housing and housing with care solutions to maintain mental wellbeing

This chapter outlines the interaction of social care support with other services such as housing and housing with care solutions. While our examples are in the main from sheltered housing, they seem highly applicable to housing with care schemes where older people are owner occupiers or tenants of accommodation that is specially designed to meet their needs and can be flexible if situations change by offering more support.

Although there are successful examples of housing associations specialising in services for BME people, such as ASRA, they tend to be concentrated in those parts of the country where there are higher proportions of people from BME groups. In most of the housing schemes where members of staff were interviewed, BME tenants or owners were very much a minority and so a particular challenge was ensuring that they did not become isolated within predominantly white settings.

Giving an example of this, Barbara, a sheltered housing manager in a rural part of the Fen Town locality, talked of her work with Mrs Chan, who was the only person from a BME community living in the housing scheme she managed. Barbara spoke of the attention to detail that was needed – giving as an example the need to ensure that someone explained workmen's messages to Mrs Chan. Barbara had asked Mrs Chan if she wanted an interpreter in such circumstances but she preferred to use her family. On a day-to-day basis, Barbara described frequent communication with Mrs Chan's family, in person and over the telephone. As with all tenants, the manager saw it as part of her duty to ensure that tenants were not isolated, arranging entertainment, and lunch clubs, and enabling tenants to travel to social activities in other similar settings nearby. While Mrs Chan did not often attend these events, Barbara was alert to whether her family members were regularly visiting and she, herself, was interested in learning a few Chinese words. Together with other scheme managers in the locality, she was also thinking about other potential new tenants, anticipating possible demand in the future from older Polish people.

Mrs Patel, whose mother was now privately renting a sheltered housing flat in Fen Town, described the sense of wellbeing that this arrangement seemed to provide, which allayed her mother's underlying and long-term anxiety:

'It works for her insofar as she's used to somebody always keeping an eye on her, from her father doing it to my father doing it. I think if she was completely on her own she would be very nervous and in that respect having the warden here and having other people around does help.' (Mrs Patel – carer)

The scheme had made arrangements for written information to be provided to her mother in her own language but these communications were still difficult for her to manage as she did not read well. Likewise, the scheme had given

permission for her to have a satellite dish installed so that she could receive Indian television programmes, which she enjoyed hugely. Mrs Patel acknowledged that support generally reflected the capacity of individual wardens, and had found that most were excellent. She had nothing but praise for the housing scheme management overall. However, the main problems the family had encountered had been with other residents. They had complained about cooking smells and about her mother's use of the laundry:

'I think, with give and take, we seem to have reached a place where everybody is reasonably happy. It took us quite a while but we got there ... We have been through a whole series of issues of the fact that nobody here is used to living with Asian people. I think the place obviously suits her. She is happy here and it is home. It's the lack of all things Indian around her that she really misses.' (Mrs Patel – carer)

Mrs Patel's mother had reduced mobility and so outings and visits out were getting less easy and she was mainly reliant on her family for support and company. In many ways she was a 'pioneer' in this care facility.

Another sheltered housing manager, Tina, described the ways in which two BME older tenants took part in social activities in the scheme where she worked. She described the popularity of reminiscence sessions whereby cultural exchanges – for example, how the washing was done in the old days – translated well across all groups and were often a unifying experience. While there were resources available through local libraries that could be used for specific communities or religions, in her experience, talking about household activities, such as wash day, were very inclusive.

Although sheltered housing might be seen as 'solving' problems of isolation and depression, according to Theresa, another housing scheme manager in Fen Town, practitioners still needed to be active in promoting social opportunities and activities. In her view, loneliness and depression were endemic. Others spoke of the importance of supporting older people to access faith or religious groups for emotional and spiritual support. Colleagues in the NHS were reported to often know who these were and how to contact them as well as other faith leaders. Relationships with family were important for everyone, and now these could span the globe. One housing scheme manager described a family on the other side of the world telephoning their grandmother during a family wedding ceremony in India to keep her in contact with the celebrations.

Main messages about housing and housing with care solutions to maintain mental wellbeing

- Scheme managers and other sheltered housing staff need to be sensitive to the particular cultural needs of each BME older person, especially if they are the only BME person resident in a housing scheme.
- Managers need to be alert to possible discrimination and racism and develop ways of managing such behaviour, using contacts in local adult safeguarding services, for example, to obtain advice or support if necessary.
- Staff in sheltered housing should ensure that support plans provide opportunities for BME older people and others to access faith or religious groups, if they wish to, for emotional and spiritual support.
- For BME older people living in sheltered housing, maintaining links with family can be very important; staff should recognise this need and help to promote them. Access to, and sometimes assistance in use of, information technology may enable people to keep in touch with family and friends across the globe. Sheltered housing residents, as well as BME older people in other housing with care facilities, may find that using such technology can reduce feelings of isolation.
- Encouraging engagement between sheltered housing residents from different ethnic groups may reduce isolation, particularly among individuals who are from a different ethnic, cultural or religious group from other service users.
- Creating opportunities for tenants or owner occupiers to talk to people in their own language may be welcomed; even those whose English is fluent may appreciate this.

6 Relationships between older people using services, their carers and practitioners

We came across many older people who used the term 'respect' when speaking of how they wanted to be treated (Butt et al, 1999). While this term has some similarities with the term 'dignity', the latter term seemed to be more frequently linked to personal care and ideas about privacy and modesty. This chapter explores various aspects of the interactions and communication that were identified as important in promoting mental wellbeing of older people from BME groups.

Respect and dignity

Respect seemed to cover wider aspects related to psychological wellbeing. As this comment from Mr Kinross, who joined the Royal Air Force (RAF) from Jamaica during the Second World War and now received home care support, illustrated:

'[respect] ... it's a very nice word. A precious word in Jamaica ... I don't care who looks after me, as long as they are efficient and they treat me with respect.' (Mr Kinross – older person)

However, 'dignity' was also a word used by some practitioners. Zee, for example, a mental health community worker for BME groups in Fen Town, associated it with older people being able to practise their faith:

'My colleagues are Muslims and I know particularly the older generation they need time a few times a day and somewhere to pray. It's very important to them. It's something what they believe in and it is part of their lives and I think it's part of dignity as well, if that's what you have, and then suddenly it's been taken away with no choice. It's talking about choice and dignity. They can't complain because of the language barrier. It takes a very strong person to complain and ask exactly what they want and what they are entitled to.' (Zee – mental health community worker)

Communication

Understanding gender-related communications was also identified as important by Zee. This required careful preparation, such as meeting with leaders first to get to know the background of the community; sometimes this identified that leadership was very male dominated. In Zee's experience, this would mean having to arrange to speak with men and women at different times. This could entail additional costs, especially in interpreting fees. Meetings could also take a long time, as there might be the need to 'go slow' and explain things. Apparently similarly sounding and similarly spelled words such as 'access' and 'assess' could be mystifying for some people.

Terminology such as 'mental health workshop' could be off-putting and might be better phrased by terms such as 'talking about wellbeing' and 'keeping active'.

Participants in this study talked about communication at several levels. In terms of access, voluntary groups were generally keen to publicise their services and some had taken the view that different forms of communication were needed to reach different groups of BME older people. One carers' project, working within a voluntary sector mental health provider in Pier Town, had invested in the translation of many of its leaflets into the main community languages in the area. It thought that this had been effective in reaching carers and community leaders who were not aware of its activities. Likewise, this project undertook numerous presentations to community groups, generally receiving a 'polite and friendly reception', but finding that older people often talked in generalities and were not keen on talking directly about possible problems. However, Naomi, the project worker, was keen to stress that these efforts did not always ensure that BME older people who were supporting family members felt that they were approachable for 'people like me':

'The language isn't a main problem. The culture is something else. For a start off, if we have Muslim ladies coming forward it would usually be up to me or one of my female workers. I won't send a male worker out on a Muslim lady's issues. I know different people have different views on life. You have to bear that in mind. What we see as the norm in our culture may be totally different to theirs.' (Naomi – carers' project worker)

Naomi had also found that where mental health problems were concerned, carers sometimes preferred to meet with a worker outside the home, and she had experience of carers not wanting to be telephoned at home.

While many working within local councils made efforts to communicate well and to audit their activities, problems could arise in other parts of the council. They were aware that promoting mental wellbeing was not just about improving social care services for people with high support needs. If promoting mental wellbeing was to make an impact on prevention then it would also need to enable older people to take part in activities such as leisure and volunteering to reduce the risks of depression and so on. There were reports of some leisure providers being less accommodating than they should be, despite contracts with local authorities, in making provision for female lifeguards for swimming sessions for Muslim women, for instance. Encouragement to take up swimming, for example, therefore fell at the first hurdle.

