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Ageing, ethnicity and psychiatric services

SUMMARY

In 2001, the Royal College of Psychiatrists produced Council Report (CR103) which concluded that services for Black and minority ethnic elders had received little attention.

The report also called for an urgent need to establish a reliable and informative database of good practice and increased research. It is currently under review by the College. This article attempts to set out some

of the issues that remain as well as newly identified ones. In particular, the article hopes to heighten awareness and raise debate about these issues and to link these with the College's Race Equality Action Plan.

In 2001, the Royal College of Psychiatrists produced a report on psychiatric services for Black and minority ethnic elders (age ≥ 65 years) (CR103), which concluded that services for this group of users had received little attention. The scattered distribution of Black and minority ethnic elders had resulted in their lack of knowledge on how to access services, leading to underrepresentation of the psychiatric needs of this small but significant population group (Royal College of Psychiatrists, 2001). Information about psychiatric services for Black and minority ethnic elders was reported to be largely inappropriate as it relied on translation and did not make adequate use of other forms of communication. The report also called for an urgent need to establish a reliable and informative database of good practice and increased research. It is currently under review by the College.

In this paper we set out some of the issues that have remained since the publication of the report in 2001 as well as newly identified ones. We hope to heighten awareness and raise debate about these issues and to link them with the College Race Equality Action Plan (Royal College of Psychiatrists, 2007).

Census data

Over the past 30 years the UK population has grown by 7%. The proportion of Black and minority ethnic individuals over the age of 65 has increased from 3% in 1991 to 8.2% in 2001 according to the 2001 population census in England and Wales (Shah, 2007). This contrasts with 17% of the White British population being over 65 years old in 1991 and 2001. The most prevalent Black and minority ethnic groups in 2001 were the Irish (25%), Black Caribbean (10.6%), other White (10.4%), Indian (6.6%) and Chinese (5.1%). There was a sizeable number of elderly individuals from four Black and minority ethnic

groups of mixed race. The total number of elderly people from all Black and minority ethnic groups combined was 531 909. The ratio of 'young:old' (65–80 years old) to 'old:old' (over 80 years old) was higher in most Black and minority ethnic groups than in indigenous elders (Shah, 2007). The demographic data from the census are almost 8 years old. Unfortunately, more recent demographic data are not available, but it is likely that the number of Black and minority ethnic elders has increased further since 2001.

Dementia and depression among Black and minority ethnic elders

The prevalence of dementia and depression among elders from several different ethnic minority groups in the UK is generally similar to or higher than among indigenous elders (Bhatnagar & Frank, 1997; Lindesay *et al*, 1997a; McCracken *et al*, 1997; Livingston *et al*, 2001). (The above are the most recent available studies, but we have assumed that the current prevalence figures are similar.) Thus, with the increase in the Black and minority ethnic elderly population, the absolute number of cases of dementia and depression is also likely to have increased in this group. A recent study estimated that in 2004 there were 11 860 Black and minority ethnic individuals with dementia in the UK (King's College London & London School of Economics, 2007). Another study has estimated between 33 559 and 52 980 cases of depressive illness among Black and minority ethnic elders (Shah, 2008). In some Black and minority ethnic groups physical illnesses which increase the risk of dementia, including diabetes, hypertension and ischaemic heart disease, are very common.



What are the key issues?

Since the publication in 2001 of the College report on psychiatric services for Black and minority ethnic elders, there has been little research in this area, including the issues of equity of access to primary and secondary care and understanding the diversity existing between and among Black and minority ethnic communities. Because of the absence of evidence-based research it is not known if there have been any systemic improvements in services since the report's publication. However, individual papers on good practice exist.

Some literature-based information is available, for example on access to old age psychiatry services and Goldberg & Huxley's (1991) pathways into care. This encompasses several sequential stages, including the awareness of an illness in the community, consultation with the general practitioner (GP), identification and management of the illness by the GP, referral to old age psychiatry services, and identification and management of the illness in those services.

