Black and Ethnic Minority Older People's changing care needs

Today and Tomorrow 2010



A study on the lifestyle changes affecting access to care in Bradford

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November 2010



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Report Summary

The research was commissioned by Bradford Council Adult & Community Services to help them to understand the social care needs of the BME older community and to support their development of short and long term service strategies. A mixture of literature review and primary research was used to support the study. The primary research was conducted through focus group work, questionnaires to service users and professionals and one-to-one interviews with service users and potential service users from the target groups. Concentrating mainly on BME participants the study also included some participation from the older Eastern European community.

The research mainly concentrated on the South Asian Communities with reference to other BME communities, and investigated the impact that changes to family structures would have on the requirement for social care, both formal and informal, to older people in BME communities.

Key findings from the research were:

- South Asian family structures across the board had evolved from the typical extended family structure, where different generations lived in the same household, to one where more younger families are moving out of their parents home due to a host of factors that included greater economic independence, greater aspirations, overcrowding, family politics and need for greater independence. However, this has not meant that support structures have dissolved but instead that they have evolved to a community which contains individually organised families that come together to create an extended family network when support is required
- Information, advice and guidance about services and support (and individual budgets) needs to be available when required, and accessible to those who need to access it
- Services need to be available in the localities and neighbourhoods where communities reside and should be culturally and religiously sensitive to the needs of the service users
- Formal support to augment informal care should be more readily available, and where people are ineligible for formal support good signposting to VCS services should be provided
- The needs of people from within a community need to be considered more with better and more targeted consultations – individuals within a community should not be seen as having exactly the same needs as the whole community to which they belong
- Further development and promotion of preventative services and signposting services should be conducted
- Opportunities and support should be provided to enable BME older people to become socially active in the civic life of the District, communities and their neighbourhoods
- A strong feeling from the communities who participated in the study that the state should pay for the care and not the individual.

The report recommended that in order for these findings to be accommodated within Bradford Council's future older people's care strategies that it take into account 10 main factors, detailed within the 10Ps Engagement Framework, which front line staff could use to help improve the flexibility, adaptability, awareness and responsiveness of service provision in meeting end service users' needs, (refer to Pages 26-27).



Introduction

Bradford Metropolitan District Council Adult & Community Services commissioned Seeds Consultancy to look at the lifestyle changes taking place amongst the Black and Minority Ethnic (BME) communities living within the Bradford District; with a particular focus on South Asian Communities.

A number of research methodologies were used to investigate the level and degree of change and their social and economic impacts on older people from these communities. This included a literature review, face to face interviews, questionnaires and focus groups to gather information from a wide audience. (Refer to Appendix 1 for further information on the research methodology and sample.)

The available research on BME older people seemed quite significant due to the amount of information available focusing on areas of social care and black communities (Mind, 2009). However, many academics and researchers within the field tend to criticise the studies for being too small-scale, and concerned in the main with the policy and practice implications for service development rather than the incidence and prevalence of needs (Mind, 2009).

More recently, other researchers have begun challenging BME elderly research for generalising and relying on old stereotypes in order to develop service strategies and policies. It is argued that they do not take into account BME older people's various differing circumstances which include culture, language, family structure, employment history and so on (Age Concern, 2009).

The community dimension, the changes within the demographics and lifestyles, family and support structures and to a lesser extent sub-cultures¹, and their impact on future care provision for BME older people, have been largely overlooked in public policy as there was little national data uncovered during this research that allows detailed analysis of these areas.

Existing evidence tends to focus on snapshot socio-economic data of BME communities, societal barriers and the lack of support for informal carers rather than a systematic mapping of changes in BME lifestyles and support structures and their impact on future care provision. Therefore policy on elderly care in the BME community was rooted within the stereotype which assumes that self-supporting social networks of families, friends and neighbours would form one of its central planks (Griffiths 1988, Katbamna et al 1991).

This research aims to challenge these long-standing assumptions through assessing how changes in lifestyles and family or support structures within the South Asian community are impacting on the increasing care needs of a growing community of BME older people.

¹ Sub-culture – communities within communities which have differing cultural practices and norms.

Overview of BME Elderly Community

Local and national analysis of the BME elderly community indicated several key findings, which highlighted nationally how the BME over 50s population was expected to grow ten fold by 2030 from 175,000 to 1.7million people (Patel, 1999). In comparison, there is expected to be a 90.5% increase in the South Asian community from 98,694 people in 2005 to 187,978 people by 2030 within the Bradford District, which will see a massive increase in the size of the older people population. It is worth noting this, together with the fact that Bradford's birth rate is the opposite to national trends as there is also a higher number of younger people in comparison to the levels in most other cities.

In breaking down the demographics of the South Asian elderly community further, national research highlighted how Indians tended to have a higher proportion of middle-aged people who will reach old age in the next 20 years; in comparison to Pakistani and Bangladeshi groups who had a higher proportion of school-age and a young adult population (Age Concern, 2007). These statistics were in agreement with local research which highlighted how the Indian community has the highest proportion of over 60s (8.8%), followed by the Bangladeshi (5.1%) and Pakistani community (4.8%).

Religion tended to play a major role in older people's lives within the South Asian community. Nationally, Muslims comprise the largest community amongst the Asian population leading with Pakistanis and Bangladeshis (50%), followed by Chinese and other groups (13%) and Mixed group 10%. Among the remaining Asian groups, 24% of them were Hindus and 14% were Sikh (both groups mainly from India) (Age Concern, 2007; Age Concern 2008). These sharp contrasts were also reflected within the local review, which detailed how Muslims make up the largest of the sub-continents religious groups with an estimated 75,188 people, followed by Sikhs (4,748) and Hindus (4,457) (ONS, 2004).

The role of gender within the South Asian community amongst older people tends to be traditional and remains quite static in correlation with views and traditions from their country of origin. Whilst older Muslim households generally allow the men to make their own decisions about health and social care, women still rely on their social networks, even though this tradition is beginning to be challenged by younger generations; in comparison, the Sikh and Hindu older people tend to make their decisions together (Hamlett et al, 2008).

Statistically, national research indicates wide variations between men and women within various ethnic groups, with the Indian population having the most balanced distribution of males (49%) and females (51%), followed by Pakistanis with a slightly less balanced distribution between men (55%) and women (45%) and Bangladeshis at the bottom with close to 67% of males and 33% of females (Age Concern, 2007). This shows a growing gender imbalance particularly amongst the Pakistani and Bangladeshi households, with more men currently age 65 plus than women. Implications for the future indicate that there will be a disproportionate number of widowed elderly women.

In regards to the health of South Asian older people, ONS (2009) indicates how nationally, 60% of Asian people aged 65 and over were affected by limiting long-term illness and are at an increased risk of diabetes, coronary arteries disease, arthritis, stroke, and respiratory disorders (ONS, 2009).

Research conducted by Age Concern (2001; 2002), Sullivan (2009) and Ud-din (2009) highlighted how a combination of growing factors had led to the increasing isolation of older people within public life and raised barriers to accessing care. These factors included lacking access to information and public services, prejudice and racism, poor public transport, fear of crime, ill health and lack of money or a lack of funding for BME voluntary organisations. Furthermore, a report by the Age Reference Group on Equality and Human Rights (2005), which was published by Help the Aged, showed that older people receive a different level of service provision based upon their command of the English language.

