Diversity in older people’s mental health services: black and minority ethnic groups or the universality of the rainbow?

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Summary
Dimensions, concepts and definitions concerning minorities, cultural diversity and equality continue to evolve. In psychiatry, fulfilling diversity needs has often meant the provision of services for black and minority ethnic (BME) groups. However, this relates to only one of many facets of diversity. In line with recent government health service proposals and the Equality Act (2010), the Royal College of Psychiatrists’ Old Age Faculty has withdrawn its College Report (CR156; 2009) on services specifically for BME communities. How to achieve accessible and best quality services for a diverse population needs further consideration.

Introduction
The Royal College of Psychiatrists’ Old Age Faculty discussed College Report CR156, Psychiatric Services for Black and Minority Ethnic Older People (2009) at its annual conference in York in 2014. The question of personal identity was brought home to the Faculty by reports the same day of demonstrations in York and headlines in the Yorkshire Post: should the bones of Richard III, killed in battle in 1485, be reburied in York Minster or Leicester Cathedral? Salient features of personal identity, including culture, history, religion, values and family ties may be retained over many generations. An individual’s identity is far more complex than the ‘black and minority ethnic’ (BME) label often used in health and social services to indicate culture and diversity.

What is a minority ethnic group?
The Equality Act (2010) refers to ‘protected characteristics’ including age, disability, religion or belief, race (based on colour, nationality, ethnic or national origins), and sexual orientation. It does not define ethnic group. According to the Office for National Statistics, ‘there is no consensus on what constitutes an “ethnic group”’. 3
Definitions of BME are fluid and depend upon the ‘majority population’ denominator. The 2011 Census indicated that, in London, the category ‘White: English/Welsh/Scottish/Northern Irish/British’ – itself full of cultural diversity – comprised 45% of the population, a minority. If the world wide ‘majority population’ denominator is used, it can challenge assumptions. For example, world wide, most religions have dietary rules and restrictions: the protestant Christian approach is a ‘minority’ against this denominator, but the norm in the United Kingdom (UK). BME definitions ignore within-group differences and changes in society: families increasingly comprise people originating in more than one country and of more than one religion.

CR156 used the term ‘indigenous’ to describe the ‘majority’ population. That is an oversimplification; many people tick the box ‘White British’ as ‘best-fit’, but would never consider themselves ‘indigenous’, a label which they may regard at best as inaccurate, at worst, offensive. Many people from BME groups feel ‘main stream’, others labelled ‘White British’ do not.

**Psychiatric Services for BME Older People**

The 2009 report derived from the 2001 version (CR103) of the same name. Based on an analysis of policy, research and examples of good practice, CR103 provided important recommendations, including: to provide services for psychiatric assessment and treatment within mainstream services; to ensure staff have ‘ethnic awareness and sensitivity’; providing continuing care ‘specifically for the appropriate user group.’

CR156 was thorough. It surveyed policies and research including on epidemiology, protective factors, access to services, service evaluation, awareness of depression and dementia, and diagnostic screening instruments. It reiterated earlier proposals, with some additions, including carrying out research and service evaluations and creating a Faculty working group to collaborate with other relevant organisations. It acknowledged lack of progress in implementing existing recommendations.

Much effort goes into researching local needs, but too often findings are not incorporated into practice, possibly associated with a tendency of authorities to ignore data on patient experience and to request additional evidence even when plenty exists, especially for undervalued people with mental illnesses. Some proposals are unlikely to be feasible. For example, CR156 recommended a ‘racial mix of multi-disciplinary staff members reflecting the population served’. That, however, did not take into account whether career aspirations of younger people would reflect their community’s needs, or whether they would continue to live in the same area. CR156 gave few examples of good practice, disappointing for a clinical specialty where understanding and valuing the diversity and significance of life experiences should be at the heart of person-centred work.

