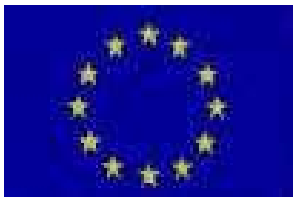

SEEM (Phase I)

Personal Social Services for Elders from Black and Minority Ethnic Groups in Leeds (Great Britain), Lille (France), Dortmund (Germany) and Gothenburg (Sweden)

Summary of the Final Report

December 2003

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Contents Page

I. Background and Introduction

1.1. In many European countries the development and delivery of personal social services for minority ethnic elders have become important social and political issues. The formerly ‘national’ European countries of the 1950s have changed to migration societies whose economic, cultural and social spheres are increasingly influenced by population groups who have immigrated.

1.2. The total number of elders from these minority ethnic groups are still small today, but they will increase rapidly within the next twenty years.

1.3. There are special challenges for the prevailing systems of community care. Although the care needs of all elders result from universal biological ageing processes, black and minority ethnic elders also have specific needs resulting from their prevailing legal, cultural, ethnic, religious and linguistic backgrounds.

1.4. Elders from minority ethnic communities are identified by numerous sources as being particularly at risk from social exclusion and poverty. Across Europe, older black and minority ethnic people, from a wide and diverse range of cultures and backgrounds, are more likely to be socially excluded than indigenous elders and also face additional discrimination. This is especially so in relation to income, housing, health and access to services.

1.5. To combat these risks, minority ethnic elders require a range of appropriate, good quality services. These services are of all kinds, ranging from creating possibilities for continued independent living and social participation, to providing special health and social care services for much older people.

1.6. Because the term ‘black and minority ethnic (BME) groups’ appears to the majority of SEEM participants to be more inclusive than the term ‘immigrant’ DOES, it is in general used in the report to describe those people who are not indigenous to the respective countries. However, when speaking of a certain country, the respective ‘national’ terms are used.

2. The SEEM Project

2.1. Within the last ten years some European countries have begun to develop and provide social services for BME elders. However, up to now there has been hardly any exchange of good practice between different European countries in this area of work.

2.2. Against this background, and led by Leeds City Council, the project ***Services for Elders from Ethnic Minorities*** **(SEEM)** was set up. It is a European funded project[1] for four cities to exchange good practice in promoting social inclusion for elders from black and minority ethnic communities.

2.3. The project comprises seven partner organisations which are Leeds City Council, (United Kingdom), Leeds Older People's Forum (United Kingdom), Ville de Lille (France), Stadt Dortmund (Germany), Forschungsgesellschaft fuer Gerontologie e.V. (Dortmund, Germany), Verein fuer Internationale Freundschaften (Dortmund, Germany) and SDF Gunnared – Elderly Services (Gothenburg, Sweden).

2.4. The aims of SEEM 1 have been to:

- build good partnerships
- involve BME elders and their organisations
- exchange good practice
- produce and disseminate policy recommendations
- raise awareness of this important issue in the partner cities and at a European level.

[1] The project has received funding from the European Commission from December 31st 02 to September 30th 03 within the framework of programmes and actions in the social and employment sectors.

2.5. Within the project two partnership meetings took place in Dortmund (March 5th-7th 2003) and Leeds (April 30th – May 2nd 2003) where the partners presented and exchanged background information and visited and discussed existing models of good practice. Additionally, each city wrote a background and a recommendation report and held a dissemination seminar at the end of the project. The city of Leeds produced a webpage (www.leeds.gov.uk/seem) and a flyer for the project, which is available in English, German, Swedish and French. Also, the project was presented at the fifth European Congress on Geriatrics and Gerontology in Barcelona, Spain (July 2003).

2.6. The SEEM Final Report is available in full on the SEEM website. It describes the groups and migration histories of BME elders in all four cities, their life circumstances and important social-political and legal aspects. It draws together existing experiences in the field of personal social services for BME elders, identifies models of good practice, analyses the conclusions of the different local projects and gives the recommendations (as provided in this summary below) for further strategies for action on different political levels.