Ginn and Arber (2000) found that many retired older people from the South Asian community are more likely to be at risk of poverty because of their employment history in the UK. The current 50 plus year old women, in particular, have stayed at home to raise families, which has meant they are less likely to have paid full National Insurance contributions. These communities also worked in lower paid jobs primarily without private pension schemes.

The myth of 'returning home' has not materialised for the vast majority of now ageing and retired South Asian older people who made Britain their home. Instead, Patel (1999) writes in the report, 'Ageing matters Ethnic concerns' that 'Sectoral – segmentation' in employment, discrimination, unions and earnings with current under-claiming of entitlements have generated a pattern of low pensionable income and consequent lifestyle choices (Patel, 1999).

CLG (2008) highlighted how BME older people, especially within South Asian families, tended to suffer from overcrowding with poor housing conditions, which in turn impacted their mobility and overall well-being, especially when they did not have carers in place to provide them with support. The majority of Pakistanis and Bangladeshis live within the inner city areas (BMDC, 2008); whilst Indians (Sikhs and Hindus) tend to live in more suburban areas (Phillips, 2008).

This research highlights lifestyle changes such as increasing nuclear families, diminishing responsibilities of care, relationships and values between generations. Perceptions of 'quality' in care services, personal attitudes towards people's own health and cultural competency (or lack of competency) of staff are shaping the future of older South Asians accessing appropriate care.

² Sectoral-segmentation – implying difference in treatment, terms and conditions for different communities within the workforce

South Asian communities in Bradford

Roughly a fifth of the population of Bradford District is of South Asian origin or descent. The vast majority of the community is of Pakistani heritage, followed by Indians and Bangladeshis and then a smaller Nepalese and Sri Lankan population. In terms of religious identity the majority of Bradford's South Asian population is Muslim with the remaining communities being Hindu (approx 24%) and Sikhs (approx 14%), whilst other smaller communities are Christian and of other faiths.

Figures indicate that the 98,694 South Asians in 2005 will increase to 187,978 by 2030 within Bradford District, with a substantial increase within the older age groups. This highlights an expectation for local government needing to increase or build the capacity of care provision for the South Asian older community in the coming years.

	0-15	16-59	60+	All Ages
Pakistani	27,100	49,000	3,900	80,000
Bangladeshi	2,200	3,400	300	5,900
Indian	3,100	10,400	1,300	14,800
Other Asian	1,000	2,900	200	4,100

Figure 1 – Breakdown of Bradford's South Asian Community by age (ONS 2009) – table

Like most other British cities, Bradford has an ageing population. However unlike the rest, there is a higher percentage of young people in the District with a high birth rate. With regards to BME older people, whilst they are not a significant proportion of the older community, their rate of increase is proportionately higher. This is due to the young migrants of the 1960s and 70s reaching retirement age.

Bradford (Population) Projections outputs 2005 – 2030

Ethnic Group Populations						
	White	Mixed	Asian	Black	Chinese and other	Total
Start (2005)	366,767	8,439	96,694	6,816	4,248	495,000
End (2030)	364,803	16,377	187,987	9,456	11,491	590.104
Change	-1,964	7,938	89,283	2,640	7,207	105,104
%age change	0.5	94.1	90.5	38.7	166.2	21.7

Ethnic Group Proportions						
	White %	Mixed %	Asian %	Black %	Chinese and other %	Total %
Start (2005)	75.6	1.7	20.3	1.4	0.9	100
End (2030)	61.8	2.8	31.9	1.6	1.9	100
%age change	-13.8	1.0	11.5	0.2	1.1	0.0

University of Leeds School of Geography 2006, Yorkshire and the Humber Population Projections: Age and Ethnicity for Yorkshire Futures

Figure 2 – Breakdown of Bradford District's population by ethnicity

The majority of these older people who migrated in the 1950s, 60s and 70s may have come with short-term plans and with the intention of returning to their country of birth. However, with a better quality of life, better income and more opportunities, the majority chose to stay within the UK permanently. Nevertheless, this does not mean they have not experienced their fair share of problems. Racism, social isolation and exclusion, along with poverty, have been realities for many of them. The difficulties of the past may be playing a role in the problems faced by these communities in their current circumstances (Social Services Inspectorate 1998; Mind, 2009).

Though national figures show the Indian elderly community to include a large share of people aged 65 and over, Bradford's larger Pakistani community will have proportionately more old people. This number is expected to change dramatically, in particular with the Pakistani and Bangladeshi community who by 2030 will have seen an estimated 30% enter 'old age' (Age Concern, 2007).

In turn this is highlighting the importance for policy advisers, service planners and providers in central and local government and the Third Sector³ to take note of the significant increases amongst the BME and South Asian elderly community in order to help build capacity and create new services, as well as improve specialisation of health and social care services so that they are better tailored to the needs of the South Asian and growing BME elderly community. (See Figure 2)

Research conducted by Berthoud (2000) and gathered within the primary research, indicated how younger couples within South Asian families, in particular from Indian (Hindu and Sikh) backgrounds, were gaining greater independence over who they choose to marry. This in turn impacted their ability to leave their parent's home earlier to set up home for themselves, which in many cases would mean leaving a gap in care for their older family members and parents.

³ Third Sector – voluntary and community organisations

ONS (2009) details how the main forms of carer support for dependent family members within South Asian families comes from within the immediate family, in particular from female carers. Pakistanis and Bangladeshis spend the highest rates of time caring for dependent family members, averaging at over 50 hours a week, in contrast to Indians who are more likely to spend 1-19 hours a week on caring for dependent family members (see Figure 3). A contrasting statistic that tends to be reflected in South Asian migration and settlement patterns, which highlight Pakistanis, and in particular Bangladeshi migrants, were later arrivals to Britain.

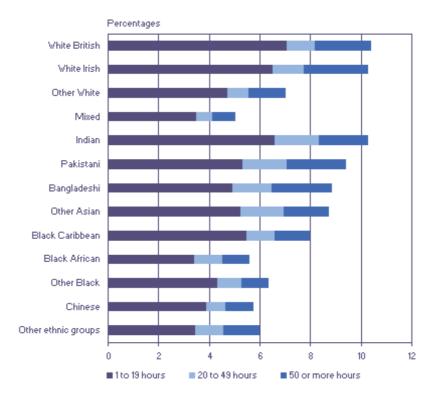


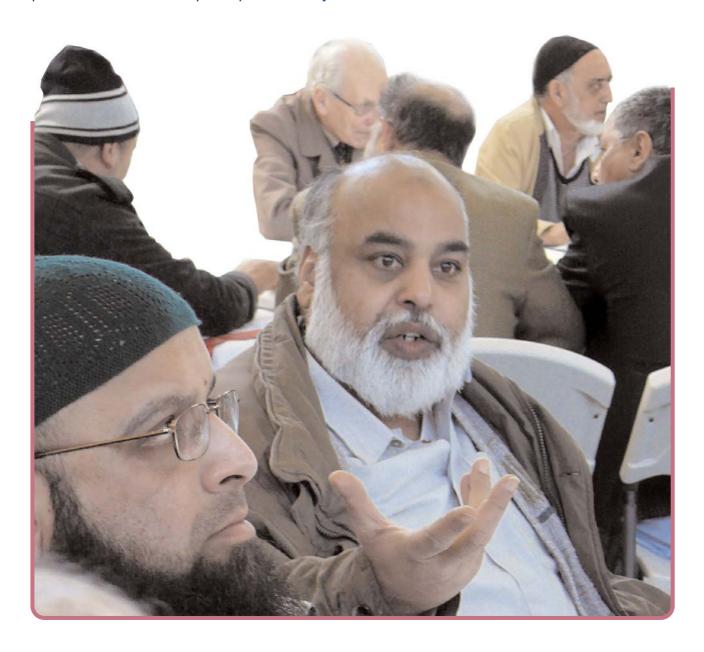
Figure 3 - Carers by ethnic origin and time spent caring per week (ONS, 2007)