**Accessing services: stigma, fear and other factors**

One concern of people advocating specifically for BME communities is that some groups might be less able to access services because of stigma about mental illness, such as if their traditional views of mental illness attributed it to supernatural forces, possession by spirits or as punishment for previous sins. But stigma and fear of mental illness affect other groups in different ways. Gay people might fear that their sexual orientation will engender rejection or criticism from psychiatric services, so
might also avoid seeking help when it is needed. In cultures which teach acceptance of disability in old age and expect families to automatically care for dependent older people, chronic illness might be regarded as normal ageing and families might struggle on for long periods without seeking help. For people brought up in the UK, help-seeking might be influenced by disturbing recollections of the large, now closed, mental hospitals.

Although some groups may have certain fears greater than the mean for the population, similarities and overlap may outweigh the differences. Arguments regarding culture and accessing services extend well beyond BME groups.

**Individual and group identity**

The 2011 Census revealed that people from ethnic minorities are ‘spreading out’, shifting the focus from geographically based groups to individuals in more mixed areas. Links with the larger centres of their communities can be maintained while living more remotely. Living at a distance does not equate with diminished identity. Indeed, the UK’s diverse population would not have emerged if that had been so. In addition, the assumption that minority groups will move gradually towards adopting the culture of their adopted homeland is not always borne out; for example, within the Jewish community in England, the ‘ultra-orthodox’ are the most rapidly growing sector.

Values and beliefs also vary within groups and have relevance for clinical practice. Social class and education may be important influences, and intergenerational family expectations can affect the management of health and wellbeing of older people. An individual might defer health decisions to family and community. For example, the one-to-one Western model of medical confidentiality might not fit with the one-to-one plus family model in the Somali community. Many people use ethnic alternative or complementary therapies inside and outside their original cultural context; recent clinical experience has included Jewish people passionate about acupuncture for depression and Chinese people using it for delirium and pain.

Staff need to know more than just the main facts about different groups, otherwise they risk applying stereotypes to patients which can undermine clinical management, such as that Asian communities ‘look after their own’ or Muslims are invariably teatotal. They also risk overlooking subtle but important differences: non-verbal communications also relate to cultural backgrounds. Making eye contact, for example, between different generations or genders, has different meanings in different cultures, from showing understanding and confidence to displaying disrespect or being inappropriate according to a religious code. Self-awareness of one’s own values and biases is an important step to decreasing ethnocentrism, homophobia, judgementalism and cultural imposition.

Old age specialists should be experts on empathic understanding of the social, cultural and psychological influences in patient’s lives, since, because of age alone, staff could not possibly have shared many of their patients’ experiences. Being a single mother in the 1930s, or a child bereaved in the Blitz, or living in the pre-NHS era, are temporally and culturally outside staff experiences. Clues to the meaning of many experiences can be learnt by asking patients and learning from the humanities, for example reading *Carrie’s War* by Nina Bawden about being an evacuee in Wales in...
the Second World War, or Morris Gleitzman’s powerful novels about the Holocaust, or The Secret Scripture by Sebastian Barry about a patient in a mental hospital in Ireland. None of these are intellectually taxing, but they are likely to improve understanding of the impact of formative cultural experiences on mental illness and wellbeing in older people. Knowledge and exploration of cultural and personal identity complements recent recommendations for mental health staff to understand their patients’ spiritual needs. Understanding the individual, being able to ask the right questions, having the humility to learn from patients and their families, and reaching out to local groups should be integral to clinical work. One size does not fit all.

A framework for diversity in old age psychiatric services
From the perspective of the Faculty, age discrimination has perhaps rightly dominated attempts to comply with the Equality Act. Old age services are currently feeling the impact of a ‘colour blind’ approach. New ‘ageless’ services to treat all adults with functional disorders ignore valid differences by assuming that everyone is the same, rather than providing for authentic different needs as the Act envisioned. When older people and social diversity are investigated together, age has tended to be been marginalised. For example, the Care Quality Commission ‘Count me in’ censuses of ethnicity of in-patients in mental health units did not provide separate analysis for over 65s or analyse findings for that age group in a way which would be meaningful to those providing services for them. This is alarming since cultural experiences and needs may differ between generations: plans for services relating to BME younger people do not necessarily apply to older people.