3. SEEM Principles

3.1. Against the background of national differences outlined below, it is not possible simply to transfer solutions or models of good practice from one country to another. However, there are certain principals that offer the framework for developing and improving health and social care for BME elders that all project partners agreed upon during their second SEEM meeting in Leeds. These are:

- **Respect** for the individual. With this as the basis for any service delivery, then ethnic or cultural needs, such as specific food or religious requirements, would automatically be taken into account.

- **Involvement:** as a natural part of respecting the individual, service users, in this case BME elders, need to be asked about what they want and need, and to be involved in planning their own care.

- **Equality:** all service users should have the same rights and possibilities to access whichever services they need.

- **User Empowerment:** social care providers are increasingly aware that providing and using services is a two-way process. Information on services needs to be appropriate. It has to be ensured that the whole process involved in getting a service is completely understood by the person receiving that service. BME elders have to be given good quality information so that they can decide which services they want, when, and how, and so they can remain in control of their lives.

- **Consultation:** this includes consulting BME elders' organisations, as well as elders themselves through a variety of consultation methods. This consultation needs to be the basis for planning, improving and developing services.

- **Collaboration and Partnership:** better collaboration and partnership between the different actors involved is urgently needed. It is necessary to build co-operation and collaboration in a variety of ways between the BME organisations, the different service providers, and elders themselves. The partners and the mechanisms for this collaboration differ between the cities and countries involved in the SEEM project.

- **'Active Citizenship':** this principle refers to the broader involvement of BME communities in the political and cultural life of their city. Again, the SEEM partner cities have very different situations and possibilities, according to the nationality and status of their BME communities.

3.2. **And underpinning these principles** it has been agreed that there is a need to:

- Strengthen self help
- Actively support BME voluntary organisations
- Evaluate existing services and how they meet the needs of BME elders
- Create sustainable strategies to provide ongoing services for BME elders

3.3. Some of these principles and terms have different meanings and implications in the different countries, so therefore the practical application of the principles may vary between the four cities. However, the principles form the basis for SEEM Phase II, within which there will be a focus on a mutual exchange of experiences.

4. Elders from Black and Minority Ethnic Groups in Leeds (United Kingdom), Lille (France), Dortmund (Germany) and Gothenburg (Sweden)

4.1. Migration Histories

The European countries in SEEM are characterised by clear differences in their migration history, demographic features and specific socio-political and cultural development:

- The **United Kingdom (UK) and France** are strongly influenced by their colonial past which has put a stamp on their current population mix and migration policy.

- **Sweden**, which also has a history of emigration, was the first Nordic country to become a country of net immigration. During the 1950s and the

1960s the migration flow consisted mainly of migrant workers but from the end of 1980s on, the influx of migrants was dominated by refugees and asylum seekers.

- **Germany** found itself as an importer of 'guest workers' from south-eastern Europe after World War II. (They were needed to enlarge the workforce during the post-war economic boom. Initially these workers were expected to return to their original countries and so they were considered as 'guests').

- These different backgrounds are also reflected in the respective collective perceptions of 'migration'.

Although linked to different migration histories, all four countries are characterised by increasing processes of immigration after World War II:

- **The UK** experienced immigration from the New Commonwealth (especially the Caribbean Islands, India, Pakistan and Bangladesh). These were people who were already subjects of the British Crown being 'invited' to work in the 'mother country'.

- Until the beginning of the 1950s, the situation in **Germany** was dominated by large numbers of refugees who mostly came from the former Eastern parts of the German Reich and the Sudetenland and people from the Russian occupation zone and then the new German Democratic Republic. From the mid 1950s on, Germany recruited 'guest workers' from South East Europe, North Africa and Turkey. In the 1990s, Germany received refugees from Yugoslavia, asylum seekers, and so called 'late emigrants' of German origin from the former Soviet Union territories.