In regards to health both national and local research highlight how BME older people are more likely to suffer from long term illnesses. In turn this causes an increased likeliness of suffering from a debilitating condition in old age. These illnesses are further compounded by: (1) stigma attached to illnesses; (2) lack awareness of services; (3) discrimination; etc (Age Concern, 2007). Other research indicates that specific groups within the South Asian community, like Pakistanis and Bangladeshis are more likely to report their health as not good, in contrast to Indians who report much better health (APHO, 2005); which researchers indicate could be correlated with their socio-economic status and level of deprivation.

There is a need amongst front line staff and policy makers to understand the importance that religion and spirituality has within the South Asian community, as within other communities. Mind (2009) describes how religion plays an important role in BME older people understanding and interpreting their physical, mental and emotional lives, which therefore must be taken into account in circumstances where better health behaviours are being promoted.

Research on the education and employment and income rate of the South Asian community highlighted potential indicators for their ability to pay for care in the future. Indians were more likely to attain better education and qualifications in contrast to Pakistanis and Bangladeshis; which tended to explain why Indian men had a lower unemployment rate of 7% in contrast to Pakistani men (11%) and women (20%); and Bangladeshi men (13%-14%). The dire significance of these statistics are further emphasised by the West Yorkshire Economic Partnership's (2007) research into Bradford's BME community, which highlighted up to 60% of the BME working age population are unemployed. This figure could be higher when taking into account under employment.

Philips (2008) highlights how Pakistanis and Bangladeshis tend to live in the inner city areas of Bradford with all local amenities located as such, whilst the Indian population have a distinctive geography according to the various sub-groups and religions within that community. This tends to cause many within each community to use services offered by local voluntary services from community centres rather from mainstream service providers from 'one-stop' shops within city centres.



Changing housing needs

As with all migrant communities, there is a shift from settlement patterns to one of a greater diaspora. However, looking at Bradford there is a clear generalised view of where communities are living. Whilst the greater proportion of the South Asian communities are living around inner-city Bradford and in Keighley, there are now sizeable communities living in areas such as Nab Wood, Shipley, Thornbury, Pudsey, Wibsey, Clayton and so on.

What seems to be hidden when simply looking at settlements is household composition. The inner-city neighbourhoods suited the migrant populations and their communal networks, 'biradari'⁴ systems and social contacts. The younger generations have very limited affiliation with the countries of their parents' origin. They seek better housing, albeit often smaller than the larger Victorian terraced houses of the inner-city (Ballard, 1982).

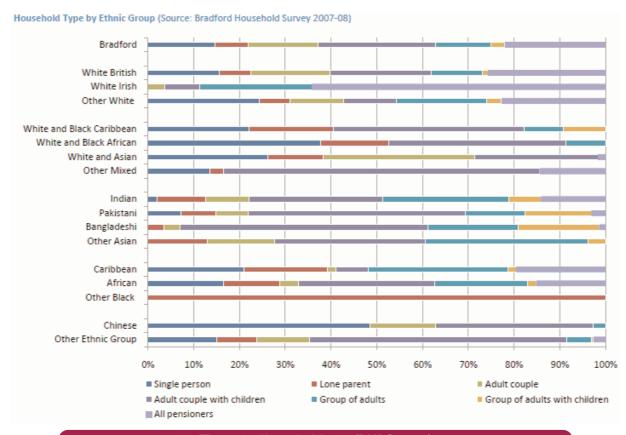


Figure 4 – Household type (BMDC, 2008)

Although currently it is the Indian community which has a proportionally higher significance of older people aged 65 years and over, the next five to ten years will see a greater influx of Pakistani older people due to demographic changes. Research also demonstrates that there is a gender imbalance amongst the over-65 year olds. It is this uneven representation of sexes in the over-65 age group in some BME groups which will have a major impact on the composition of pensioner households, which in turn will have major implications for the provision of formal and informal support in the future.

⁴ Biradari – Family networks based on kinship or clan

The number of owner occupied properties tends to be higher amongst the South Asian communities, especially with the older generation, mainly located in the poorer more deprived wards in Bradford with the older Victorian houses having bathrooms and bedrooms upstairs. There is a growing potential need for future aids and adaptations by older BME people wanting to stay in their own homes.

The contrast to this is the potential need for an increase in extra-care housing for older BME people who are living away from family or possibly with no close family. There is still the on-going issue of service providers needing to seek a better understanding of issues faced by BME older people (Help the Aged, 2008).

There also appears to be a growing acceptance of the need for supplementing informal care within family households with formal home care which is appropriate to the needs of the family, rather than the availability of service provision.

Cattan and Guintoli (2010) support the findings of this research by pointing out that more support for moving into one-level housing is needed, as is extra support for older people wishing to move from their impractical homes.

Findings suggest that all South Asian older people and those who are younger would like a more culturally sensitive approach within services which relates to aids and adaptations to help older people live in their own homes independently, and for a longer time. The Muslim community also expressed the need for support to help with the maintenance and repair of property.

The recurring feeling expressed by the older people participating in this study of wishing to access housing support or indeed extra care housing was coupled with the desire that it would need to be within Asian localities so that social and cultural contacts and amenities could still be accessible. However, many older people also expressed the opinion that they did not know how to access extra care housing or what was actually available to them.

One potential concern is also raised by HACT⁵ (2007) in their report, 'Bridging the Gaps: Social exclusion of BME elders', which suggests that many providers of housing services continue to make assumptions about BME older people, such as 'they look after their own', which results in services being poorly marketed to these communities. This then results in poor uptake of what is on offer, culminating in an assumption that services are not needed. The findings of this research echo these views.

⁵ HACT – Housing Action Charitable Trust

Changing family structures

Early migration and the settlement patterns of the South Asian communities in Bradford were along religious and ethnic grounds based on where immigrants had migrated from. This enabled communities to maintain cultural norms, language networks and community support. Cultural expectations, such as men being the main earners and the public face of the family whilst women were housewives and mothers, were established as the norm. This subsequently led to women creating their own networks, and thus the current need for service providers to use such networks to establish appropriate community engagement links and disseminating information to communities through them. However, for many women, especially older women and women who recently migrated from the sub-continent, their husbands or male relatives still act as their primary intermediaries through which they are able to access services.