Access to old age psychiatry services

To access the old age psychiatry services, service users usually consult their GP first. Elders and their families from several Black and minority ethnic groups have high awareness of GP services (Bhalia & Blakemore, 1981; Barker, 1984; McCallum, 1990) and make good use of them (Donaldson, 1986; Balarajan et al, 1989; Gillam et al, 1989; Lindsay et al, 1997b; Livingston et al, 2002). However, the number of Black and minority ethnic elders in contact with old age psychiatry services is low (Shah & Dighe-Deo, 1997). This discrepancy between high general practice consultation rates and low take-up of old age psychiatry services exists despite the community prevalence of dementia and depression being similar or higher among Black and minority ethnic elders than among indigenous elders. There needs to be more research in this area, as it is likely that this situation is caused by a number of related factors, for example the relationship between service users and their families, general practice and old age psychiatry services, stigma. Professionals and the community also need to be more aware of services for this group of users. Service providers in particular need to consider the way in which structures and processes can affect access.

There is some evidence that poor access to old age psychiatry services of ethnic minority elders is changing in some UK services. Since the publication of the 2001 College report, one London study reported that Polish elders have equitable access to health and social services at the same frequency as indigenous elders (Bhatkal & Shah, 2004). This finding was consistent with identical findings from two earlier studies of elders of Indian origin in the same locality of London (Redlinghuys & Shah, 1997; Odutoye & Shah, 1999). Also, a population-based study of a mixed group of ethnic minority elders in Islington, London, reported similar findings for the use of primary care, secondary care and social services, but old age psychiatry services were not included (Livingston et al,

2002). The *Count Me In* survey (Commission for Health-care Audit and Inspection, 2007) of all psychiatric in-patients in England and Wales on 31 March 2007 reported that the standardised admission ratios (the standard being the rate for England and Wales) for those over the age of 65 were: higher in the White Irish, Other White, Other Asian, Black Caribbean, Black African and Other Black groups; lower in the White British and Chinese groups; and not significantly different in the Indian, Pakistani and Bangladeshi groups.

Black and minority ethnic elderly groups are not homogeneous and therefore the temptation to amalgamate all such groups together should be avoided.

Implications of the College's Race Equality Action Plan for those working with Black and minority ethnic elders

To meet its obligations under the Race Relations (Amendment) Act 2000, in particular the general duty to eliminate unlawful discrimination, promote race equality and good race relations, the College has established a race equality scheme with an extensive Race Equality Action Plan. The College's commitment to race equality must extend to the standards and practice of old age psychiatry, and the updating of the 2001 College report (CR103) remains an important way forward.

The Action Plan drafts specific commitments relevant to old age psychiatry, in particular:

- core training and education – cultural capability
- promoting access to services for users and carers
- consultation with Black and minority ethnic users and carers
- research – inclusion and focus

These commitments require rigorous evaluation to establish their effectiveness in ultimately leading to better access to culturally appropriate and sensitive old age psychiatry services for Black and minority ethnic elders.

Core training and education – cultural capability

The CR103 report highlighted the need for greater improvements in cultural capability for mental health services for older people. Clinicians working in mental health services should receive regular and rigorous formal training in cultural capability, awareness, appropriateness and sensitivity to improve their knowledge, skills and attitudes (Department of Health, 2005). This should include training on local policies for racial harassment and discrimination, and legislation relevant to racial discrimination (Patel et al, 2003; Department of Health, 2005). Such local training should be complemented by workshops and seminars conducted by the College, the Race Equality and Cultural Capability Programme that is being developed by the National Health Service Institute for Learning, Skills and Innovation (Department of Health, 2005), the common skills set for mental health practitioners that is being developed by the National Institute



for Mental Health in England (NIMHE; Department of Health, 2005) and the emerging training manuals (e.g. a manual on cultural capability due to be published by the College).

The College should promote the need for training in the ascertainment, recording and monitoring of ethnicity, stressing the importance of using such data to identify discriminatory practices, service user needs and new service developments. It should also emphasise the importance of ongoing discussions with local Black and minority ethnic organisations, service users and carers as a means of understanding and auditing service delivery.

Promoting access to services for users and carers

There are significant issues related to access to mental health services for Black and minority ethnic elders, particularly lack of awareness and understanding about services and lack of appropriate information (Royal College of Psychiatrists, 2001). Thus, the College has called for a database of services including information about good practice, accredited interpreters, educational meetings, screening tests and, where possible, access to translations of essential information for Black and minority ethnic users and carers (Royal College of Psychiatrists, 2001). This could be held by the College Faculty of Old Age Psychiatry, with input from the Transcultural Special Interest Group.