Working with carers of people with mental health problems was often difficult despite the need for this to reduce the risk of carer stress. In Naomi's experience, where there might be cultural or other complexities, it was good practice to ask family carers to explain their needs and wishes when undertaking assessments:

'I found that if we don't understand about some of the cultural issues the best thing is just to ask straight out, because it's just a basic misunderstanding and rather than do the wrong thing, you know, it's amazing the number of people that will just do what they think is right rather than say, 'look, this is what I think is a good idea'. You need to build up that rapport with the person so that they trust you to say, 'no, I don't like that' and why. You can't know it all.' (Naomi – carers' project worker)

The use of interpreters

While many participants in this study were working with BME older people whose English language was good, the subject of interpreting services arose in all four practice enquiry areas. These were often linked to a 'cohort effect' in that many BME older people had not learned English, or that the English language skills they once possessed were receding. Others referred to the lessening of the numbers of other people around who could act as interpreters – families had moved or died. Not only did a shrinking of social contacts and networks reduce some individuals' contacts, it could also be a risk factor for isolation and possibly loneliness. Some family members were placed in the position of seeming to be the only lifeline for a relative, with younger members of the family not being able to communicate with them since they only spoke English. Even in localities with comparatively small BME populations, such as Pier Town, there could be over 50 languages being spoken with the advent of new migrant populations, thus getting the right interpreter could still be a problem. This might entail some discussions about choosing to wait for a female interpreter, for example, or taking the only interpreter available whatever gender they might be. However, some participants, like Magda who worked in a specialist service that provided counselling in Pier Town, found their assumptions challenged when they offered older people a choice:

'Strangely, I would assume that a Middle Eastern man would say he would want to work with a man, but they don't. It's almost as if (the man is) breaking with their tradition anyway [and] might as well go the whole way.' (Magda – specialist counsellor)

Elsewhere, Kathy, an occupational therapist working for the local authority in Fen Town, said that the local authority did not allow its assessment staff to use family members to interpret because of the risk of them controlling the conversation and the information that was being provided. While she appreciated this risk, Kathy felt that this then might delay matters for the older person, as interpreters 'were not on hand at a moment's notice' in her area. A senior manager in the same area, Tom, confirmed the local authority policy to avoid using family interpreters, and saw this as important in ensuring, for example, that the responsibilities of personal budgets were fully understood or for the purposes of enhancing safeguarding.

Racist or distressing language

Further communication problems occasionally arose in day-to-day interactions in social care and other settings. The potential for some 'confused' older people to make remarks that were racist or distressing to BME older people was identified by a number of participants as a problem that required a response. Heather, a manager of a local authority care home, spoke of the problems that might arise if residents with dementia made such remarks to a BME resident, perhaps due to underlying fear, or a lack of knowledge, and were disinhibited in their words or behaviour. 'We've had some very frank discussions here', she recalled, but she was also very sensitive to what might be behind such behaviour:

'I do believe that if people are mentally frail and people are old, we have to have those discussions. If someone says, 'I'm frightened of somebody because they are black ...', we start to explore their reasons or start to observe and start to look at people's histories and start to look at why. We don't know everything about people ... I think it takes a lot of skill when a lot of the staff and the senior staff haven't really met people from any other cultures.' (Heather – care home manager)

Listening to older people

Magda, a counsellor, described the importance of listening to older people, especially refugees and asylum seekers, and how someone working in social care might be the first person with the time to do this:

'I think that what a lot of older people have said to me is when they've come to England as an asylum seeker, they've been through the system but then they see the first person that's listening to them. It seems to be really important that somebody has taken time and seems to have been understood, rather than just be processing them. Even when there's lots of trauma and lots of horrid things that you can hardly imagine. Being able to sit and hear that – you've survived. That's wonderful. You are valuable. These people [elsewhere] didn't value you but you do, and I do, and others will.' (Magda – specialist counsellor)

It was not just refugees who were described as more appreciative of more informal approaches. Lorna, the project manager of a befriending scheme in Fen Town, spoke of older people's vulnerability and their reluctance to get involved in anything 'official'. This could apply further when people were anxious or depressed. Like many voluntary groups, especially those that were reliant on volunteers, this project manager had to be careful that volunteers were not asked to take on befriending people with severe mental health problems that were beyond their capacity. In her experience this was happening more often nowadays. She regretted the general decline of long-term involvement of social workers with older people with mental health problems.

Moreover, some practitioners were very aware of the possible frustrations of interpersonal communication difficulties and the ways in which these might compound mental health problems. Tina, the manager of a housing scheme in Fen Town, described her practice when talking to one tenant (Maria) who had lived in England for many decades and whose family spoke only English:

'Maria still speaks with a very heavy accent and sometimes that can be a problem for people to understand. I always make sure that I give enough time to sit and then I can ask questions if I don't understand. She can speak to me again. There is nothing worse if you want to say something and you are upset about something, you're angry and then you're trying – the more angry you are or the more upset you are, the harder you find it to get the right words, don't you? And she finds it even more so ...'
(Tina – housing scheme manager)

Irene, working for an Independent Mental Capacity Act (IMCA) service in High Town, talked of communication being more than a matter of language; she gave as an example from her practice of taking care when carrying out assessments when it was Ramadan because a person might be weak from fasting. This participant was one of the few who had not received training on BME issues, possibly because the organisation she worked for was new and prized itself on keeping a certain distance from other organisations in order to keep its independence and had therefore not linked in with the local training on offer.

Some matters did require some delicacy. Managers interviewed had debated how to handle the offering of gifts, which seemed to be culturally important for some families or individual older people and staff policies made it clear that staff should not accept these. Delicacy and sensitivity were needed in order not to offend those offering gifts; having a special fund for donations was common.

Sometimes, social workers' interventions were just not wanted. Jethro, secretary of a well-established BME social centre in High Town, spoke of a friend and longstanding member, Idris, who 'was losing the plot mentally'. Social services had made various offers of support to Idris but 'he was the sort of person that didn't like people doing things for him'. He didn't want to go into a care home but was not managing well in his flat. Social workers, despite care being refused, in the end had arranged a supply of furniture for his comfort and tried to provide personal and domestic care, often adjusting the service to his routine: 'He didn't want to be beholden and in at a certain time'. Often it was the caretaker on the housing estate who knew where Idris was, and helped him around the locality. Jethro felt that his friend had been provided with a network of support but Idris' underlying fear was that he would be required to give up his independence, thus, Jethro felt that social services had done what they could for his friend and had 'respected' his wishes.

Access and engagement

Complicated perspectives on access often seemed to relate to appropriateness. Among a group of Travellers interviewed, there were assertions that social care services did not understand their culture and therefore could not meet or even establish their needs. They believed that social care practitioners, like other forms of officialdom, were trying to push 'their way of life' and 'ways of doing things'. Participants spoke of trying to keep secret aspects of their culture or 'certain customs'. They felt that social care was not something for outsiders, but could be done by family members, possibly with the help of some trusted professionals. Mrs Smith, a recent carer, added:

'The problem is that we like to care for our own. We don't like outsiders coming in. We like to care for them because we understand the Traveller's way of life, because we've lived it. If we get a strange carer coming in, they don't understand what the needs are of the Travelling people, like Travelling people do themselves. We are prepared to care for our own and not have outsiders care for them ... Our elderly, we usually don't like them going into care homes. We usually look after them ourselves.' (Mrs Smith – carer and Traveller)

In addition, cultural expectations and norms influenced approaches to positive risk taking, which is also part of personalisation. This was illustrated by Finulla, a Gypsy and Traveller liaison worker in High Town, who described how many care workers wanted to move older travellers to receive care, in their 'best interests':

'I think that when care providers actually go on to the sites, their first thing they want to do is get them people off the site, because it's not a very nice place. The conditions of the sites are not good. Living in a caravan where the toilet is external and you walk across your pitch and go to a wash house, which is basically like a garden shed with a toilet in. It's not very nice.' (Finulla – Gypsies and Travellers liaison worker)

In Finulla's experience, what worked best was a system whereby social care and other statutory staff were introduced by a trusted intermediary to the Traveller community and, if possible, named members of staff were attached to sites. Finulla thought that the emphasis should be on helping family members how to care well and she thought that training could be beneficial, particularly around care and support for people who have had a stroke (often at high risk of depression).

Such views suggest that training that only focuses on cultural issues and misses the complexities of access and engagement may be superficial. Finulla also noted that literacy might be a problem when working with such groups and this also suggests the importance of learning to provide information in non-written formats (often required by other older people who may not be literate in their own or other languages). Literacy has also been

identified as a key factor in access to services for some groups from other communities such as Asian people (Ahmad and Walker, 1997).