A move from the extended family households to one of more nuclear settings has created a change in family dynamics and decision making. It is well documented that there is a higher level of overcrowding in South Asian households, with many households being multigenerational, usually over three generations. This change is also creating a shift in how older people see their care being met in the future, i.e. differently to the traditional roles expected of sons and daughter-in-laws. This change is seen more with middle-income families who are more economically mobile, rather than those who tend to come from unemployed and working class families.

When asked if such modern family structures are changing power dynamics in families, 72.7% of the Muslim respondents and 85.7% of the Hindu respondents said that it was the case. There was an acceptance that as children attained better qualifications and job prospects they were understandably more likely to set up their own family home closer to their place of work. Sikh participants' view was in contrast to this, with 75% of respondents disagreeing with the notion.

Acceptance of a change in family structures is however leaving older people isolated. These isolated older people then have subsequent difficulties in accessing information and respective services. However having said this, there is a higher prevalence of unemployment amongst local BME populations and some academics argue that this leads to overcrowding in houses. Conversely this does not equate with 'they look after their own' as young people are still seeking work opportunities and better lifestyles which might impact on their capacity to take on caring responsibilities.

Even though the current generation of South Asian males and females are much better educated and earning more than early migrants who first came to this country, research still indicates a high level of unemployment amongst this group of people. The West Yorkshire Economic Partnership (2007) indicates how up to 60% of Bradford's BME population were unemployed, which challenges the extent of economic mobility amongst younger generations of South Asians. Nonetheless, research gathered from survey data highlighted how 88% of Muslim respondents, 83% of Hindu respondents and 50% of Sikh respondents said that as more men and women from the family were going out to work, this had an adverse affect on the support and care available to older members of the household.

Selective acculturation ⁶ is a concept that helps to explain how younger generations have begun to challenge traditional relationships and positions within the South Asian family which tend to be based upon status, age and gender through accommodating western values and traditions without completely assimilating to the 'host' culture. As mentioned before, this has meant the increasing independence of sons and daughters from their parents, who now play more of a figurehead role and whose opinion is to be more respected than followed. The impacts of this shift must be investigated further, but it is evident from this research that there is potential amongst younger generations to feel less obligated towards caring for their elders which could increase gaps in elderly care within the future.

These shifts in intergenerational relationships have also helped evolve gender roles within the South Asian community. Where once South Asian women were expected to progress through several roles that had varying degrees of power from newly married bride to mother, then mother-in-law and finally grandmother, increasing independence saw women take charge of their own home much earlier. This increased level of independence amongst younger South Asian women has developed the perception amongst older South Asians that daughters-in-law from the sub-continent were more likely to care for family members whilst British-born young women would be more interested in their jobs and careers.

This is reflected in the research on Bradford, by Cattan and Guintoli (2010), who highlighted that even extended families had little family support with regards to care. Care duties were often left to the lead female in the house. Hence gaps in care are evident if this carer was not present for whatever reason. As a result of this it is important that more formal care is introduced to support lead carers in families.

Family decisions relating to choice of marriage partner for sons, whether from the subcontinent or from Britain, does have an impact on availability of care and support for older people, as does the issue of the number of children in the family i.e. potentially leading to overcrowding. The impact of such decisions and their effect needs to be analysed so as to be able to influence decisions relating to developments in future care provision.

Overall, these changes within South Asian family structures are attributed by some researchers and academics to the increasing move towards Modern Individualism⁷ within the South Asian community. Research indicates how all BME groups are moving in the same direction, which is away from traditional values to Modern Individualism. However, the extent of this shift varies between different ethnic groups with Indians in front, followed by Pakistanis and Bangladeshis who remain closer to traditional values. However, this does not mean that the South Asian community will abandon its entire values. Instead, it is a concept that needs further study as it is not fully understood in terms of: its impact on family dynamics, politics, roles and responsibilities to the extended family, and the decision-making process affecting services for older people who are more affiliated to traditional norms and practices.

⁶ Selective Acculturation – is a concept identified cited by SCIE (2009), originally sourced from the work of Portes and Rumbaut (2001), which refers to the extent ethnic minorities integrate within the host society

⁷ Modern Inidividualism – refers to the level of independence and individualism people have away from their families and networks.

Future care needs – overcoming barriers to accessing care

In assessing the future care needs of the South Asian community, the research looked at a multitude of life needs (physical, mental health, social, housing, etc) that would affect the level of support South Asian older people would require in the not too distant future. From that assessment, the research was able to identify a host of barriers that prevented South Asian older people from accessing services, whilst at the same time highlighting key factors that service providers needed to consider in order to share future care and service provision in both the short-term (5 years) and long-term (20 years).

In identifying barriers, researchers have given us a whole host of different issues which act as a barrier to accessing social care by older people from BME and South Asian communities. These include cultural differences, a lack of cultural competency in service provision, language difficulties, attitudes of staff, experience at first contact, differing expectations by both service users and service providers and location of services which prevent service users from accessing services effectively.

However local research has added to these by including additional factors such as who makes the decisions, the role of different children and siblings, gender roles and their expectations within the home and a misunderstanding or inappropriateness of service provision. Service users who participated in the study see 'tick box' exercises, service cuts, lack of follow-up and interpreters, staff who are not fully briefed, which leads to the somatisation of symptoms⁸, whereas service providers are always striving to offer services at excellent value for money that are seen to be appropriate for the needs being presented.

The Muslim community in particular raised the issue of social and cultural stigma associated with accessing services that provided care outside the family. This stigma tended to be fuelled by negative stereotypes that usually emerged from extended family members rather than the immediate family who were in need of those services. This is exacerbated further when and if a need arises to tackle mental ill-health, where specific occurrences of courtesy stigma⁹ would tend to take place. The Muslim respondents also stated that they felt their children knew better than them as they were more educated and informed than the older people.

The Hindu community felt that language barriers and a lack of awareness of services coupled with insensitivity of staff created barriers to accessing care. These views were also shared by many Sikh respondents, who added that transport and financial difficulties made access to services problematic.

Both national and local research indicated that BME, including South Asian, older people like their White counterparts would want any future care provision to seriously concentrate on maintaining high quality service delivery in order for these barriers to be overcome.

⁸ Somatisation of symptoms – converting inaccurate communicated symptoms into an ineffective diagnosis

⁹ Courtesy stigma – is when social and or family bonds would be severed due to stigma attached to illness and diseases people they know would suffer from

This means that service quality should be: more reliable and consistent, should be better linked and integrated with other services that impact on their well-being (housing, benefits etc) (Butt and O'Neil, 2004; Chahal and Temple, 2005; Manthorpe et al., in press), and should place greater emphasis on facilitating follow up and feedback.

A clear way forward from the service user perspective would be then to provide people with accurate information, accessible to them at a time when they needed it. They would need information about which services were available and how these could be accessed, with suggestions that recommended a more integrated approach amongst service providers in promoting information and raising awareness about available services. It was also identified that the availability of suitable interpreters would help people with English language difficulties to understand information more accurately.

