

Psychiatric services for Black and minority ethnic elders

Council Report CR103
June 2001

Royal College of Psychiatrists
London
Due for review: 2006

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Acknowledgements

Thanks to Drs Ajit Shah and Geetha Oommen for their advice during the revision of this paper and to Drs Susan Benbow and Don Williams for their helpful comments.

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Summary

Psychiatric services for Black and minority ethnic elders have, to date, received little attention. This is understandable, as the 1991 census revealed the number of White elders as being ten times greater than that of elders from all minority groups. This quantitative relationship may change with the 2001 census.

The diversity of people of different ethnic origins, in small cohorts scattered throughout the UK, and their lack of knowledge about access to services, has led to an underrepresentation of the psychiatric needs of this population. To compound this situation, traditional beliefs held by ethnic elders and a firm view that support will be forthcoming from the extended family are frequently not shared by the younger ethnic minority population.

Information available about mental health issues is currently not effective as it relies on translated leaflets and posters rather than on more appropriate mechanisms, such as disseminating information through general practitioners and other stakeholders.

It is recommended that, at present, all acute psychiatric services for ethnic elders involving assessment and treatment should remain within mainstream psychiatric services. Ethnic awareness and sensitivity is to be encouraged by training staff in culturally sensitive issues. Services providing continuing care in the community should be developed specifically for the appropriate user group. Efforts could be made to recruit a racial mix of multi-disciplinary staff, reflecting the population served. Ethnic elders need accessible and appropriate mental health services.

There is an urgent need to establish a reliable and informative database of good practice for ethnic elders. A way forward would be to create a website linked to that of the Faculty of the Psychiatry of Old Age at the College. This new development will also serve to offer training opportunities to interested specialist registrars for their special interest sessions and could lead to research which would define appropriate services for ethnic elders.

There is a wealth of projects still to be explored.

Introduction

The prevalence and management of depression and dementia in ethnic elders living in England, Wales, Scotland and Northern Ireland have never been established or described in any detail and little attention has been paid to this problem. Sporadic, single-case studies and the occasional commissioned report (e.g. the needs of people with dementia and their carers within three ethnic minority groups in Haringey (Brownfoot & Associates, 1998) have highlighted the difficulties faced by this population in their attempts to access mainstream services and to encourage providers to plan for ethnic-sensitive resources. The Executive Committee of the Faculty of the Psychiatry of Old Age, in its mandate for 'Seizing the Initiative', is endeavouring to take ownership for establishing the current clinical situation and the need for specific services.

It is interesting to note the change in College guidelines over the years for the provision of 'special' services for ethnic minority populations of all ages.

Previous council reports

In its recommendations 17 and 18, the Rawnsley Report (Royal College of Psychiatrists, 1990) was against the establishment of such services by the National Health Service (NHS) and other mainstream services, shifting the onus onto the voluntary and non-statutory sectors. The report recognised, in recommendation 19, 'the growing number of Black elderly in Britain, with their attendant illnesses and disabilities, who require some resource that is sensitive to transcultural needs'. These recommendations did not make a striking impact on the target group despite the development of joint working groups between the old age services and voluntary and non-statutory bodies.

However, in its review of recommendations 17 and 18 of CR10, Council Report CR48 (Royal College of Psychiatrists, 1996) proposed that 'Services should be relevant, comprehensive, accessible and adapted to the needs of the local population depending on local circumstances. Emphasis on the role and empowerment of users in defining the type of service should occur as well as attempts to influence purchasers. Some general principles of services for ethnic minorities are, however, appropriate to any setting'. This review increased the awareness of psychiatric services to ethnic needs. Of some significance for the Faculty of the Psychiatry of Old Age is the response in CR48 to recommendation 19 in CR10: 'The Section for the Psychiatry of Old Age, already sensitive to the needs of ethnic elders, should collaborate with the British Geriatric Society to address the need for appropriate services for this group'. This option has yet to be fully explored, although some links have been established. In addition, essential links are being forged with voluntary and non-statutory services, of which contact

with PRIAE (Policy and Research Institute of Ageing and Ethnicity) and the DSDC (Dementia Services Dementia Care) network may prove useful.