Attitudes and behaviour of older people

A minority of other participants spoke of the ways in which social care skills were needed to address behaviours and attitudes of older people themselves about people they perceived as different. At one community group in High Town where exercise facilities were on offer, Tracey, leader of this section, described how an older man who had been using the facilities for some time was 'a bit put out' when a Chinese man began to use the facilities: he declared he would no longer come to the centre. However, this threat had not been sustained and when the two men were at the same session, the staff had seen the older Chinese man offering the other man a leg massage, to apparently good effect. Tracey reflected:

'There is no doubt that there are some elements within older people that are very strongly opinionated about what they think should be and shouldn't be allowed in this day and age. But we've made it very clear, our staff are trained in equalities and diversity ... we make it clear as an organisation that if there is any inequality with anybody from any group the person who may cause the problem wouldn't be allowed to access our premises if they wouldn't treat everybody fairly. Sometimes our users say they don't want social work students (born outside the UK) because they can't understand them, now that's where people's choices come in, but if we thought they were discriminating against somebody then we actually would deal with that issue with the person.' (Tracey – voluntary sector manager)

Social care skills of managing conflict were also needed if there was a degree of conflict between different ethnic groups using the same facilities. Zia, a health development worker working with several BME organisations in Pier Town, was also familiar with the problem that different communities want a service, but 'just for them, with their language and their needs fulfilled'. This necessitated negotiation and willingness to adjust. In a sheltered housing complex in Fen Town, Kirsty, the scheme manager, reported the delicacy of managing cultural issues around gender. She described a situation where a male tenant made comments that female tenants found slightly offensive and how he would ring her up to get him a cup of tea, for example. She added:

'He doesn't see anything wrong in that and I think that is his culture. I do find he thinks a woman's place is in the kitchen. I think that's culture but I'm not sure. I do think it's where he comes from. I think the women do everything. I think he finds it hard over here that a woman doesn't.'
(Kirsty – housing scheme manager)

The skills of managing relationships in communal settings, even where older people had their own front doors, were evident, especially among social care managers and their staff who had little professional input from social work or health practitioners, or opportunities for supervision and reflection. While some of these issues might relate to differences of race, ethnicity or gender, many of those working in housing with care settings or sheltered housing described how managing relationships was very much part of their role, whether this could be cast as working to resolve clashes of personality or dealing with anti-social and possibly racist or other discriminatory behaviour. This was a further form of enhancing mental wellbeing.

Main messages about relationships between older people using services, their carers and practitioners

- Particular sensitivity about the use of language around mental health issues is required in order to make services acceptable. Practitioners should be aware of the possible stigma of mental health problems generally and among certain groups or communities.
- Checking with people using services, and their families if appropriate, whether support plans or approaches are acceptable and understandable will help promote support for older people from BME groups.
- Careful management of the types of relationships and interactions involved in working with BME older people with mental health problems may be needed to avoid the risk of exacerbating problems arising from the behaviours or attitudes of volunteers, other service users or workers without sufficient experience, skills or training.
- Focusing staff training on access and engagement as well as cultural awareness is necessary in order to maximise the potential for supporting older people from various cultural or ethnic groups.
- Helping staff to develop good conflict resolution skills is an important element of maintaining good services that support older people with different cultural backgrounds and beliefs and to challenge racist behaviour or attitudes.
- It is not adequate or appropriate to expect that family members will act as interpreters in important decision making but the preferences of BME older people must be taken into account.
- It is important to be sensitive to the need expressed by some carers of BME older people with mental health problems for opportunities to communicate in confidence and privacy with professionals.
- Some families and individuals may resist contact with formal services out of fear or based on incorrect assumptions. Practitioners working with BME older people may need to get in touch with individuals and families through intermediaries and should be aware of the local networks that can be used for such approaches. Home visits may be more acceptable than other appointments but it may be that practitioners will need to be accompanied by a trusted intermediary.

7 Training and skills development

Training and skills development are crucial areas in providing culturally acceptable services to BME older people, especially in situations where staff do not share the same backgrounds as the people they are supporting. We heard of different approaches to training: some as part of an individual's preparation for a job or profession; others as part of their practice; and other training opportunities that had been accessed more circuitously. Many elements of training were about developing skills; others sought to increase knowledge or change attitudes.

Diversity and equality

Tina, a housing scheme manager, stated that training across all areas of practice was a priority for her employer in Fen Town. She had recently visited the local mosque for a day as part of her training, 'learning about the religion and [getting rid of] a lot of misconceptions, and we went to see the prayers, ... that was very interesting and coming back here afterwards everyone was very interested in how I'd found the day ... and I had to explain ... That was a very positive outcome of that'.

In the same area, but working for another housing with care provider, Theresa, a housing worker, was fairly confident in her ability to work with diversity, and spoke of feeling very well trained in equality and diversity: 'In fact, sometimes people here I think do more training courses than anything else! But I think it's important to be kept up to date with how things are changing and they are changing, aren't they, a great deal'.

In addition to training based around the acquisition of National Vocational Qualifications (NVQs) in social care, some specialist providers of social care reported specific attention to training in cultural sensitivity. Noreen, the manager of a Jewish care home in High Town, outlined the expectations for new workers:

'All new staff have an induction, which includes information about the Jewish religion and they are given a handbook to help with understanding the Kosher rules, which are strictly followed.' (Noreen – care home manager)

This was necessary for care workers who were unfamiliar with the culture of service users. The value of familiarity about such rules was evident to this home's residents and their families who felt assured that the rules were being followed. At a commissioning level, the council in this area also paid higher fees for places in this home to cover the higher costs of Kosher food, while there was strong support from the local Jewish community in terms of volunteering and help with management. However, even within the ethos of one religion, the manager maintained that it was good practice to ensure that

other residents' faiths were respected and their choices of worship were facilitated:

'We don't just have Jewish support. We've got three ladies who are Roman Catholic and their priests come in and the nuns come in, Somebody comes along and takes them to one of the churches for a dinner once a month.' (Noreen – care home manager)

Other larger care providers were also able to demonstrate that equality and diversity were integral to initial staff training. Karen, manager of a care home in a rural part of High Town with few BME older people, explained that all direct care workers participated in such training, through distance learning packages, study books and group sessions. The scope of this training covered care plans and reviews, as well as communication with relatives. Her colleague, Shamine, outlined her practice when an older woman from an Indian background moved to the home:

'We were trying to fulfil her needs and we did fulfil her needs. We had a meeting with our kitchen staff, the chef, about specific food and dietary needs. She [the resident] used to speak fluent English but with dementia she completely forgot and couldn't say much in English. With her family's help and my own Urdu background I could understand her. We made some signs and some simple sentences to help the rest of the staff. I think that helped to give quality of care to that particular resident.'
(Shamine – care home manager)

Shamine also talked of the importance of working with this resident's adult children to find out ways to support their mother. She recalled that the family described how their mother would always make sure that her children were fed before she would eat herself and together they worked out that this might lie behind some of the problems that were arising for staff when helping her to eat. Once staff started eating food as well, then the lady seemed more willing to be helped to eat. The family had also expressed a preference that their mother's personal care be provided by female rather than male care workers and the managers were able to accommodate this through adjusting shifts. As Karen acknowledged, it is important to be clear about what is possible and what is not:

'We always like to try and match staff with the resident. On pre-admission assessment, for example, if I felt that we couldn't meet that resident's needs, we would make that clear to them and their family. If they are willing to teach us, and to carry that through, that works ...'
(Karen – care home manager)

Other ways in which residents' diversity were addressed included taking note of the wide range of care workers who increasingly were of different nationalities, particularly from West Africa and Eastern Europe. In several of the homes where this study took place, managers said that care staff now offered a wider range of languages, especially Eastern European, South European and (some) South East Asian languages, to residents. In the home

where Karen and Shamine were managers, direct care workers were encouraged to learn from each other about different cultures, with events celebrating international nursing, for example. It appeared that employment practices for staff that respected their diversity were very telling evidence that attitudes and practices were positive in the organisational culture of the home. Shamine, for example, spoke of how the care home company's respect of her faith during Ramadan indicated that they took these matters seriously; they 'never made me feel awkward'.

Insufficient training in some areas

Diversity and equality

For some practitioners there was concern that their employer was not providing sufficient training and did not give the subject of diversity and equalities great priority. Lucy, a local authority reablement (rehabilitation) worker in Fen Town, had not received any training in diversity, and would have welcomed this. Lucy said that when going out to visit people for rehabilitation, it seemed rather 'hit and miss' if anyone making the referral had ensured that she would be able to communicate with the older person. Not being able to communicate with a service user made it difficult for Lucy to observe any changes to a person's demeanour, motivation or mood. Nick, a white British social worker in the same area, felt that many social care workers knew very little about religion (he had experience of some care workers mistakenly thinking that being a Catholic was not a form of Christianity). He felt that practice could be better if social workers got in touch with different community groups when working with BME service users. In his view, training should not be like a "sledgehammer; it should not hurt people or punish them for their opinions and it should not create resentment". This comment echoed other comments made that training about culture and diversity could be seen as threatening and deskilling. Moreover, some practitioners, like Heather, manager of a care home in Fen Town, acknowledged that practice reflection helped:

'I've learned from bitter experience that one must not rule out the fact that because somebody comes from a certain ethnic background, they may not always want to eat the kind of food that their families or their community do.' (Heather – care home manager)

Heather pointed to the risk that if staff just 'read up' on diversity they were in danger of developing rather stereotypical views.