Greater participation and engagement of service users and potential service users were felt to be a valuable factor when service providers were planning and developing services. It was clear that Adult & Community Services have been working in the community to raise awareness of services through a variety of means such as radio programmes and community road shows. However, a criticism raised was that sometimes these were too few and far between.

The Sikh and Muslim respondents also stressed the importance for service providers to improve their assessments. Improved assessments would look at the needs of the carer and the person they are caring for. A number of people felt that social workers were doing their job, but what they offered was not appropriate for the actual needs of the families or the individual concerned.

Much of the findings of this research are in line with national research which indicates that BME older people and their carers (like White British people) want services that are



appropriate and responsive to local needs. Services should be able to engage with service users from planning through to delivery stage, and there is a need for better information and access to treatment and choices at home (e.g. Telecare [Safe and Sound], Tele-health and E-care, etc.)

Whilst Bradford Council has taken many steps in involving older people through organisations such as Bradford Older People's Alliance and Bradford Older People's Partnership, older BME

and South Asian respondents were not easily able to identify with either organisation as a voice for them and their community. This led many participants involved within the study to call for Bradford Council to focus less on funding gatekeepers and emphasise more on delivering services within the heart of the South Asian community that involved BME and South Asian voluntary organisations and end service users directly.

Changing care needs of informal and family carers

Research on the support needs required by informal and family carers in looking after their older relatives highlighted several issues pertaining to quality of support, barriers in accessing care and the various degrees of support carers within different types of family required. Survey research highlighted how Muslims and Hindus tended to either have family to care for them or care for themselves in contrast to Sikhs, who had a sizeable amount (20%) of support from Adult & Community Services. Participants within the study expressed that in order for formal care to be a more attractive option to South Asian older people, a relationship based on trust must be built that conforms to the service users' religious and cultural requirements as well their language and communication needs.

Katbamna et al (2004) and Patel (1999) identified how informal and family carers tended to face several barriers in accessing support which prevented them from leading an active life in society. These included lacking communication aids for carers as well as lacking access to service information; and a lack of co-ordination and knowledge sharing between service providers which tended to slow down support when it was most needed.

The level of formal support that older people expect from external agencies depends on their own awareness of what is available and what cultural norms and expectations allow. These are often themselves dependent on the gender, background (class) and skill level (employment) of the individual concerned. Many surveyed preferred an integrated approach to disseminating information about support for carers, whether it is from their local GP office, the dentist or their housing provider.

Many researchers have pointed out that the key issues include the relationships that carers and their dependants have, as well as the relationship they can or cannot develop with service providers. Staff attitude is often cited as a 'make or break' scenario in terms of being able to access additional support by the carer to enable him or her to offer better care for their family member.

Family politics mean the person who makes decisions about care may not be the primary carer or the dependant. Added to this, unhelpful interference from extended family members could also make it difficult to access care services, especially if it relates to mental health. Given that dementia in older people is on the rise, there are worrying indicators as to how best carers will be able to support their loved ones given the social stigma attached to mental ill-health and the notion of family respect, izzat, sharam¹⁰ and the impact of labelling the family (Katbamna el al, 2004).

Local research found that communication was a key issue in being able to help people access services i.e. as a two-way process. Service providers need to be able to provide interpretive services and utilise bilingual staff and understand care needs and family requirements, as well as family members being able to trust service providers in their ability to deliver appropriate care packages.

¹⁰ Izzat (honour), Sharam – shame brought on family honour or one's own self-respect.

Given that there are an increasing number of nuclear families within the South Asian communities, there is a need to adapt service provision to take into account the dynamics of cultural shifts in family lifestyles and cultural practices, in particular adapting care to meet the needs of carers with nuclear families, single-parent households and extended families.

Our research participants have shown there to be a degree of difference in how Muslim families see the need for support and the views expressed by Hindu and Sikh families. Muslim families prefer family-based care i.e. support for carers within the family setting, whilst Sikh and Hindu families are more comfortable with outside agencies having a more hands-on involvement in giving care. Muslims want more training for family carers with additional help and support from formal care (e.g. Home Care, Respite etc) to supplement informal care activities. Sikh and Hindu families felt that better financial support and access to activities and support groups would be more beneficial.

On a gender level, the views expressed by local BME women who were carers were similar to national findings, such as their duty to care for their husband's family; many felt that the lack of emotional support undermined their ability to cope (Ahmad & Atkin 1996). However, this tended to be for women in single-parent households rather than those within nuclear and extended families where husbands would be able to offer them the emotional support they required most of the time. Men who cared for someone preferred support either from their wives or daughter-in-laws depending on who it was that they were caring for.

Muslim male carers felt they needed better training to be able to care for someone at home, with some financial recompense in place to offset the reduction in ability to go out and earn a living. Hindu male carers were more reluctant to ask for help as they felt that there was a cultural stigma attached to being a 'male carer'.

A key area of emerging need is that of reducing social isolation for the dependant and providing breaks for the carer. Patel (1999) noted that informal care and support through voluntary organisations was a way in which many people sought support to reduce the gap that existed in the access to services from mainstream service provision. This then allows advocacy by voluntary community organisations on behalf of the service users, enabling a potentially better package of care from the mainstream service providers.

Carers complained of limited access to information and a lack of access to information giving details of a full range of services. Though there is extensive evidence of health and social care service providers working to offset such claims, it may be that people seek particular information only at the time of need. This gives rise to a feeling of a lack of available information, and may indicate that information provided is either not accessible to those who require it or that it is not available at the time of need and place of convenience.

Other issues raised by participants in the local study are on a level with carers' issues in general such as not giving worthwhile recognition to carers (particularly family carers), a lack of culturally competent trained staff at frontline services such as Home Care, a lack of perceived co-ordination of services and referrals to appropriate specialists.

Improving uptake of services

In order to increase the uptake of services by older BME and South Asian people and their carers a number of mechanisms and processes need to be in place to enable ease of access and use of services.

National research has shown that Individual Budgets lack detail on their implementation at the frontline level (Glendinning, 2009). Coupled with this there has often been a lack of resources to implement such schemes, with some staff even resisting change (Community Care, 2005). However, now that the Personalisation 11 programme is under way developments should address some of the concerns expressed by researchers.

Local research has agreed with this to a large extent. Our respondents were of the view that whilst such schemes as Individual Budgets and personalisation of services were a good idea, they needed to be properly explained to communities. Once that has taken place and people understand how to effectively use them, there would still need to be back-up systems in place to enable services to benefit from them. Some carers who participated in the study said that though the idea was good, it would be very difficult for individuals (especially older people) to manage employing someone and for them to deal with the bureaucracy attached to it.

Being able to use a third party, such as the voluntary sector, to help manage the process could be a halfway house in enabling access to personalisation. The issue of dealing with the bureaucracy can then be left to organisations that can do this on behalf of the service users.

Though 59% of the Muslim respondents and 66.7% of the Hindu respondents felt that Individual Budgets would help increase uptake of care, only 20% of Sikhs were sure that this would be the case. People had reservations, but felt more information and training about the new way of working would help, particularly if some of the services could include household chores that many older people struggle with.