The College has a register of psychiatrists with fluency in different languages, often updated. Audio-tapes, videos, CDs and diagrammatic representation of management and service-related issues can complement the use of interpretation services and may be particularly helpful for illiterate service users and carers (Lindesay et al, 1997b). Educational videos on dementia have been developed internationally (e.g. by Alzheimer's Disease International, www.alz.co.uk), nationally (e.g. PRIAE, Policy Research Institute on Ageing and Ethnicity, www.priae.org) and locally (e.g. Alzheimer's Concern Ealing, www.alzheimersconcern.co.uk). Additionally, translated versions of all information leaflets should be made available to service users and carers who can read their mother tongue.

Screening instruments for dementia and depression are emerging in several languages for Black and minority ethnic elderly groups, but there is a paucity of diagnostic instruments. However, there are some fundamental problems. The appropriateness and validity of some translated scales in this age group has to be considered. All existing screening instruments for dementia and depression for Black and minority ethnic elders have been developed in the target participants' language. As translated versions of instruments have questions in the participant's language, the clinician cannot directly administer the instrument unless they are fluent in that language. Moreover, the clinician cannot solely rely on the interpreter to accurately administer the instrument because the clinician will not be able to ascertain the accuracy of this mode of administration. There is an

urgent need to develop instruments for use in day-to-day clinical practice, whereby the interpreter can administer predetermined and standardised set of translated questions given by the clinician to the patient. Furthermore, the development of self-rated screening instruments, like the Geriatric Depression Scale (Yesavage et al, 1983), is problematic in individuals who are unable to read their mother tongue. For this group there is a need to develop interviewer-administered instruments.

For everyday communication on in-patient units, day hospitals, day centres and residential and nursing homes, it may not be practical to have an interpreter present all the time and bilingual staff are uncommon. Appointing bilingual staff should be encouraged both to aid communication with service users and as an information source on cultural issues.

A manual of translated versions of commonly used key phrases (e.g. 'please come and have breakfast', 'please come and have your medication', 'would you like to go for a walk?'), together with a paraphrased version in English, needs to be developed. In this way, the user could read the staff's request or, where they cannot read their own language, staff can read the paraphrased version to them. Common responses should be available to the staff to ensure communication and appropriate care.

Consultation with Black and minority ethnic users and carers

The evidence on consultation with Black and minority ethnic elders tended to be mainly anecdotal. Over the past few years, well-attended national conferences have been held by organisations such as PRIAE and NIMHE, which have highlighted issues already identified on the local level. This has included the problems of institutional racism affecting access and delivery of care. The assumption that Black and minority ethnic communities in a particular area are homogeneous often leads to perpetuation of inappropriate services.

Black and minority ethnic service users and carers should be consulted on such matters as appropriate communication, language, religious and ethnic diversity and transport. Ways of working with Black and minority ethnic elders should be established so as to empower them to articulate their concerns themselves rather than through others. The College review of the 2001 report could investigate ways of disseminating information about good practice in this area, for instance through links with NIMHE.

Research: inclusion and focus

The College's CR103 report acknowledges the relative dearth of the mental healthcare needs of Black and minority ethnic elders. Although subsequent studies remain scarce, their number is growing. The College is committed to ensuring that Black and minority ethnic groups are included in all research programmes.

It is important not to assume that findings from epidemiological studies from the country of origin of



Black and minority ethnic elders are applicable in the UK, because the process of migration, fluency in English, the degree of assimilation and acculturation into the host culture and other environmental changes are likely to influence the findings in the UK.

In general, population-based epidemiological studies and studies evaluating the effectiveness of treatment interventions often exclude Black and minority ethnic elders and therefore findings from such studies cannot readily be applied to this group. Black and minority ethnic elders need to be included in these studies. There is also an urgent need for population-based epidemiological studies of different Black and minority ethnic groups to examine the prevalence of mental illnesses, their severity and the resultant disability, as well as risk factors, natural history, clinical features and clinical presentation and issues related to carers, including stress and strain. These studies should be complemented by others designed to identify barriers in the pathway to secondary care, for example using the Goldberg & Huxley's (1991) model of pathways into care. The elderly should be included in studies which use the traditional limit of 65 years – clinical issues do not change on the 65th birthday. Such exclusion particularly disadvantages Black and minority ethnic elders as they are generally in the 'young:old' (65–80) range (Shah, 2007).