From the voluntary sector, a voluntary sector manager in High Town, Brenda, described her staff and volunteers as sometimes lacking confidence in their interactions with older people from different backgrounds, especially if they were from outside the local area. Staff could feel 'ignorant' and worried about 'easily offending' people, by doing something inappropriate. Brenda herself was not always sure about what was right or wrong. Kathy, an occupational

therapist working for another local authority, had undertaken training around race equality, but as she noted in her area, it could probably be over a year before she would be putting this in practice with an assessment of a person from a BME background, such as the socio-demographic profile of the area. 'I've got the awareness but not the experience', she added.

Prejudice

Practitioners from BME backgrounds also spoke of the ways in which their colleagues and managers sometimes exhibited prejudice. Zee, a community worker from a Chinese background in Pier Town, spoke of a small minority of colleagues who superficially accepted equalities but then expressed the view that people 'should integrate' with local communities and who used expressions that she felt were racist, such as 'Chinese whispers': she added 'With these people it's very difficult to change them even though they have had training'.

Working with older people

One theme that emerged when talking to practitioners who were working with BME groups generally, was that they were not always confident about working with older people. There has been a national programme of employing community development workers in mental health to work with BME groups and individuals, but few of these have been employed to work with older people. Their work is likely to improve conditions overall, as Zee, the Pier Town community development worker mentioned earlier, explained. She was working with hospital staff to ensure that patients' dietary and religious needs were met, but was also working with BME groups to address fear of mental health issues and the stigma of seeking support for such problems:

'As soon as we say mental health, people don't want to know. They keep them within the families, partly because they don't know there is a lot of help out there and second, is the stigma ... when they hear "mental health". People think that's it, [for] the rest of their lives ...' (Zee – community worker)

Zee had experience from another job of working with BME older people and her own family, which had given her greater confidence in working with older people but she admitted that she knew little of work with older people with mental health problems. She was familiar with the barriers that built up between older people and professionals when older people did not speak English. In areas, such as where she worked, where there were few BME organisations, practitioners who were bilingual were often in short supply and lacked experience of working with older people. Furthermore, because older people in general were less likely to have access to computers and so on, they were not generally able to access information themselves. Indeed, Zee was one of the few practitioners interviewed who had not heard of personalisation, indicating that BME older people may be further

disadvantaged if those acting as 'links' with mainstream services are not fully informed of major changes to social care services. While she had heard of direct payments, she thought that these did not work well for BME communities, although the source of her beliefs was unclear.

In Fen Town, a mental health community development worker appointed to work with migrant groups had no clients from an older age group. Frederica's experiences of individuals' expectations were interesting nonetheless; particularly her views that some people who were recent migrants felt "short changed" by generic primary and community services in England and wanted faster access to what they saw as better specialists at secondary care level. While she could see the value of individual community groups, she criticised their proliferation and potential to confuse.

For some training providers, these complexities had led them to develop a variety of programmes. Ayasha, for example, who ran a BME infrastructure or umbrella group in the voluntary sector in Pier Town, talked of the ways in which social care providers wanted to learn more about issues of culture and languages, faith and religion, barriers to services and how to change them. In contrast, the training that they provided for community organisations was geared towards mental health, taboo and stigma and how to access services. For people who were recent arrivals to the UK, including refugees and older people who had recently migrated to the UK, there were often fears based on their experiences of what they thought were poor or non-existent services in their home country for people with mental health problems, worries that confidentiality would be breached and a lack of trust in government or official services. In her experiences, these led to fear and people trying to hide their problems or those of their family members. Training was one way of breaking down barriers but it needed to go beyond information provision and address attitudes and communication. It could also be linked to equality impact assessments that were being undertaken in a number of organisations as well as local authorities. For instance, Kieran, the manager of a housing with care voluntary sector group funded by the NHS and local authority working with people with enduring mental health problems in Fen Town, saw the process of conducting an equality impact assessment as an important way to ensure that diversity training and policies were being put into practice, and talked of how it was often a risk that minorities could be overlooked, whether they were from BME groups, or were older people. While there were not many BME older people in his area, he felt that staff had been very receptive to training around race and age:

'We recognise that the work of the service as a whole is focused on people who are marginalised from society and people who feel stigmatised and people who feel that they are experiencing social deprivation. A lot of these kinds of care issues can be very relevant to people from black and minority ethnic backgrounds.' (Kieran – manager of a housing with care service)

In Kieran's view, this positive attitude encouraged staff to become good at creating resources themselves: 'we always take the view that you only get one

chance to make a good impression. We try and encourage a strengths focus within our staff'.

Main messages about training and skills development for social care staff

- Training and skills development work need to incorporate a range of areas including: communication with BME older people and their families; dealing with negative attitudes from others; providing appropriate information; and understanding the importance of cultural and religious practices and beliefs.
- Training needs to be supplemented by identifying skills within staff teams and providing opportunities for staff to learn from each other.
- Learning from BME older service users and family members about specific needs or general points is a valuable way to increase skills.
- Ensuring that people acting as links between communities and services are trained and aware of the ethos and approaches being developed by local authority and other services will reduce the potential for misunderstanding, which can disadvantage BME groups.
- Practitioners from all backgrounds, in terms of roles, religion, culture and ethnicity, are not always confident about working with older people generally, and not just those who are from BME communities. This needs to be acknowledged and workers should be supported.
- It is important that managers support social care staff who feel they lack knowledge about different cultural backgrounds and are concerned about easily or mistakenly offending BME older people and their families.
- Staff and commissioners need to be aware that the term 'mental health' can have negative meanings for some BME communities and possible alternative acceptable phrases and words need to be explored when engaging with some older people and their families without being over-simplistic or patronising.
- BME older people may not be taking full advantage of some of the opportunities arising from personalisation because workers from voluntary and community organisations are not aware of this development. Examples of ways in which this might lead to better outcomes for individuals could be usefully shared.
- Specialist input may be helpful when working with older people facing additional problems, such as trauma from wartime and dislocation. There are several sources of such help in the NHS and these should be made available to support social care staff.

8 Specialist or integrated support – staff views

The debates about whether specialist or integrated services are better able to meet the needs of BME people are longstanding (Butt and Mirza, 1996). A variety of views was expressed about ways of organising social care and delivering services to support BME older people from different faiths, cultures or ethnicities, ranging from those who were highly supportive of specialist provision, to those who saw its disadvantages or impracticalities in their areas.

Older BME people themselves often went to tremendous efforts to find settings in which they did not feel in a minority. In Pier Town, through a translator, Mrs Yan spoke of making the move to a specialist Chinese sheltered housing with care facility, from over 100 miles away. She had previously lived with her son but was getting increasingly isolated as he was at work all day, compounded by the effects of her long-term health conditions and a recent stroke. She had been on the waiting list for over a year before there was a vacancy. The support she valued was the language, the food and the general atmosphere, just being able to watch a game of Mah-jong now she could no longer play herself. Another tenant, Mrs Lu, appreciated the company of the facility, with people to talk to and the flexibility of the support on offer. Other people similarly reported that the paramount advantage of the scheme and the lunch club associated with it was being able to talk and to be understood.

Some practitioners contrasted the benefits that specialist services brought to individuals with the need to avoid stereotypes about where they were needed and attitudes that were sometimes held among the wider community. Nick, a social worker working in the rural area of Field Town, talked of the way in which he had been able to “spot purchase” personal care for a male Muslim service user from a home care worker who was also a male Muslim. The council had ceased its contract with the care agency concerned and had taken on a new agency, meaning that there was no guarantee that the new agency could find another male Muslim home care worker. The service user had protested and Nick had been able to argue that if the user were to lose his care worker then this might be seen as discriminatory; “I fought for that so he could retain his carer. I checked with the new agency to see if they had a male carer but they hadn't ... there were difficulties in my team from people who asked why he was getting special treatment ... it can be quite difficult in the office at times”. At the same time, he commented on the need for avoiding stereotypes, citing the example of a Polish older person whose relatives thought that Polish-speaking care staff distressingly triggered reminders of wartime and who wished for other care workers from a different ethnic background. Nick also talked of the problems of specialist services being seen by some as ‘generating resentment’.

Noreen, manager of a Jewish care home, shared some of Nick's ambivalence. She stated that in general: ‘I don't believe in segregation and positive discrimination. In my view I find it offensive’. For the older age group,

however, Noreen was sure that a specialist home provided a 'little refuge' and she linked this explicitly to mental wellbeing:

'Their religion is very important to them and that is very much part of their mental wellbeing ... In some respects I feel quite envious of them. I think we've lost a lot in this country from losing our churches ... It's not necessarily going and praying on a Sunday, but it was the bigger network, we've lost that.' (Noreen – care home manager)

Lorna, organiser of a voluntary befriending scheme in Pier Town, considered that specialist services ran the risk of making people further isolated by their separation: 'I've found that there are quite a few people that come from different countries that enjoy being part of the English scene, rather than sort of being separate'. In her experience, a great diversity of opportunities and choices seemed to be what people wanted, and she gave as one example, a social club, formerly run by social services, that was aimed at older people with interests in current affairs and adult learning. This had attracted a small number of BME older people who had told her that this club suited their needs and interests.