Women carers felt that the Personalisation process could be beneficial especially if it were monitored properly. This was a tactful way of suggesting decision makers in the family may not feel that the concerns of the carer or the older person were of high priority.

Given the fact that mental health, and dementia in particular, is on the increase in older people, there are some real issues in getting people to engage with service providers about the way communities can be supported. Social taboo and stigma is the cause of shying away from mental health services although evidence suggests that depression is more acceptable these days.

Respondents from all communities stated that staff with better cultural and religious sensitivity training would help improve access to services. The services themselves would need to be offered in local venues rather than in intimidating hospital

¹¹ Personalisation – is a process through which service users decide what type of services and providers they require to support their assessed needs within the individual budget allocated to them. It also describes the process by which provided services are personalised to the service users' unique requirements.

environments. Most respondents felt that the stigma attached to mental health issues would need to be tackled through education and awareness-raising events. Other local research, such as that of Sullivan (2009), argues that older BME people want a better range of mental health services.

With regards to social care in general, local research suggests that improved assessment of carers and adapting services to make them more linguistically and culturally competent would help older South Asian people make better use of them. Furthermore, survey data suggested that raising awareness of services and relocating them to local venues through the use of the voluntary and community sector would facilitate cultural sensitivity within services that would help increase uptake amongst South Asian people.

Hindu community respondents pointed out that if more BME staff were recruited they would equip service providers with a better understanding of community needs. In essence, the uptake of services requires better information and trust in the service providers.



Paying for care

Many older people and their carers have a view that care is not only expensive, but the access and usage of it is quite complicated. People who took part in our research were no different. They had a strong view that care of older people should be supported by the state. Asked why this was, respondents from all three South Asian religious communities felt that older people had worked and paid taxes during their working lives, and now that they needed services the state should provide it rather than asking people to give up what they had worked hard to create, i.e. their home, their savings, etc.

There was also an element of concern that service providers were more interested in getting their quality marks than in giving 100% attention to the genuine care needs of older people. Participants in our research felt that there was very little actual understanding of BME older people's needs. With regard to buying in services such as Home Care and day care, many respondents claimed that paying for care did not guarantee quality in delivery. Of all the people asked about payment and quality of care, only 30% of respondents (all of whom were Muslims) felt that paying for services would offer a better quality of service.

Asked about a compulsory state insurance to pay for care in old age, 78% of Muslim, 33% of Hindu and 100% of Sikh respondents felt it was not a good idea. The main reasons for this are that it does not encourage people to work and save, it does not encourage active ageing¹² and people had already contributed by paying taxes during their working life, rather than having to pay 'another tax'.

Forty-two percent of Muslim, 67% of Hindu and 33% of Sikh respondents felt they could and would use their pension to pay for care services if these are needed. The majority of Muslim and Sikh respondents felt that paying for care should be dealt with on an individual basis. Some people require care sooner, whilst others may only need it near the end of their life. 50% of the Hindu respondents said individual circumstances should dictate what needs to be paid, whilst 33% said they would prefer to pay throughout their working life. 16% of the respondents said they did not know what the best or most favourable option was, i.e. whether to pay throughout their working life or to pay a lump sum when they retire.

It was also felt important to take into account the amount of informal care the individual was getting when calculating the amount the state would charge for any additional support.

Research did indicate that in order for the topic of paying for care to be discussed, social services must challenge the negative perceptions associated with paying for care. In particular, social services must offer explanations on how care charges are arrived at, provide facilities to negotiate charges through intermediaries and allow for flexibility which prevent the charging system from discriminating against the employed and borderline groups just above thresholds.

¹² Active ageing – refers to older people being more active, independent and able to make their own decisions in later life.

Dignity in care

SCIE (2009) defines dignity as a 'state, quality or manner worthy of esteem or respect'; and cites the work of Griffin-Hessin (2005) who explains how dignity in care is influenced by a host of factors which include respect, autonomy, empowerment, self esteem, privacy, communication, choice and so on.

It is clear from the research that there is evidence of a lack of dignity for some older people. Macdonald (2001) highlights how barriers to dignity in care, especially for older people, can be grouped into three themes. These are: (1) Ageism (poor treatment, stereotyping, rationing of services), (2) Abuse (physical, verbal and psychological) and (3) Inequality, discrimination and disadvantage (lack of respect towards religious and or cultural beliefs, lack of privacy).

The findings from the NHS Bradford Teaching Hospitals (2010) research highlighted the following barriers faced by Bradford's elderly community: (1) ageism,

- (2) degrading treatment by staff, (3) lacking respect to families from diverse backgrounds, (4) lacking accountability for poor practices and (5) lacking involvement of older people in
- decision making. The research was supported by the findings of this study as participants highlighted similar concerns.

When participants were asked what they felt were the main threats to dignity in care, carers and family members felt the lack of involvement of the older person in their care management and the attitude of staff can be very detrimental to the service user. It was perceived that abuse, such as verbal, emotional as well as sometimes physical and a lack of respect for the older person by family members were the main threats to dignity. It was vital that staff also respected the dignity of older people and did not compromise on the well-being or choices for the older person.

The Sikh respondents in this research also raised issues relating to the lack of experience or knowledge held by younger (new) staff who may not know how to deal with cultural aspects relating to BME older people's care. Agencies were perceived to be on tight budgets and targets relating to outputs, which meant that the older person was seen as a number rather than a person.

The research also found that whilst there is a debate at a national level about dignity in care for all, that for older people in particular, there was a lack of awareness amongst the study participants who were everyday users about what it meant in practice. People taking part in our research felt that in order for dignity to be maintained within care several issues must be tackled beforehand. These issues include raising awareness of service users' rights, producing benchmarks for privacy and dignity within care and service provision, facilitating feedback from service users and providing full accountability for bad practice.

The Department of Health's Essence of Care (2003) report and research conducted by SCIE (2009) both mentioned recruiting BME staff into services to support communication

and cultural sensitivity, as well as trying to match service staff with service user's needs. However, feedback from the research indicates there is a need for staff to listen to service users, be more caring and show compassion in care duties. There was a need for clearer information about what was available as well as a way to monitor that the communication was effective.

Another recurring theme raised by researchers from a national perspective is that of a need to reduce social isolation. Many older people feel isolated which leads to mental health problems; it is precisely for this reason that many BME voluntary organisations have come into being (SCIE, 2009; PRIAE, 2005). Not only are they able to offer cultural understanding but they are there to address local issues for specific local communities.

Respondents in this research were able to identify these as key characteristics. Older people could be given dignity by local services tackling social isolation to enable involvement, engagement, preventative activities and self-respect. However, transport was seen as a problem area. Older people were more likely to need transport to get to venues due to complex health needs and mobility issues.

Furthermore, research highlighted the importance of autonomy in maintaining a person's dignity in care. The research introduced concepts of delegated autonomy¹³, authentic autonomy¹⁴ and geriatric consent¹⁵ which were all important in increasing the independence of service user's, maintaining their individuality and empowering them so that they had more control over the services they received.