- **France** had already become a country characterised by immigration at the end of the 19th century when it recruited workers from neighbouring countries (especially Italy and Poland). In the 1960s there was a decline of immigration from Italy but an increase from Portugal, Spain, Morocco, Tunisia, Algeria and Sub-Saharan Africa.

- From the 1950s on, **Sweden** had an influx of migrant workers and this was replaced by refugees and asylum seekers from all over the world from the 1980s on.

4.2. National Populations and Black and Minority Ethnic Groups

- In **England**, black and minority ethnic groups make up about 13% of the total population.

- In **Germany**, 'foreign' people comprise about 9% of the population, although the total share of people with a migration background (including for instance late emigrants and naturalised people) is higher.

- In **France**, the share of immigrants (both 'foreigners' and naturalised people) is about 7.4%.

- In **Sweden**, BME groups make up about 2% cent of the total population.

4.3. Black and Minority Ethnic Elders in the Partner Cities

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- In **Leeds**, there are at least 9,167 BME elders aged 60 years and above. The biggest groups are Indian, Irish, Black-Caribbean, Pakistani, Kashmiri, Jewish and Chinese. Smaller groups include Arab, Black-African, Bangladeshi, and Vietnamese elders, and Gypsies and Travellers.

- In **Dortmund**, there are about 10,300 so-called 'foreigners' aged 55 years and above of which around 70% originate from former recruitment countries. Within the different nationalities, the Turkish community has the highest numbers of elders, followed by elders from the former Yugoslavia, the former Soviet Union, Greece, Italy, Spain, Poland, Morocco and Portugal.

- In **Lille**, there are about 3,000 immigrant elders aged 60 and above (1,755 'foreign' elders and 1,243 elders who have acquired French nationality). The biggest groups of older immigrants are Algerian, Moroccan, Austrian, Finnish, Swedish, Italian, or of other European nationalities.

- In **Gothenburg**, there are about 19,450 BME elders aged 55 years and above. The biggest groups are from Finland, Denmark and Norway, former Yugoslavia, Germany, Poland, Iran, Hungary, Estonia and Turkey, or from 'other countries' (5029).

4.4. The Types of Welfare State

The four countries involved in the project represent different types of welfare state. Although all have the same issues to confront, their different cultures and traditions have led to a variety of approaches for providing for people in need.

- The **UK** is a 'hybrid form' of welfare state. On the one side, elements such as self help have always played a crucial role and on the other side social security benefits provide income at a very basic level. The system of social security is universal. Universality, comprehensiveness and appropriateness are the underpinning principles.

- **Germany** is the prototype of the 'conservative' welfare state and was one of the first countries to develop and implement a social security system in the 19th century. The social security system is focused on the working population. It is dominated by the principle of insurance and has the five pillars of old age pension, health, accident, unemployment and long-term care insurance. Leading principles are freedom, equality and solidarity, social fairness and subsidiarity, (the latter meaning that society should only help when people are no longer able to help them selves).

- The **French** model of welfare state is often described as a 'weakened conservative' one. In the tradition of individualism and liberalism, the introduction of a social security system took place relatively late in the

1930s. Compared to the German model, the French has less elements of the insurance and more elements of the welfare principle. The French welfare system is very complex and divided into different sectors and subsystems that cover different population groups.

- **Sweden** is the prototype of the modern welfare state or the 'classic social-democratic' welfare state. In the 1930s, traditional welfare for the poor was replaced by a social policy based on the ideals of the social-democratic party. Its underlying principles are equality, consideration, co-operation and assistance and it aims at solidarity to reduce competition and social injustice. The welfare system covers the entire population. A central element of the Swedish system of social security is a universal, non-contribution, minimum state pension.

4.5. Legal Status of 'Immigrants' and Minority Ethnic Groups

How far BME groups are excluded or included in the prevailing social security system is largely dependent on their legal status. In general, when people have citizenship in the respective country, they have full political and social rights and are entitled to the whole spectrum of welfare services.

- The legal status of people from BME groups is best in the **UK** where the majority are UK citizens.