Integrated services were seen as offering benefits in terms of promoting mutual respect. The manager of a care home for older people in High Town, Karen, thought that the diversity of staff and residents made for mutual learning of each other's cultures, and this broke down barriers and countered racism. In her view, the fact that her care home was part of a larger care provider chain enabled individual homes to access support and information. Locally, there was also access to an inter-faith group if she needed to be put in contact with a faith leader of whatever denomination or religion, and Karen said that she would also contact a resident's social worker if she needed specific help.

Other practitioners also described the balancing act necessary when managing large services that catered for older people from a diverse range of ethnic backgrounds. Liz, manager of a mental health day centre in Pier Town, spoke of ensuring that all staff were sensitive to people's needs as far as they could be. However, there was a need to acknowledge that sometimes things could not be done, that sometimes they didn't get things right. In her view, these could all be learning experiences. The balance required the day centre staff to talk to users to see if adjustments were needed and to check out if anything was causing offence. But for her the test was whether people wanted to be there, if not 'they vote with their feet'. This was reinforced by having a suggestions board, a complaints policy, carrying out surveys and consultations and so on. And, she added, the importance of not presuming or relying on stereotypes:

'We asked our Asian Elders group where they wanted to go for an outing, and they said "Pizza Place. We want to go there and to have a pizza".' (Liz – day centre manager)

Some services gave priority to people whose first language was not English. This was the case with one specialist counselling organisation that saw itself as working to empower people and to help people integrate into British society. They worked as specialists with small numbers of people, some of whom had come from 'traumatic situations' as a result of experiences such as torture, displacement and persecution in their home countries. This service was able to describe its work in terms of outcomes, which was not always the case for many services (although it was more common among people working for social services). In this counselling service with its specialist staff, the outcomes were that people would find it easier to interact with people and to have improved communication skills. As Magda, the project organiser in Pier Town said, 'It's not that we do social work but we can signpost to people'. She gave an example of an older man from a Middle Eastern country who had recently accessed their counselling service:

'I suppose there is the huge awareness in me that in his culture they don't go and see a counsellor, they talk amongst the elders and all the rest of it, instead of coming to see a woman, and he's sat there [with me] crying, I'm just actually stunned by the fact that he does that. When we'd finished our work together it was just wonderful to see this man who felt he had a better handle on things. He was just totally overwhelmed.'

(Magda – specialist counsellor)

This innovative service was one of the few that were able to offer formal training to older people as well as other age groups who wished to develop skills in mental health support. Magda described how these older people wanted to learn to listen and then go out into their community. In her experience, most interpreters were younger people. The older people concerned, 'were just taking those listening skills and wanting to use these'.

One format that had been devised to span mainstream and specialist provision was the creation of link worker posts or responsibilities that could be taken on by people in general substantive posts within local authorities. This differed from other models of link working where a person in a local voluntary organisation acts as the link between members and other public services (Chau, 2007). Susan, for example, was a care manager in a local authority (High Town) but for 10 hours of each month she was a link worker with local BME groups, one of a set of such workers in the local authority. When acting as a link worker she attended various groups and spoke to people from different communities in a form of outreach work. Generally, this seemed to be a positive way to explain local authority responsibilities and provision, although one puzzling (to us) part of this arrangement was the reluctance of her local authority manager for her to attend meetings in the evening or at weekends, which, as she pointed out, was precisely the time when most such meetings were held. All staff having a link role met with each other regularly, which she found invaluable. Other link work roles covered several aspects of diversity and inter-agency work. Stephanie, for example, who worked across criminal justice and social care housing support in Fen Town, spoke of the needs of older prisoners on discharge and older people on probation or licence living in hostels who might have mental health needs. She felt that this

group was often overlooked. A local authority mental health social worker was accessible to practitioners such as Stephanie. This social worker knew all the agencies locally for people who might be suffering from depression, for example: 'If someone has said to us they have a wellbeing complaint, – that they are feeling depressed or anxious, we do act on it, we don't just ignore it'. New emphases on mental wellbeing were influencing Stephanie's practice; she reported thinking about mental health promotion more in supervision when reflecting on people who might be 'low minded', unmotivated or at risk of relapse into drug or alcohol misuse. Opportunities to learn about BME support groups locally were welcome, and Stephanie was aware that she had limited familiarity with them but she noted that such information needed to be continually updated if it were to remain useful. Having a personal link was also valuable; 'it's the same with any service, having a contact, having knowledge of what they do and having knowledge of their criteria (for taking on a case)'.

Specialist services might be regarded as not always needed for carers, for example. Nasrin, a project worker with a small voluntary organisation in Pier Town supporting South Asian women, thought that the prevalence of caring was high among her group's members and so a separate carers' group would be just duplicating: 'you will find that most of them care for their mother, father, mother-in-law, father-in-law. That is just the way it works in this community'.

In Nasrin's view, the way to work with older BME women was to get in touch with them through younger female relatives. While this could place a burden on some, particularly when they were the main female carer for several older people, they were more likely to take home messages and to encourage older relatives to seek help if needed. She felt that this was very much a cohort effect:

'I think that it's a generation thing. My mum is second generation, she has still not moved away from those traditional views, whereas us, our children, we are fully adapted to the Western world ways. Not saying that we've forgotten our roots but we are more willing to move forward, whereas they feel that if they do move forward they are going to lose everything that they know and have.' (Nasrin – voluntary organisation worker)

Other views on specialist provision were that needs and circumstances changed over time. Amita, a day centre worker in Pier Town who had supported a group of Muslim older people for a couple of years, had witnessed the declining numbers of group members, as they were getting more frail or dying. The group used to meet in a separate room in the day centre and their food was cooked separately. Now, smaller in number, they met in the main lounge:

'They weren't happy with this at first because in the separate room they can talk louder, get more animated and excited, and even shout, which is usual for Asian people. Here they just eat together separately; they are always quieter when English people are around. They have made some good English friends and I think it's good they sit in the main area,

I think they're happier about it now but they don't like to mix with men. Again this is a cultural thing. Sometimes a man goes and sits with them, trying to talk, then we have to explain to him that they don't like it and move him away ...' (Amita – day centre worker)

In the same area, Lee, a former social services worker who now worked in the voluntary sector in Fen Town, described a group for Vietnamese older people (mainly refugees who had arrived in the UK nearly 30 years ago) that had been meeting fortnightly for 15 years. Members of this group did not speak much English and most lived with family members who dealt with 'officialdom' on their behalf. Attending a mixed local day centre would not meet these older people's needs in his view: they would not be able to communicate, they would not like the food and they would not be able to socialise and reminisce with other Vietnamese refugees. For this group of older people, shared experiences and maintaining contacts were described as making the difference in terms of reducing loneliness. Lee felt that most families did know about local authority social care provision and the group was addressed by visiting speakers who covered various topics, including mental health.

However, not everyone was confident that information was sufficient and accessible to all BME older people. Neica, an older people's commissioning lead in housing with care services in Fen Town, thought that not everyone knew about the local handyperson service. While she did not wish to commission a separate service for BME groups, she felt that there needed to be greater publicity about such preventive services.

Debates about ways in which services should be organised were a little different from support that emerged from and within communities. Overall, there was understanding of the benefits and disadvantages of both approaches. Diana, a senior social worker in High Town, regretted that her opportunity to gain practice experience with BME older people was limited, partly because there were separate teams in her area for Gypsies and Travellers and for refugees and asylum seekers. Ayasha, managing a BME infrastructure or umbrella project, pointed out that generic services had their own value and were likely to be straightforward and cost-effective, especially if they avoided a 'one-size-fits-all' approach. Specialist services required extra resources, but could be better at access and appropriateness. She believed that these choices were generally not there for BME older people, since whatever model was adopted, older people's services were regrettably far less resourced than others.