Policies seem to be moving away from referring specifically to BME groups. The National Dementia Strategy (NDS) in 2009 stated the need to promote access to services for everyone who needs them. The NDS took a broad approach, recognising that people with a learning disability, younger people with dementia, those from minority ethnic groups or from rural, island or traveller communities may require specifically tailored approaches. It did not mention gay people. In the National Institute for Health and Care Excellence’s (NICE) dementia guidance (2012), the breadth of person-centred care, including ‘diversity, equality and language’, was emphasised, without specifically mentioning BME groups. The Prime Minister’s Challenge on Dementia (2012) emphasised ‘knowing the person, their life history and their personal culture’. It did not identify specific groups. It is difficult to find the right balance between group-specific guidance and looking within groups. Not mentioning groups risks neglecting them; it becomes easy to overlook them, and might fail to engage them with policies and plans. Thus non-specific and broad government policies might undermine aims to achieve equality and social inclusion, with implications for clinical practice. Other initiatives such as the Faculty’s Developing an Ideal Old Age Service (2013) is relevant in its entirety, not just the BME section. The Alzheimer’s Society and the All-Party Parliamentary Group on Dementia have focussed on the experiences of BME communities. The Faculty collaborates in these initiatives.

Steadfastly sensitive and assertive local interpretation of directives concerning older people’s mental health is vital, including working directly with communities, voluntary organisations, and minority-focused media. There is a huge amount of goodwill in the community. For example, in North West London, volunteers help
provide cultural clubs, drop-ins and home-cooked lunches for older Asian people. Faith based organisations are applying for accreditation as ‘dementia friendly communities’. Clinical teams need to work with this process and expand beyond it: combined ‘depression aware, dementia friendly’ communities might help even more people. Talking with religious leaders or addressing older people’s clubs in mosques and temples (even if an entire presentation requires an interpreter!) can be an intensely rewarding experience for a clinician. The cross cultural nature of such work can itself lead to building rapport, trust and understanding between a community and statutory services.

Conclusions
The Faculty executive decided to withdraw CR156, aware that this might be controversial for those who struggle to establish services for BME communities. It does not want to undermine that work, but feels that crucial and clinically relevant diversity issues affecting the complex needs of patients reach far beyond this (Box 1). Old age psychiatrists need to advocate broadly and vociferously for older people with all mental illnesses and personal identities, on national policy, local community and individual levels. Staff education to ensure person-centred clinical work is crucial, while retaining group categories for research and in localities where there are substantial populations who might require a more community focussed approach.

Your comments are welcome as the Faculty determine the next steps.

Box 1:
Direction for diversity
- Educating staff about diversity, including acknowledging their self awareness.
- Non-judgemental understanding of the complex strands of personal identity encountered in the clinical setting.
- Working with religious and other communities and their leaders to improve understanding, encourage people to seek help where necessary and support the communities’ initiatives.
- Interpreting policies for local needs, and working with statutory authorities to ensure diverse and appropriate services are available.
- Building on existing good practice, and re-evaluating appropriateness and feasibility of existing recommendations.
- Encouraging research and exploration of diversity as related to service provision.

Acknowledgements
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References
2 Anon. King of all battles, Yorkshire Post, March 13th 2014.

5 Centre on Dynamics of Ethnicity, University of Manchester, Dynamics of Diversity: Evidence from the 2011 Census. http://www.ethnicity.ac.uk/census/869_CCSR_Bulletin_More_segregation_or_more_mixing_v7NW.pdf


9 Coulter A, Locock L, Ziebland S, Calabrese J. Collecting data on patient experience is not enough: they must be used to improve care. BMJ 2014;348:g2225.