A project group, chaired by Professor Cox to review Council Report CR48, subsequently produced Council Report CR92 (Royal College of Psychiatrists, 2001), with ten revised recommendations.

The *National Service Framework for Older People*, published by the Department of Health in March 2001, makes the point that older people from Black and ethnic minority communities need accessible and appropriate mental health services and it addresses a number of reasons why services may neither be readily accessible nor fully appropriate. These issues are fully discussed in this report.

The minority ethnic elder population

Between the publication of council reports 10 and 48, the 1991 census of the population of Great Britain revealed the following data:

Total population	54.9 million
All ethnic minorities	3.1 million

Population aged 65 years and over:

White elders	9.2 million
Minority ethnic elders	97 430

A further breakdown of the number of ethnic elders shows (approximately):

Black elders	33 750
Asian elders	44 470
Chinese and others	19 200

Definition of an ethnic minority group

A fundamental issue facing planners and service providers for the minority ethnic elderly population is the difficulty of defining what constitutes an ethnic minority group (Lloyd, 1992). In the UK, where the indigenous White population forms the majority, a good working definition is that of individuals with a cultural heritage distinct from the majority population (Manthorpe & Hettiaratchy, 1993). Bhugra & Bahl (1999), in their discussion of the issues involved in the definition of ethnicity, make the point of excluding national minorities such as the Scottish, Northern Irish and Welsh who, despite their equal rights, have their distinctive cultural traditions and values respected in the way they are offered services. This view is not shared by some clinicians working in English catchment areas where there are large Irish, Welsh and Scots populations. They feel their cultural traditions and values are not catered for sufficiently. This may be a point for debate.

Language

The next problem is that of language. Many ethnic elders do not speak English and a number are illiterate in their own language (McCallum, 1990). Ethnic carers may not have a complete grasp of English and are therefore unable to seek appropriate help. Many work long hours in restaurants and manual jobs and have neither the time nor the energy to learn English. In some instances, illness leads to the loss of acquired language, which further compounds the problem.

Most sufferers and their families cling rigidly onto values derived from their country of origin, juggling these traditions against the practical demands made by life in their adopted country. Families view dementia and depression as a natural hazard of old age.

Kleinman (1977) describes the difficulties of applying diagnostic concepts across cultures, calling the process a 'category fallacy'. Cases are hidden and contained, often disruptively, within the extended family system. In epidemiological studies, Leff (1999) highlights the important problem of 'unrecorded people'. This situation is amplified for ethnic elders as basic data on many epidemiological facets are incomplete or absent. The extended family system is fast becoming a fragile structure, unable in many cases to provide the necessary buffer and support (Redelinguys & Shah, 1997). Elderly relatives may have migrated to the UK against the wishes of younger family members. Family tensions and financial burdens may make it difficult for the extended family to provide the necessary care (Silveira & Ebrahim, 1995). Inappropriate demands are made on the primary care service, as the emphasis when presenting complaints is frequently on somatic symptoms, as shown in a study of Gujarati elders in Leicester (Lindesay *et al*, 1997). The underlying fear of the stigma of mental illness further compounds the number of sick individuals who remain unrecorded. Gods and devils are called on for help and exorcism.

Several of these factors are shared by the indigenous White population but, as most ethnic groups are scattered and divided into small communities, the migration from the motherland and break with ancestral traditions often result in these difficulties being magnified and inadequately understood. A concept of 'multiple jeopardy' due to age- and race-related disadvantages, gender disparities, restricted access to health and welfare services, internal ethnic divisions and class struggle (Rait & Burns, 1997) highlight the many difficulties faced by ethnic elders.