Main messages about specialist and integrated services for BME older people

- Identifying and agreeing the mix of culturally specific and more generic services are necessary in devising the best approaches to working with older people from different ethnic groups. This may be best addressed in joint strategic needs assessments or 'total place' commissioning decisions.
- It is important not to make assumptions about the wishes of older people from different ethnic groups, who may well want to experience other aspects of different cultures, in addition to maintaining practices and customs from their own culture.
- A mix of cultures among older people using services can provide opportunities for learning and fostering new relationships, although it is also necessary to carefully consider strongly held desires for separation among certain groups, genders or faiths.
- Offering training to older people in relation to mental health support work, volunteering and interpreting, for example, may help provide more appropriate support to other older people.
- It is important to be able to balance the different cultural needs of older people from various ethnic and other backgrounds when managing services that cater for a diversity of individuals.
- The creation of local authority link worker posts (linking local authorities with BME voluntary organisations) may be an effective means of two-way communication and dissemination of information about local authority and mental health provision to local BME groups.
- Services should not overlook the needs of carers of BME older people in supporting their mental health needs and reducing risk factors such as stress and isolation.
- Communication with older BME women may be enhanced through direct dialogue with other family networks, such as young female relatives, who often take on caring, interpretation and community roles.
- More publicity about preventive services, such as handyperson services, is needed to promote mental wellbeing.
- Refugee support groups working with older people may play important roles in promoting mental health and details of their scope and resources should be available to social care workers.

9 Conclusions

'You've made me think about things differently. Things have been coming into my head while I've been talking about the things we don't consider on a day-to-day basis and the things we don't have in our area for all people. We are still dealing with white British octogenarians and we can't keep doing that ...' (Kathy – occupational therapist)

This enquiry has raised as many questions as answers, but the aim has been to stimulate discussion as well as illustrate some practice methods that seem to work well. In terms of social care, there are clearly issues about the stigma of mental health problems and its negative associations with mental wellbeing. How today's younger people are treated will influence their own psychological resilience in their future old age. For the moment, how can localities meet current BME older people's mental and physical needs? One key message from this enquiry is that practitioners find that talking to BME older people is an important way of finding out what they want and what they might choose.

The second issue arising from this opportunity to listen to practitioners is that there seem to be very few spaces for practitioners to discuss working with families and social contacts overall. These were generally very positive encounters. However, very few practitioners were able to draw on practice wisdom or training about handling difficulties in relationships with family members or members of social networks, such as fellow tenants or service users. If there were family therapists, or consultants available to frontline staff who were troubled by family and interpersonal dynamics, they were not known to the people we interviewed. At times, practitioners were facing complex, possibly entrenched patterns of behaviour and interdependencies, such as the isolation of older people or behaviour that might be racist or bullying, which might be culturally rooted or expressions of distress, but they were largely on their own. Debates about access and appropriateness hardly touched upon these challenges. There were seemingly few opportunities to discuss this in supervision and how to manage manifestations of racism and interpersonal disputes. There were many references to the need to be sensitive to cultural practices, and about conflicts that arose through different cultural beliefs and practices. However, there was very little identification of racism as an explanation of conflict and the exclusion of certain groups from social care services. We did not ask specifically about racism and future studies may wish to explore this directly, adding to recent research that has explored aspects of racism when experienced by BME and migrant workers (Stevens et al, In press) and notes that experiences of racism can negatively affect people's mental wellbeing (Karlsen and Nazroo, 2002; Karlsen, 2007).

Third, an observation that arose from some voluntary and community groups was that of BME older people playing their part in reducing risks of depression by acting as volunteers or being involved in peer activities. Few accounts exist in the research literature of managing the risks of depression or of supporting people with depression that touch on the potential of older people in contributing to these elements of prevention. There were several examples of older people being interested in community work and some were playing a

part in mental health promotion. Social care practice may have much to learn about how it can support such activities and include volunteering as an option for people to help in recovery or to prevent mental health problems, especially if it is linked to physical exercise.

Fourth, signs and symptoms of depression were generally linked by participants to problems arising from loneliness and isolation, although many saw that people could be isolated in communal or family settings and that they might be less active when not participating in outside activities. Promoting mental wellbeing had sometimes a rather one-dimensional picture, and there were few illustrations of how to combine therapies that have been found to be effective for some older people in reducing depressive symptoms (such as counselling and medication) or of promoting healthy eating and exercise. Many of the practitioners working in social care services that took part in this enquiry were working on their own, despite the rhetoric of partnership with primary care services. Shared care, shared financing and shared records were unusual, although such arrangements were valued where they existed.

Fifth, there were very negative perceptions of care homes for older people among some but not all BME groups, especially among those who had not had any personal experience of using this service and contrasted with the positive experiences among those who were actually living in homes or their family carers. This may be related to concerns about homes' abilities to meet language or other needs or it may be related to the perception that moving to a care home represents a failure of the person and their family (Lloyd, 2000). If care homes are to provide supportive environments for the minority of older people who may wish to live there then they may need to foster links with BME groups to enable greater community engagement. Otherwise, there is a risk that older people from BME backgrounds may not be able or willing to choose this type of support, which may meet their needs if they are depressed or anxious or have other mental health problems. There may be a need for the care home sector to develop communications strategies with BME groups to challenge perceptions that care homes consign residents to a life devoid of company and meaning, and that even their very basic communication needs will not be met. There could scarcely be a more complete set of risk factors for depression and possibly guilt among family members. The needs of a person with dementia and depression, for example, may be met in a highly person-centred way – in a care home if there is no other support network able to meet them.

It is to be remembered that the areas chosen for this enquiry were deliberately selected to represent areas with lower levels of ethnic diversity than many parts of the UK, in order to identify practice opportunities where social care practitioners were working, often infrequently, with small minorities of people from different ethnicities. Clearly, areas with higher densities of people from different ethnic groups are faced with different contexts, populations and staffing profiles. In such situations, it is likely to be easier to adapt services to meet the needs of much higher proportions of BME service users. However, some of the issues noted about managing services with very mixed groups of service users are directly relevant for such areas.

Lastly, one test for social care services in the future will be the extent to which *all* services are personalised and for *all* users of social care support services. This enquiry revealed mixed levels of understanding about personalisation, confusion with personal budgets, and some disquiet about its potential effects on BME older people with mental health problems. These reflected concerns that apathy and low mood would not encourage older people with mental health problems such as depression to take advantage of new choices and may risk them becoming isolated and under-stimulated. However, others were more optimistic that personalisation may provide new opportunities for making use of community facilities and, through generating services and solutions more appropriate to each individual, could enhance quality of life for people who were not well served by current social care provision. It may be that there will be very mixed outcomes and this suggests the value of a close listening to practitioners and older people about what improves outcomes and in what circumstances. One element of personalisation is the wish to improve information and advice for all older people. Social care practitioners will need to improve access to such material and build on the lessons they have learned about communication with people who may be hard to reach or seldom heard.

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Appendix 1: Methods

Given the nature of the brief for this enquiry, which was to understand the nature and type of social care interventions available in different localities that help to promote the mental wellbeing and quality of life of BME older people through a person-centred approach, it was decided to undertake a series of semi-structured interviews in four areas, as described in Appendix 2.

Participants, who were social care practitioners, managers, commissioners of services and BME older people and their carers, were selected to include a broad range of perspectives. Most interviews were recorded, with permission, although a small number of participants were unwilling to be recorded.

Detailed notes were taken in these circumstances. Recorded interviews were transcribed. Transcripts and notes were read and analysed thematically by members of the research team. To protect confidentiality, all names used in this report have been changed and the study sites are not revealed. We decided to use pseudonyms for the study sites in order to personalise the presentation of the findings.

The study received approval from the King's College London Geography, Gerontology and Social Care Workforce Research Unit Research Ethics Panel REP(GGS)/08/09–27, and research governance approvals or agreements from the sites involved. Participants were all given information sheets and asked to sign consent forms. Where necessary, the information sheets were read out to participants by translators or the researchers.

Sample

It is widely recognised that there are practical and methodological challenges to recruiting samples of BME older people (Sin, 2004). In all, 81 interviews with practitioners, commissioners and BME older people and their carers were carried out in the four sites. Not surprisingly, practitioners were fairly evenly spread over two working-age groups, with a small number in the older age groups. Older people and their carers were of a similar wide age range. Many of the people involved in community groups, either as trustees or volunteers, were older people themselves.

Table A1: Age group of participants

Age group	N
25–40	21
41–60	43
61–80	13
81+	4
Grand total	81

Participants were also asked to describe their ethnicity, which is summarised in Table A2. Fifty-one per cent identified as 'White English' or 'White British', with a small number of additional people from various other white backgrounds. At 14 per cent, the largest group of BME participants were those who described themselves as being from an Asian background. Small numbers identified themselves as being of mixed ethnicity or as 'other' ethnicity, in keeping with the age structure of the population in that most people from mixed backgrounds are in the younger age groups (ONS, 2002).

The demographic profile of the study areas is described in Appendix 2. However, it is important to recognise that we were not seeking to achieve statistical representativeness in recruiting study participants, rather to obtain a group that reflected the considerable diversity of the groups comprising the BME population in the UK.