- In **Germany**, most people from BME groups are 'foreigners' and thus only have very limited political rights. However, so called late emigrants have the advantage of being regarded as German citizens. The proportion of naturalised people is not very high. (You can apply for German citizenship after eight years, but in gaining it you will have to relinquish your original citizenship).

- In **France**, there is a bigger group of naturalised people from BME groups (about 2.4 million). Still, there are about 3.3 million 'foreigners' with very limited political rights.

- In **Sweden**, most immigrated people are naturalised, (for example, 76% of the elders born abroad are naturalised Swedes).

5. Services for Elders

5.1. In all four SEEM countries there is a distinction between the provision of health and of social care services for elders and this often leads to problems in co-ordination and provision.

- In the **UK**, 'community care' for elders aims at securing an independent and self-determined life in freedom and dignity. Services at home rather than in institutions are preferred. Compared to Germany, home based services are a lot more widespread. However, there is a mix of residential and nursing care homes for people assessed as no longer able to live at home. These 'packages of care' are paid for by the individual, the local authority, and the national government. Although legislation in Great Britain aims at including commissioning of services from the private and voluntary sector, the public sector is still the biggest provider of personal social services for elders.

- In **Germany,** social services for elders also cover a broad spectrum. As in the UK, services aim at securing an independent and self-determined life in freedom and dignity. Within social services for elders there is generally a distinction between so called 'open' community care services providing opportunities for leisure and culture; outpatient services (services at home); inpatient services (institutional care); and a combination of inpatient and outpatient services (intermediate care). Due to the principle of subsidiarity, outpatient services enjoy priority over services in institutions. Services for ill elders (health care) and elders in need of care are provided by the health care system and the long term care system for which the federal level is responsible. Both are financed by health insurance and long term care insurance. Health care is mainly provided by the private sector such as general practitioners and hospitals. Long term institutional care is provided by nursing homes (mainly run by charitable associations) and long term outpatient care by private outpatient services and outpatient services run

by the charitable associations. Most social services in Germany are based on the welfare state principle and are financed through taxes. In terms of elders' community care, voluntary organisations have a limited role compared to public providers except for services which are covered by long term care insurance. Thus, the charitable associations, as providers of community care for elders, play a predominant role. Compared to other European countries, the extent and role of the German charitable associations is unique. They do not only offer community care services for all age groups but also offer advice services for people from ethnic minority groups (so called Migrationsberatungsstellen).

- **France** has a great variety of services, help and institutions for elders, especially for home based and institutional services. Intermediate care is not that widespread. In France, too, older people have the possibility to stay at home as long as possible. There are several services assisting elders at home: home helps, home care services, day centres and council-run social programme centres. Apart from living at home, elders can obtain support and care in communal housing, retirement homes and long-term care units.

- **Sweden** also aims at giving elder people opportunities to live an independent life at home for as long as possible. The range of services is broad, including residential homes for the very old and home help services that have been expanded from the 1960s and now benefit some 300,000 pensioners. There are municipal pensioners' dwellings, which are an intermediate form of housing care based on a high degree of self-help.

6. Approaches and Models of Good Practice in the Partner Cities

6.1. Because of the different legal and political frameworks and political cultures, approaches and models of good practice differ in the four cities analysed, as does the degree of awareness and the extent of progress.

6.2. Leeds

In Leeds, the needs of BME elders are included in the planning documents of the City Council and the health organisations. National anti-discrimination legislation requires that all services have race equality performance indicators: government inspections at all levels must report on measures and progress for the delivery of services to BME people.

Following the strategy of the UK's Commission for Racial Equality, Leeds aims to ensure all services respond to the needs of BME elders and at the same time provide a range of specialist or separate services that concentrate on the needs of specific BME groups.

- Within the 35 neighbourhood network schemes offering services such as home support visits and befriending, advice and information or social activities, there are 12 schemes that specifically target the needs of BME elders.