Black elders from the Caribbean fare better on the whole as they have almost no difficulties with language, have vocal and active Black user groups to fight their cases and are ahead in the development of culture-specific screening tests (Abas, 1996). In contrast, many Black elders from the African continent face the difficulties listed above. This strongly illustrates that ethnic groups should not be amalgamated and consideration should be given to each individual subgroup.

Current provisions

It is perhaps pertinent to reiterate the functions of a comprehensive psychiatric service for all older people. Wattis & Martin (1994) group the clinical functions into four sections: assessment and communication; community treatment and support; acute in-patient treatment; and long-stay care. The service should also have a training and educational role, be involved in research and development and undertake audits, if only at a local level, to ensure that the best possible quality is achieved for the resources invested.

Council Report CR83, *Good Psychiatric Practice 2000* (Royal College of Psychiatrists, 2000), defines the qualities of old age psychiatrists, among whom there is particular clinical significance in the awareness of the interrelationship of biological, psychological and social factors in the aetiology, presentation and management of both functional and organic mental illness in old age, and an understanding of how treatments developed for working-age adults may be adapted to an older population. Expertise in the consideration of moral and ethical dilemmas at the end of life and the ability to discuss these with patients and families, where appropriate, are also essential for every old age psychiatrist.

For ethnic elders, good practice for both service providers and practitioners should include an awareness of and training in culturally sensitive issues and accountability for racially discriminatory behaviour.

Regional service provision

A quick snap-shot survey of currently available services for this population, gathered from answers provided by some regional representatives of the Faculty, confirms prevalent clinical impressions. Most regions have only a very small proportion of ethnic minority elders and justifiably feel that it would be inappropriate to develop specific services for them. They also consider that current services meet the needs of this population. Even in regions where the numbers of ethnic minority elders are noticeable, this group has not reached a significant level for service provision.

However, there is some indication from certain regions (the North East Thames and North Western regions) that current services do not meet the group's needs and that a greater awareness of the problems is required although, to date, there have been no complaints about existing services from ethnic elders and their relatives.

The regional representative from the West Country reports a finding that requires further investigation. In Bristol, there is a small Polish community with an elderly population which does not use the psychogeriatric service. What are the reasons for this?

In September 2000, 'Structuring Services for Ethnic Elders: A Conundrum?', a joint meeting between the Faculty of the Psychiatry of Old Age and the Transcultural Special Interest group, was held at the Royal College of Psychiatrists, London. Recurring themes were the little apparent evidence of mental illness in ethnic elders, reflected by the poor uptake of psychiatric services compared with high admission rates for diabetes, and the fallacy 'They look after their own kind...'. It has been clearly shown that older people from minority ethnic groups have a wide experience of xenophobia and racism. As well as the more specific issues discussed, the continuing debate between 'colour blindness' and a tendency to create 'a fetish of ethnicity' was discussed. A fine balance between being able to access psychiatric services and having a pool of ethnic-sensitive services throws responsibility upon both users and providers.

During a workshop on psychiatric services for ethnic elders, held at the residential meeting of the Faculty of the Psychiatry of Old Age in March 2001, there was strong support for the idea of identifying a lead clinician with management support in trusts with large numbers of ethnic elders. This is a possible way of increasing awareness for initiating appropriate services.

The way forward

One of the main tasks of this report is to address the ongoing debate on the need to develop separate psychiatric services for ethnic elders. An increasing awareness of the special needs of this group, combined with the emotional views held by political user groups, tends to push the argument for separate services. However, there is a caveat for not rushing into this emotive train of thought as there are numerous arguments against such a line of development. As illustrated above, there are far too many different and disparate ethnic groups to cater for each one individually. Within the larger groups, there is the problem of subgroups who speak different dialects and hold different values and beliefs. The number of ethnic elders within each group is still small and they are scattered throughout the UK. There is evidence that those who have been treated by local services have been well served and there have been no major complaints. A strong case can therefore be made for psychiatric services for ethnic elders to remain within mainstream services, with an awareness of culturally sensitive issues.