Respondents went further to say that they needed to be apart of the decision making process with the Council, which would allow older BME people to be apart of service development planning and policy making. It was only by engaging and listening to real people that real changes could take place in service provision. Whilst service providers might argue that they are engaging and consulting communities, perhaps there is a need to review the timescales relating to revisiting community groups to offer information and to consult on care needs.



¹³ Delegated autonomy – refers to providing older people and patients with opportunities and information, which enables them to delegate some activities and decisions to care staff

¹⁴ Authentic autonomy – refers to allowing patients to make choices consistent with the person's character, in turn increasing independence and control over services they are provided with

¹⁵ Geriatric consent – refers to care staff working with people with dementiaa to take full account of their individual and personal views and preferences; by actively engaging the patient in any major decision.

Recommendations

Although issues will change over time, the findings from the literature review and primary research carried out identified several notable recommendations applicable to both short-term (five years) and longer term (20 years) care strategies to direct the development of care services for BME / South Asian older people.

- 1. Formulation of a 'Best Practice Guide' which adapts service provision along the lines of language, cultural and religious traditions: though there are similarities within South Asian communities, many differences exist when it comes to family structure, responsibilities, etc. BME or South Asian older people's needs should not be taken as requirements of a homogeneous ¹⁶ group but of heterogeneous ¹⁷ communities. This would contribute to developing trust between carers and service users and formal carers and care providers
- 2. Further development and promotion of preventative services (e.g. better information and awareness, education and training): requiring a concerted effort by health and social care sectors and others to promote services and implement strategies which try to minimise long-term illnesses common to the South Asian communities, as well as the difficulties inside the home preventing independence and wellbeing
- Acknowledgment of older people's individual preferences by undertaking better consultation with specific communities: in order to shape service provision to the needs and requirements of the individual service user and make provision accessible and welcoming. This report welcomes the Personalisation agenda
- 4. Increase awareness and educational campaigns: which tackle barriers to care, promoting services so that they directly target end service users instead of traditional gatekeepers
- 5. Safeguards and monitoring necessary to promote effective choice in Personalisation: the Personalisation of care is bringing forth a revolutionary change in how care is delivered, with the service user at the forefront in shaping care services. Older BME people want safeguards in place to prevent bad practices, discrimination and being taken advantage of by 'opportunist' carers
- 6. Better promotion of information and support for Individual Budgets: even though Individual Budgets were welcomed, many of the participants, especially older women mentioned how they preferred to be in charge of determining care provision instead of distributing actual money

¹⁶ Homogeneous – everyone is alike, with same or similar needs

¹⁷ Heterogeneous – everyone is different, with differing or diverse needs.

- 7. Ensure strong proactive partnerships between the Council and BME voluntary and community organisations across the District and in neighbourhoods, and with BME service user groups: ensure current structures and partnerships, such as those developed under the Council's Personalisation Programme's Market Development Project, are strengthened or expanded to enable BME and South Asian older people and their voluntary and community organisations, to be partners in work to identify, develop and support appropriate local and district-wide provision to meet the social care needs of these communities. Where necessary, they should develop new partnerships to support this area of development
- 8. Supplement areas of informal care with formal care where the service user meets the eligibility criteria, or signpost to VCS provision in other circumstances to improve care and independence within the home: particularly important for women carers so that care can be continued within the home
- 9. Promote and use the District's Active Citizen Framework as a method of increasing participation in community, social activities and governance: a need on the part of older people to have a greater role in the running of their local communities, bypassing traditional gatekeepers in order to promote social inclusion (and reduce social isolation) in all aspects of social life
- 10. Improve co-ordination between service providers (health, social, housing, police etc): to reduce the vulnerability of BME older people and service users and improve the overall wellbeing of older people. Better co-ordination and sharing of information between service providers to improve effectiveness of service provision
- 11. Review recruitment and training policies and practices: make them accessible to all by introducing a better recruitment and training protocol. A workforce reflecting population demographics would be more acceptable, particularly if it were culturally competent (trained) thereby having a greater impact in providing better services
- 12. Explore training and accreditation of family, neighbours and friends to provide formal support: older people may prefer service providers to train and accredit family, neighbours and other people of their own choice to care for them
- 13. Maintain an ongoing dialogue about services and developments with clients and potential service users: ensure clients and potential clients are aware of what is available, are part of the process to develop provision and are aware of their own responsibilities in relation to their care needs.

Conclusions

The research has reinforced many of the existing conceptions of care needs of the growing South Asian older communities. It also supports the growing concerns of lifestyle changes which are changing the way communities are thinking and undertaking caring responsibilities. It reinforces many of the existing arguments for better information and communication with (potential) service users and their carers. The requirement to meet individual needs through the Personalisation programme is evident from the respondents. Changing demographics and lifestyles will mean there will be more nuclear families, placing a greater pressure on the family members who remain within the extended family setting.

Whilst there are differences, such as some people wanting carers within the home to have access to accredited training, other communities are calling for better access to day and respite care services to give carers a break. Better use of Individual Budgets will enable carers and service users to buy into services they see as more appropriate to their needs, but this would also require support from external organisations (such as the Third or Voluntary Sector) to help manage the bureaucracy that comes with this.

Tackling social isolation, together with making people more aware of the services available to them, will no doubt help redress older people's sense of vulnerability and their fear of institutions.

This report therefore proposes greater communication and dialogue with existing and would-be service users, whilst acknowledging that a great deal of activity and service planning is already underway (a prime example of which is the Personalisation Programme.)

It is also the contention of this report, that if any new learning is to be disseminated then it should come in the form of the 10Ps Engagement Framework. This framework helps managers and front line staff understand what service users require in their future care services so that they are more flexible, adaptable, promoted and responsiveness to their needs:

- 1. Participation: services which contribute towards social inclusion or greater involvement in their community, and provide care and support which empowers service users and informal carers to take control of their life
- 2. Promotion: creating greater awareness of service provision, understanding most effective points of information and at the initial point of contact, promoting service user and informal carer rights and their entitlements, bypassing gatekeepers to directly target service users and informal carers
- 3. Personalisation: to create flexible services that are easily adaptable to service users' and informal carers' linguistic, cultural, religious and individual needs and preferences

- **4.** Protection: ensure safeguards and best practice guides are embedded through an independent system, which monitors care and allows and follows up complaints in order to address carers and service providers' poor practice
- 5. Performance: to undertake continuous need assessments to make sure care and support meet the needs of service users and carers, and that feedback is taken seriously and followed up
- **6.** Provision: to offer various degrees of care and support respectively to both service users and informal carers, as the need for supplementary care grows such as when informal carers become less able to offer full time care
- 7. Presence: provide opportunity for service users and informal carers to be a part of commissioning and strategic boards in order to advocate service user rights and requirements, also involving them in the development of information materials and promotional campaigns
- **8.** Partnership: implementing better integration between housing, health and social care sectors, whilst partnering with organisations for service users and informal carers in order to provide effective, efficient and credible care provision, which is easier to access and take up
- 9. Place: providing services locally and conveniently for the circumstances of service users and informal carers, using or developing tools further (Telecare, Tele-health, E-care, E-health etc) to improve the sustainable use of resources and reduce the high level of regular admissions of older people into hospitals
- **10.** Practice: offer training and best practice guides for staff and carers (formal and to some extent informal carers) to improve their adaptability and flexibility in meeting individual needs (language, cultural, religious, personal preferences) to improve and maintain a high standard of care.



