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Out of the frame

To be elderly and black is to be doubly disadvantaged in accessing culturally appropriate services. Alicia Clegg reports

- **The Guardian, Wednesday 3 September 2003**

It is lunchtime, and Steve Crawford is halfway through his delivery. He pulls up outside a terraced house in Chapeltown, Leeds. Someone inside fumbles with a key and an elderly resident appears. "Is it any good, Steve?" she asks. Crawford consults the menu. "Chicken, rice, fried plantain and gungo peas. Will that do you?" The woman jokingly replies: "I'll let you off!" He sets down the foil trays, declines her offer of a glass of sherry, and heads off towards his next client in Harehills.

Crawford coordinates a Caribbean meals-on-wheels service run by Leeds Black Elders Association (LBEA) and the New Testament Church of God, with funding from Leeds social services and health authority. "It's a lifeline," says Crawford. "Before we began, people were paying £5 for Caribbean takeaways because they couldn't handle the standard food. Now they pay £1.70 for something they enjoy."

Wesley Grant, director of LBEA, is optimistic that the Caribbean scheme will be continued when it comes up for review. However, he is frustrated that it is only after six years of "banging on doors" that his clients are able to access a service so vital to them. "You can't expect an elderly person to change how they've eaten all their life," he says. "There are a lot of personal care issues that mainstream services don't cater for."

However, black minority ethnic (BME) organisations unintentionally bolster the view, already widespread among local authorities, that the needs of BME older people are catered for by their own communities.

By default rather than design, BME organisations began shouldering the responsibilities of statutory service providers - but without the capacity to replicate the full range of their facilities. In this sense, argues Naina Patel, director of the Policy Research Institute for Ageing and Ethnicity (PRIAE), BME communities have been doubly penalised - by not having access to culturally appropriate support via mainstream agencies and by being denied the core funding to develop their own services to mainstream standards.

Patel's view that BME pensioners are "the most disadvantaged members of an already disadvantaged group" (older people in general) is apparently shared by the Department of Health (DoH). The national service framework for older people, which aims to eradicate age discrimination, acknowledges that black and minority ethnic elders are likely to suffer more discrimination in accessing services than other elderly people.

"If you come from an ethnic minority that is dwarfed by a larger minority community you get overlooked," says Margaret John, the co-founder of the North East of England African Community Association, which is negotiating with Newcastle social services to part-fund its care work with older people. "It shouldn't be about numbers," she adds. "We are all human beings with needs."

So how can health and social services providers make progress on this issue? A central part of the DoH's thinking is for authorities to move beyond ad hoc arrangements to ones in which the needs of minority groups form part of mainstream service development.

Andrea Biggs, an ethnic health service manager at Pennine acute hospitals NHS trust, has worked in Oldham, where the development of services for minorities was integrated into mainstream procedures long before the idea was promoted centrally. "It's about reflecting people's cultural needs in service design right from the outset, and ensuring that essential support, such as access to interpreters, isn't dependent on short-term project finance," she says.

A more integrated approach encourages agencies to collaborate, allowing the costs of service provision to be shared. An example of this is seen in Oldham, where Asian language speakers from Biggs's hospital-based team spend 30 hours a week supporting GPs at a health centre. Another team member works full time in the community, helping to maintain elderly people from minority ethnic backgrounds in their own homes. The post is funded by the primary care trust and managed by a partnership board of local statutory and voluntary agencies.

Nevertheless, some observers worry that the DoH's drive to mainstream services could spell trouble for BME voluntary organisations, unless it is implemented skilfully. Patel is concerned that local authorities may misinterpret mainstreaming as a mandate to subsume BME services into "multi-cultural" facilities run by themselves or an independent provider, such as a national charity. The risk is that these broadly based centres may fail to reflect the crucial differences between diverse ethnic and religious groups.

Abdul Rouf, services development manager at Bradford social services, shares these worries and criticises the tendency of councils to regard the BME voluntary sector negatively. "There's a myth that BME organisations cannot fulfil regulatory requirements, so many authorities prefer working with commercial providers or age-related charities." However, he says, elderly men and women in ethnic communities would often rather have the services developed by ethnically-based organisations that have come up through their own communities.

So what is the solution, given the tension that exists between the users' preferences for community led programmes and the concern of councils to safeguard quality control?

Perhaps the way forward is for statutory providers to engage more constructively with BME organisations, by making a contribution to their core costs and providing help with management training, where needed. As Rouf says: "We have a responsibility to develop the professionalism of BME organisations." Fulfilling that obligation demands far more investment on the part of local authorities. The payback is that the elderly people concerned will finally gain access to the services they need.

Skills exchange

Bradford has one of the largest ethnic minority populations in Britain. Many of the day care services available to these communities are purchased from BME voluntary organisations.

Although extremely knowledgeable about local needs, many BME organisations initially lack management skills and proper administrations. In such situations, Bradford's policy is to work with the organisation for a trial period of six to 12 months. The organisation receives "pump-priming" investment and training and support in areas of weakness, such as regulatory compliance. At the end of the period qualifying organisations move to a three-year contract, sometimes receiving a further grant award to assist with day-to-day running costs.

Working in this way has enabled Bradford to supplement the care it provides in-house with a network of 22 BME voluntary providers. These include seven organisations supplying day care to different ethnic and religious groups within the South Asian community. A key aim for the future is to expand the range of culturally appropriate services available to smaller ethnic groups.

"Commissioning BME organisations allows us to adapt our services in the ways that matter most to the users - for example, by making separate social provision for men and women [important in some cultures] or simply enabling people who share a common language and culture to get together," says Bradford's services development manager, Abdul Rouf.