This sensitivity can be further reinforced by recruiting a racial mix of multi-disciplinary staff members who reflect the population they serve. They could double-up as translators as they would speak the patients' languages. It is well established that there are advantages and disadvantages to using relatives and friends as translators. They are readily available, know the required history and symptoms well and their presence may reassure the patient. However, translation in both directions may be biased because of the good or unscrupulous intentions of the translator and a reluctance to reveal some problems to close relatives (Phelan & Parkman, 1995). Using clinical staff as translators with an unbiased approach increases the accuracy of the communication, as they will have a mental health training.

When the focus moves from assessment and treatment in in-patient wards and day hospitals to day centres and residential and nursing care, the urgency for specialist ethnic-sensitive services becomes an important issue. There are many anecdotal examples where ethnic elders, especially those with some degree of cognitive impairment, withdraw from an unfamiliar social milieu and become more disabled. These are often single case studies, well illustrated by that of an elderly Chinese man who was thought to be profoundly deaf until he was placed in a Manchester residential care home for Chinese elders. He complained that people had just been yelling at him, as he could not understand what they were saying (Eaton, 1999).

There are now several well-established day centres and residential homes for Asian elders which are examples of good practice. The Asian community has, in recent years, made great strides in providing community care for their elders. They admit to feeling persuasive obligations to provide this care since there is a need to augment traditional support at home.

The all-Asian day centre in Ealing, run under the auspices of Alzheimer's Society, is a striking example of a model that works effectively. Local general practitioners are well instructed in the referral system. All day places are fully occupied and the centre runs at full capacity. Activities and food are culture-bound. These are two main difficulties faced by ethnic elders placed in non-specialist homes. Here, they watch Bollywood rather than Pinewood films and eschew potatoes for rice.

Provision of information

A continuing difficulty for workers with ethnic elders is lack of information. Information about services may not be effective if this relies on translated leaflets or posters rather than on more appropriate mechanisms (Department of Health, 2001) A website for psychiatric and allied services could be easily set up and advertised. This should include a database of ethnic elder patients, up-to-date information on translators, good practice, educational meetings, screening tests which have been translated for the respective ethnic groups and, if possible, instantaneous translations of essential information for ethnic users. A member of the Faculty of the Psychiatry of Old Age, together with a member of the Transcultural Special Interest Group, could be responsible for setting up such a service; specialist registrars with an interest in this area might use their protected special interest sessions to develop such a resource. This website will need to be underpinned with new research involving ethnic elders as there is a wealth of projects waiting to be explored and a database to establish. This development would be in line with the Department of Health's proposal to identify and establish 'centres of good practice.'

The most obvious method of improving access to services for ethnic elders and their carers is through their general practitioners. With the creation of primary care trusts, the Faculty has a pivotal role in educating key players in these units, who could then circulate the necessary information through their network. This could be achieved by holding joint meetings between general practitioners working in practices with a high ethnic patient population and voluntary bodies who have a similar interest in ethnic elders. It has been established that 70% of Asians register with Asian general practitioners (Johnson *et al*, 1983) and if this trend is reflected by other ethnic groups, there is a potential target audience for the joint meetings.

Recommendations

For ethnic elders:

- Acute psychiatric services involving assessment and treatment should remain within mainstream psychiatric services, with ethnic awareness and sensitivity emphasised by training staff in culturally sensitive issues
- Services providing continuing care in the community should be developed specifically for the appropriate user group
- Efforts could be made to recruit a racial mix of multi-disciplinary staff members reflecting the population served
- A means to share information would be to set up a website on or linked to the College's site.
- There should be increased involvement and commitment by all interested stakeholders to involve general practitioners and other key players in establishing good practice for this group.

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