Table A2: Ethnicity of participants

Grouped ethnicity	Ethnicity	N
Asian	Bangladeshi	4
	Indian	3
	Pakistani	2
	Chinese/Vietnamese	1
	East African	1
<i>Asian subtotal</i>		<i>11</i>
Black	Black Caribbean	4
	Black African	2
<i>Black subtotal</i>		<i>6</i>
Chinese		7
Other	Gypsy/Traveller	2
	Jewish	1
<i>Other subtotal</i>		<i>3</i>
Mixed	White English and Fairground Traveller	1
	White and Asian	1
	White and Black African	1
	White and Black Caribbean	1
<i>Mixed subtotal</i>		<i>4</i>

White	White	3
	White British	19
	White English	22
	White Other British	2
	White Other	4
<i>White subtotal</i>		<i>50</i>
Grand total		81

These categories are based on self-defined ethnicity rather than those developed by the Office for National Statistics for the Census.

Table A3 shows participants' roles or positions. Interviews were undertaken with older people/service users (13), carers (9), direct care workers (17), fieldworkers (e.g. social workers/care manager (5), one 'other' professional worker and one trainer; with care home managers (including one deputy manager) (12), other managers (e.g. heads of service) (19) and commissioners (4).

Table A3: Participants' roles

Grouped roles/positions	Roles and positions	N
BME older person		13
Carer (family)		9
Direct care or professional workers	Advisor on benefits and services	1
	Advocate (Paid)	1
	Community development worker	4
	Community group coordinator	3
	Counsellor	1
	Home care worker	1
	Housing support worker	2
	Lunch club coordinator	1
	Occupational therapist	1
	Outreach development worker	2
<i>Direct care workers sub total</i>		<i>17</i>
Fieldworkers	Care manager	1
	Social worker	4
<i>Fieldworkers sub total</i>		<i>5</i>
Other professional worker	Criminal justice liaison officer	1
Trainer	BME trainer	1
Care home manager	Care home manager	11
	Deputy care home manager	1
<i>Care home manager sub total</i>		<i>12</i>
Other managers	Carers consultation and forum	1

Grouped roles/positions	Roles and positions	N
	coordinator	
	Deputy care home manager	1
	Development Manager	1
	Chief officer of services (VCS organisation)	1
	Housing support manager	1
	Locality manager	1
	Manager	1
	Manager of carer support team	1
	Programme manager	1
	Project manager	1
	Sheltered housing scheme manager	2
	Supported housing scheme manager	6
	Team manager	1
<i>Other manager sub total</i>		<i>19</i>
Commissioner	Older people lead	1
	Joint commissioning manager – older people	1
	Head of self-directed support	1
	BME lead	1
<i>Commissioner subtotal</i>		<i>4</i>
Grand Total		81

Participants (excluding BME older people and carers) worked in a wide range of organisations and services, in the public, private, and voluntary and community sectors (VCS), as shown in Table A4. Similar numbers of organisations were in the public (25) and voluntary and community (26) sectors, with the remainder being private sector care homes. Of those working in the public sector, 14 worked in central departments of a local authority, 10 being in adult social care departments, with four working directly for other local government departments. Most of the other public sector workers were in direct services (four in care homes, two in day centres and four in supported housing). One person worked with social services from a NHS primary care trust base. VCS organisations included a mix of small local groups working with people from specific communities (three), local branches of national VCS organisations (six) or other local VCS organisations (five). Seven participants were working in VCS social housing organizations providing social care, one in a care home, one in supported housing and one in an 'umbrella' infrastructure VCS organisation.

Table A4: Recruitment sources: service providers and commissioners

Sector	Type of organisation	N
Public	Adult social care department (social services)	10
	Other local government departments	4
	Care home	4
	Day centre	2
	Supported housing	4
	NHS primary care trust	1
<i>Public subtotal</i>		<i>25</i>
Voluntary and community (VCS)	Community group	3
	Social enterprise community development	1
	Support for carers	1
	Local VCS organisation	5
	Local branches of national VCS organisations	6
	Social housing/housing association	7
	Care home	1
	Supported housing	1
	Umbrella VCS organisation	1
	<i>VCS subtotal</i>	
Private	Care home	7
Total		58

Appendix 2: Site profiles

The four sites had different profiles in terms of populations, deprivation and geography. We have anonymised the three English local authority sites, but it was not possible to anonymise the Northern Ireland site, given the different formats of information available. We have therefore not singled out the site profile in Northern Ireland. Sites are identified by letter in this appendix, in order to preserve anonymity in the main body of the report. In the rest of the report we use the pseudonyms Fen Town, Field Town, Pier Town and High Town.

Site A

Site A is a local authority with an overall population of about 200,000, of whom 85 per cent are White British, with a further 5 per cent being White Other. Among women aged 60 and over and men aged 65 and over, 95 per cent are White British, with a further 1 per cent being White Other. Site A has a below-average population of people aged over 60/65 (women/men) at 16 per cent, similar to Site B and Northern Ireland compared with 19 per cent for England as a whole and 24 per cent for Site C. All of these figures are taken from the Office for National Statistics (ONS) mid-year population estimates, 2007 (the reference is not provided to preserve anonymity).

Site A has a moderate level of deprivation, being ranked in the fifth decile of deprived local authorities in England based on the ONS Index of Multiple Deprivation, although its ranking for employment and income is higher (i.e. it is less deprived on these indicators); both are in the eighth decile. However, Site A has many wards ranked in the first and second deciles of the most deprived in England. These more deprived wards map onto areas that have the largest BME communities within the authority (equalities report on authority website).

The council in Site A has a 'Race Equality Scheme', which covers all areas of council activity. As part of this scheme, the council funds various local VCS organisations that work with different communities within the authority. For each department, the Race Equality Scheme 'Action Plan' covers such issues as:

- multi-cultural issues
- out-of-school activities
- information
- healthy lifestyle
- access to services.

For example, in adult social care services, staff engage with community groups, offer various talks on mental health and wellbeing, and also signpost people to appropriate services (council Race Equality Scheme).

Site B

Site B is a local authority with an overall population of about 250,000, with approximately 90 per cent being White British, with a further 3 per cent being 'Other White' (ONS mid-year population estimates, 2007). Among people aged 60/65 and over (women/men), 98 per cent are White British with 1 per cent have 'White Other' ethnicities. However, the authority website 'Facts and Figures' document indicates a recent growth in the numbers of people from BME groups, as a result of increases in asylum seekers, particularly from Iraq, although these are mainly younger people. The population of people aged 60/65 and over (women/men) is lower than the national average at 16 per cent, similar to Site A and Northern Ireland compared with 19 per cent for England as a whole and 24 per cent for Site C (ONS mid-year population estimates, 2007).

Site B is the most deprived of the three English research sites, based on the ONS Index of Multiple Deprivation. The authority falls within the first decile of the most deprived local authority areas in England, with an unemployment rate of over twice the national average and higher than average levels of disability and long-term life-limiting illness (local authority website). There are pockets within Site B that are more deprived still.

The council in Site B has a Race Equality Scheme, which it relates to the Race Relations Amendment Act 2000 and as part of its duty under the Local Government Act 2000, which created a duty on local authorities to promote wellbeing. The scheme sets out broad aims and objectives, including 'What will equality look like when we have it? – Our vision for race equality', and makes specific mention of the aim to promote wellbeing for the whole community. It outlines approaches to increase accessibility of services, women-only sessions at swimming pools for example, 'because some women feel embarrassment swimming with men or cannot for religious or cultural reasons'. The scheme sets out how race equality issues are threaded through all the plans and policies within the council. Ensuring that people from BME groups can access council services is identified as part of the 'vision and outcomes' set out in the document. However, no specific issues are identified in relation to adult social care services for older people from BME groups.

Site C

Site C is a rural county, with a population of approximately 850,000, of whom 92 per cent are White British, with a further 4 per cent being Other White. Among people aged 60/65 and over (women/men), 97 per cent are White British, with a further 2 per cent being Other White. Site C has a higher than average population of people aged 60/65 and over (women/men) at nearly 25 per cent compared with 19 per cent for England as a whole and much higher compared with the other sites. All of these figures are taken from the ONS mid-year population estimates, 2007.

Ranked in the seventh decile of most deprived authorities in England (based on the ONS Index of Multiple Deprivation), Site C is least deprived overall. However, there are pockets of extreme deprivation, in the urban centres, many being 'Lower Super Output Areas' falling in the top two deciles of the most deprived in the country (local authority website).

Unlike Sites A and B, Site C does not have a separate Race Equality Strategy, but incorporates issues about race equality into a broader equalities strategy. Sites A and B also have these broader strategies, but have separate documents on race equality. The aims of Site C's equality strategy include 'improving equality of access and outcome' and to 'support continuous improvement in service delivery across all areas of the council'. However, the strategy does not identify specific elements relating to older people from BME groups; neither does its *Strategy for older people*, although both documents make statements about commitments to challenging racism and improving equalities. The *Strategy for older people* sets out an overarching objective to 'Develop a strategy to improve public mental health and wellbeing including that of older people' in Site C, which points to activities to identify the needs of older people across the authority, but does not explicitly address the needs of older people from BME groups.