Appendix 1

Methodology

There were two main sources of information utilised, and stages, in the compilation of this research reflecting local and national contexts. They were:

- 1. Literature Review: analysing both quantitative and qualitative data in order to assess lifestyle trends and patterns on both an individual and family level, in turn to gauge elderly care needs for those living under various circumstances. This study also obtained information from service providers in order to assess their current and future service provision for the BME elderly community
- 2. Primary Research (Focus Group, Questionnaires, Interviews): were utilised in order to extract both quantitative and qualitative data to gain greater direct insights into BME older people's attitudes, needs and current lifestyle patterns, and how this impacts on both short and long-term service requirements.

Sample

The initial sample this research aimed to target is described within Figure 5, which was devised in order to encompass as many different groups as possible, not only to gain insights into the realities of sub-groups within the South Asian community; but also to develop a well informed short and long-term strategy that was comprehensive enough to satiate current and future older people's care needs. Therefore, the sample best suited to the aims of the research was made along the lines of religion, ethnicity and age. The sample also included the participation of service providers from both local authority and BME voluntary organisations, in order to give a more rounded insight into the needs of BME older people.

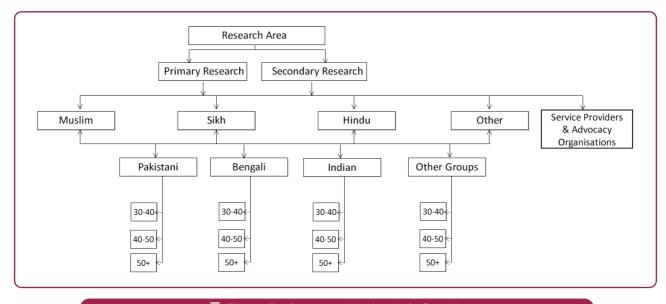


Figure 5 – Demographic Analysis Sample

Figure 6 details the sample utilised for both the surveys and focus groups, which was comprised mainly of a wide cross-section of South Asian people with Eastern Europeans and other BME groups comprising a smaller share. The sample we utilised was a combination of middle aged people to older/ retired people who were in one way or another providing or receiving care within their families or with formal care providers.

Sample Group	Male	Female	30-40	40-50	50 +	Total
1. Muslims	13	21	10	5	19	34
a. Bangladeshi	5	4	1	1	7	9
b. Indian	2	3	2	0	3	5
c. Pakistanis	6	10	5	3	8	16
d. Other	0	4	2	1	1	4
2. Hindus	3	4	2	0	5	7
a. Bangladeshis	1	1	1	0	1	2
b. Indians	2	3	1	0	4	5
3. Sikhs	2	4	1	2	3	6
4. Other	2	2	2	0	2	4
5. Sample for Focus Groups	27	26	4	11	38	53
Total (by sub-group)	47	57	19	18	67	104

■ Figure 6 – Survey sample plus breakdown of focus group sample

We utilised the following organisations and user groups in conducting our focus groups:

- **1. Girlington Elderly Association:** over 50 males from mixed religious and ethnic backgrounds
- **2. Saheili:** over 30 females from a mix of South Asian cultural and religious backgrounds
- 3. Meeri Yadain: mix of South Asian participants of various ages
- **4. Sangat**: focus groups comprised predominantly Pakistani males and females of 30 years and above
- **5. BEEP:** predominantly Bangladeshi Muslims of 30 years and above
- 6. Grange Interlink: Guaiarati Muslim, Hindus and Sikhs of 30 years and above
- 7. Eastern European focus group: held at Girlington Community Centre.

Appendix 2

Gaps in research

A number of gaps were identified during the course of this research:

- 1. Best practice guides/service standards to adapt mainstream services for BME older people and to investigate the most effective and efficient service processes and provision for BME older people
- 2. Evaluation of older refugees' care needs: research nationally and locally is sparse in identifying the barriers, level of service provision and issues refugees have to face in accessing both health and social care
- 3. Evaluation of effective detection of, and preventative measures for physical and mental health within the BME and South Asian older communities in the UK
- 4. Most data and studies carried out on a local basis which prevents credible comparison studies taking place: available literature and this report tend to focus on Indian, Bangladeshi, Pakistani and Caribbean communities but sample sizes are often small and only done on a local basis, which makes it difficult to conduct comparison studies with real in-depth analysis
- **5**. A greater body of research is required to highlight the differences between ethnic groups
- Research regarding effectiveness and process of referrals for BME older people: where studies mention services, there is little detail on the referral system, access to and effectiveness of services. (SCIE, 2008)
- 7. Research which evaluates the effectiveness of BME older people's services: the effectiveness of general or specific services for BME older people has not been the subject of any thorough investigation in any of the studies highlighted within this report
- 8. Further research on A8 / Eastern European Migrants: little is known about either the overall scale of such migration (i.e. including those who did not register) or what proportion are staying long-term, and the needs of their older people
- 9. Understanding of power dynamics in South Asian communities on a personal and family level, but also on a community level as mentioned in this report, highlighting a range of factors such as where older people receive care and how BME voluntary organisations attain funding and support to help deliver services

- 10. Statistical data and empirical research which details the life course of South Asians: further research is required adopting a life course approach to highlight how BME and South Asian people are affected by health issues, charting their health by age and gender. This will allow better comparison studies and help identify the cumulative effects of various issues
- 11. Further research which investigates why under-usage of services still exists: though this report focused on understanding how to improve uptake of services by BME and South Asian older people, we only touched upon the barriers that prevented them from taking up health and social care services. Further research on a national basis should investigate why BME older people under-use services targeted at them
- 12. Research on assessing the gender roles of South Asian males: we need research which is more balanced in its understanding of gender roles played within the South Asian community in order to allow for more effective and comprehensive studies to take place.



Appendix 3

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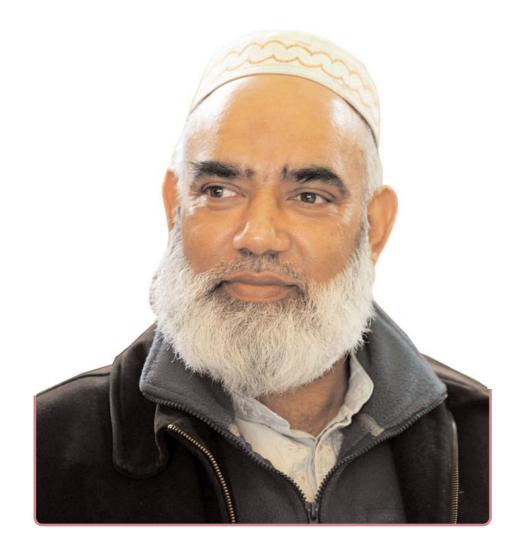
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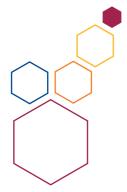
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Design:
Communications Team,
Department of Adult & Community Services