Conclusions

In summary, the College's Race Equality Action Plan has identified the slow progress of improving services for Black and minority ethnic elders with mental health problems. The College 2001 report review is an opportune time to accelerate change by emphasising this neglected area and providing robust recommendations for improvement within a time framework. The following recommendations should be given careful consideration.

1. There is an urgent need to identify examples of good practice, including old age psychiatry services providing equitable access to Black and minority ethnic elders in comparison with indigenous elders. This should be possible, because:
 - all mental health service providers are now required to routinely collect data on service users' ethnicity
 - there are a number of studies of individual services reporting equitable access
 - organisations such as PRIAE have identified examples of good practice
 - reports from the Healthcare Commission's statutory review of mental health trusts prior to 2005 may also contain examples of good practice.

A critical review of these data sources would allow identification of the specific components pertaining to the management, organisation and delivery of services which lead to good practice. In turn, these examples of good practice should be widely shared and promoted with all old age psychiatry services.
2. The Race Equality Action Plan requires an ongoing evaluation to establish its effectiveness in ultimately

leading to better access to culturally appropriate and sensitive old age psychiatry services for Black and minority ethnic elders.

3. The Department of Health and other research-funding bodies should give urgent consideration to funding research projects evaluating the effectiveness of professional interpretation services and development of alternative methods of information-sharing, including audio (cassette and CD), visual (VCR and DVD) and diagrammatic representations.
4. The Department of Health and other research-funding bodies should sponsor research projects to develop screening and diagnostic instruments for dementia and depression in languages spoken by Black and minority ethnic elders which can be administered in English by an English-speaking clinician with the aid of a professional interpreter. Priority should also be given to projects evaluating the effectiveness of strategies promoting the use any such instruments.

The Healthcare Commission, along with other agencies, has so far conducted three 1-day censuses (*Count Me In*, 31 March 2005, 2006 and 2007) of all psychiatric in-patients in England and Wales. Details on psychiatric in-patients aged 65 years and over by ethnicity have only been reported for the 2007 *Count Me In* survey. Such a 1-day census could be extended to include psychiatric patients in all service settings (community and out-patient clinics, day hospitals and acute, respite and continuing care in-patient services). This would allow careful examination over time of improvement in access to all old age psychiatry services by Black and minority ethnic elders at the national level. This collection of activity-related data should be coupled with ongoing national surveys of the experiences of a representative sample of elderly Black and minority ethnic service users pertaining to cultural sensitivity and appropriateness of old age psychiatry services. This ambitious evaluation programme could be achieved through collaboration between key organisations, including the Department of Health, NIMHE, Healthcare Commission, PRIAE, Alzheimer's Society, Age Concern and the Royal College of Psychiatrists.

Declaration of interest

None.

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Community care law for psychiatrists

SUMMARY

Although psychiatrists are well-acquainted with the Mental Health Act 1983, most are unlikely to know much about community care law, despite the fact that its provisions have the potential to significantly

improve the level of service for the users. This paper explains the meaning of community care law, looks at how it applies to National Health Service trusts and what are the psychiatrists' responsibilities. It examines how community care law

works and discusses the significance of 'fair access to care services' policy, the meaning of 'need', the benefits of direct payments, the significance of housing provision and the role of carers.

What is community care law?

Community care law potentially applies to all psychiatric patients but rather than consisting of one act it is a hotchpotch of conflicting statutes (Box 1; Clements, 2004, para. 1.30). It co-exists with the care programme approach (CPA), but unlike the CPA it has the force of law, entitling people to services.

The community care law acts are 'activated' by Section 29 of the National Assistance Act 1948 which is made mandatory for people with a disability (including mentally ill people) by Section 2(1) of the Chronically Sick and Disabled Persons Act 1970.

The gateway to all the provisions is Section 47 of the National Health Service and Community Care Act 1990, commonly known as a 'needs assessment' which, when properly performed, opens the door to all the statutory service users' rights.

How does the community care law apply to NHS trusts?

Most trusts share the responsibility to carry out needs assessments with social services. Often the assessments are integrated into the CPA. However, services recommended by the CPA do not constitute a statutory right,