Northern Ireland

Northern Ireland has a population of 1,685,260, of whom 99 per cent are White British, with a further 0.1 per cent being Other White. Among older people aged 65 and over, 99.7 per cent are White and 0.1 per cent are White Other. Northern Ireland has a lower proportion of the population aged 60/65 and over (women/men), at 16 per cent, compared to England as a whole (19 per cent), similar to Sites A and B.

It is not possible to compare the results of the measurement of multiple deprivation used in Northern Ireland with those in England (ONS website and therefore with the three English sites).

Evidence from the 'Life and Times' survey (Gilligan and Lloyd, 2006) identifies that many people in Northern Ireland perceive that racism increased between 1994 and 2005, a period that saw an increase in the numbers of people from

BME groups moving into the country. However, as the report outlines, it is hard to identify whether prejudice has increased, whether people are more aware of their prejudices or whether the threshold for perceiving prejudice has become lower.

Northern Ireland has a Racial Equality Strategy, which aims 'to tackle racial inequalities in Northern Ireland and to open up opportunity for all' (OFMDFM, 2005, p 5). The document identifies a need to address racism across many parts of Northern Ireland society, and notes an increase in racially motivated crime. However, it does not make specific reference to social care or other services aimed at improving or maintaining the wellbeing of older people from BME groups.

Appendix 3: Interview guides

Commissioner interview guide

- 1 What kinds of information did you gather in the commissioning process in services for older people in your area? (probe around nature of commissioning for mental wellbeing and/or BME older people)
- 2 How, if at all, were issues of diversity and ethnicity addressed in the commissioning processes? (probe re level of detail of contracts)
- 3 What (if any) challenges did you encounter in commissioning this/these service(s)?
 - a Ability of providers to understand the issues
 - b Ability of senior managers/council members to understand the issues
 - c Ability to provide suitable services
 - d Attitude towards the overall issue of ethnicity
 - e Increased cost demands from providers
 - f Resource limitations
 - g Attitudes of senior managers/ council members.
- 4 Please describe any particular approaches to increasing accessibility and acceptability of services that you have been able to foster in the services you have commissioned.
 - a Deployment of staff from diverse ethnic groups/gender
 - b Development of Older People's Mental Health Strategy or BME Strategy (note: we will have details of this/these if they exist)
 - c Availability of translation/interpreting
 - d Links to BME stakeholders (e.g. local CRE groups)
 - e Ensuring culturally appropriate food is available
 - f Supporting older people to practice their faith.
- 5 Please describe any particular approaches to improving the mental wellbeing of older people that you have been able to/would like to foster in the services you have commissioned.
 - a Ensuring that mental wellbeing of older people is checked
 - b Incorporating mental wellbeing as an explicit element of care/support plans.
- 6 How would you weigh the benefits and disadvantages of
 - a Generic services?
 - b Specialist services? (by age, gender, ethnicity, disability etc)
 - c Personalised services (e.g. personal assistants, personal budgets)
- 7 What other services or approaches would be of value to improving wellbeing for older people from BME groups?

- 8 Please would you outline the aims of the services you have commissioned? (taking one example)
 - a Is this a specialist or generic service? (please describe)
 - b What are the intended outcomes?
 - c How are outcomes assessed?
 - d What do you think you as a commissioner can do to improve the quality of services?

- 9 Please tell us about the take-up of the services you have commissioned.
 - a How well do the services serve people with a broad range of ethnicities?
 - b What do you do to measure/monitor this?
 - c Has the Race Relations Act (amended) made any difference to your approaches or systems here?
 - d Are there groups who are under-represented?
 - e If so how (if at all) are you able to encourage more take-up from these groups?

- 10 Is there anything else you would like to add?

Practitioner interview guide

- 1 Please describe any particular approaches to increasing accessibility and acceptability of services you have been able to offer:
 - a Working with different service users according to their preferences regarding ethnicity/religion
 - b And with gender?
 - c Please give specific examples of how you think this has been of value to *older* people who use the service
 - d Consultation with older people
 - e Ensuring culturally appropriate food is available
 - f Supporting older people to practice their faith (including prayer, access to priests/imams)
 - g Ensuring older people can practice culturally appropriate ritual hygiene practice
 - h Responding to death in culturally appropriate ways
 - i Dealing with any issues around immigration and similar.

- 2 Please describe any particular approaches to improving the mental wellbeing of older people that you have been able to offer.
 - a A welcoming and friendly approach
 - b Ensuring that mental wellbeing of older people is checked
 - c Incorporating mental wellbeing as an explicit element of care/support plans
 - d Ways of interacting with people using services and carers/family members
 - e Please give specific examples of how you think this has been of value to older people who use the service.

- 3 What (if any) challenges do you encounter in providing this service?
 - a Ability to provide suitable services
 - b Attitude towards the overall issue of ethnicity
 - c Ability to address mental wellbeing explicitly
 - d Resource limitations
 - e Attitudes of managers
 - f Attitudes of service users.

- 4 How would you weigh the benefits and disadvantages of
 - a Generic services?
 - b Specialist services? (prompts: by age, gender, different ethnic /religious groups)
 - c Personalisation of services (e.g. personal assistants, direct payments)?

- 5 Please would you outline the aims of the services you work for.
 - a What are the intended outcomes?
 - b How are outcomes assessed?
 - c What do you think you as a practitioner can do to improve the quality of services?
 - d Do you or your colleagues have links with any BME groups or link workers?
 - e Where would you go for advice if you felt you needed to consider the impact of ethnicity in relation to the support of a particular services user or group?
 - f Have you received any training on BME and ageing?

- 6 What other services or approaches would you like to see made available to improve wellbeing for older people from BME groups?

- 7 Is there anything else you would like to add?

Service user interview guide

- 1 How easy or difficult is it to access (use) this service?

- 2 How does this service (interview to say the name/describe) help you?
(Prompt if necessary after initial answer)
 - a Personal care (getting dressed washed, medication, etc)
 - b Help round the home
 - c Social contact and meals.

- 3 What do you think about the way this service reflects your particular needs?
(Prompt if necessary after initial answer)
 - a Is the type of food available to your liking?
 - b How (if at all) does the service support you to practice your faith (if any)?
 - c Are you able to have any choice in the staff who work with you?

- d If applicable, are translation and interpretation support available?
- 4 Do workers understand your cultural/religious needs (e.g. as an Indian Sikh, Irish Catholic, and so on – interviewer will need to explore with participant)?
 - a Please explain why you think this is so? (or not)
 - b What difference does this make to you?
- 5 How (if at all) has this service helped your overall mental wellbeing? (By this we mean your general mood or how you feel generally.)
 - a Has anyone checked on your overall wellbeing? If so, how was this done?
 - b Does anyone discuss how the service could improve your mental wellbeing?
 - c How do you feel about the way that staff treat you when they are working with you?
- 6 Overall, how does this service affect your overall mental wellbeing?
- 7 What (if any) things do you find difficult or unpleasant about this service? (Prompt if necessary after initial answer)
 - a Attitudes of staff towards people using services
 - b Ways that staff tend to treat me
 - c Lack of money to fund the service (resource limitations)
 - d Lack of meaningful activity (boredom, nothing to do...)
 - e Attitudes/behaviours of other service users.
- 8 Has any other service been helpful and why?
- 9 Have you been in hospital for any time (explore if mental health treatment or assessment)?
- 10 Some people think that some services might be better if they work with particular groups of people. What do you think about the benefits and disadvantages of:
 - a Services that work with people from all ethnic/religious groups?
 - b Services that work with people from particular ethnic groups?
 - c Services that work with people with many different kinds of needs?
 - d Services that work mainly with people who need support to improve wellbeing?
 - e Services that work with men and separately for women?
 - f Services for people from different age groups?
- 11 Have you used personal budgets/direct payments?
 - a If yes, what kinds of services do you use your personal budget/direct payment for?
 - b What guided your choice of these kinds of services?
 - c How (if at all) are the services you get with your personal budget/direct payment different from previous services you have used?

- 12 What (if anything) could be different about the kinds of services you use that would help improve your life?
- 13 Is there anything else you would like to add?

Supporting black and minority ethnic older people's mental wellbeing: accounts of social care practice

This report (originally practice enquiry) aimed to look at practitioners' accounts of their practice in promoting the wellbeing of older people from black and minority ethnic (BME) backgrounds in four parts of the United Kingdom (UK).

Although there is no single universally agreed definition of wellbeing, it is usually seen as including important aspects of people's lives, such as life satisfaction, a sense of achievement and purpose, and generally feeling that life is worthwhile. Although an absence of wellbeing is associated with depression, wellbeing is about more than not feeling depressed. Governments and policy makers are becoming increasingly interested in measuring the success of the services they provide by looking at how they can improve wellbeing but we know very little about how adult social care services seek to improve the wellbeing of the communities they serve. This report describes a wide range of practice methods used to promote the mental wellbeing of black and minority ethnic older people in different social care settings.

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