- Social Services funds two BME home care meals pilot schemes, aimed at providing housebound African-Caribbean and Kashmiri elders with the possibility of a culturally suitable meals delivery service.

- Provision for BME carers is built into the Leeds Carers Strategy.

- There are two social services day centres specifically catering for BME elders (the *Frederick Hurdle Day Centre* and the *Apna Day Centre*)

- There is one voluntary sector residential home particularly for African-Caribbean elders (which is now beginning to offer short-term respite care).

- To improve sheltered housing for BME elders, a development post was set up in the Councils' Housing Department. A home improvement agency (*Leeds Care and Repair*) assists low income owners (particularly elders and people from BME communities) to repair, improve and adapt their homes.

- In relation to consultation and involvement, there are a number of organisations in place that lobby for the needs of BME elders, within their work with elders generally (for instance *Leeds Older People's Forum, Leeds Involvement Project*).
- At the moment ,work is underway to build effective information systems for BME elders to ensure that they are aware of, and have access to appropriate services and benefits.

It has to be mentioned that in general and compared to many British cities, Leeds has a very strong voluntary sector that is actively and financially supported by the local authority. Leeds also has a comparatively strong BME voluntary sector.

6.3. Dortmund

Compared to other German cities Dortmund has started quite early (in the beginning of the 1990s) to look at the specific needs of 'foreign' elders. In Dortmund, community care also aims at improving the quality of life of BME elders. A recent study in Dortmund analysed how far existing services around 'open' community care still meet the needs of elders and what has to be done to adapt services to changing needs. In relation to BME elders specifically the study concludes that municipal efforts should be strengthened to integrate BME groups and to develop adequate services in the fields of open community and outpatient care.

The following approaches focus on BME elders:

- The city funded a day care centre with special and separate services for BME elders on separate days. The funding has been reduced, but the day centre still exists as a model of good practice and is now organised by the 'Association for International Friendship' *(Verein für Internationale Freundschaften*)

- In 1996, at the request of the Immigrant Advisory Council, the city installed grave plots for Moslems in the municipal cemetery.

- The city of Dortmund has developed special Islamic prayer rooms in municipal hospitals.

- Almost all of the *Wohlfahrtsverbände* (charitable associations) in Dortmund have taken special measures to open their mainstream services for elders from BME communities (for instance offering special advice services, employing more staff of matching origin, providing translated information).

- The *Jüdische Kultusgemeinde* (Jewish community organisation) offers a range of services for their members and has a day centre five days a week. Some of the services are focused specifically on Jewish elders.

- There are two minority ethnic self-help organisations which focus exclusively on immigrant elders.

- There are also many other self-help organisations that do not exclusively offer services for their elders, but take care of their needs generally. For instance, more than half the members of Islamic mosque associations are 60 years and over and for them these associations have the function of day care centres.

- A private outpatient health care service developed in May 2000 focuses especially on older people from ethnic minority groups.

Compared to the situation in Leeds, there is a lack of consultation policies regarding BME groups in general, a strong competition between the different voluntary sector groups, a lack of political influence of BME groups, and less special information and advice about existing services.

6.4. Lille

The city of Lille has a local charter to fight discrimination. Within its approach of a co-ordinated policy for elders it has a special working group focusing on the needs of elders of foreign origin. Recently, the city has initiated several

projects to help cultures meet each other, to organise information campaigns between generations and to adopt a personal approach in assisting older people. These are:

- Information campaigns about retirement organised on people's doorsteps, notably through involving retired people of foreign origin who often have difficulty in getting about and getting involved.

- Information distributed on the arrival of the Euro through the migrant workers' hostels.

- An association set up with the help of the city's 'specialist team' to cater for men of North-African origin.

- A third-age club called '*Franco-Polish exchange and discussion'* offering Polish music and traditional songs, fashion and recipes.

- A 'Muslim square' in one of the city's cemeteries, in which the customs of Islamic burial are respected.

- A meeting organised between older people of European and North-African origin in a retirement home in the district of 'les Camanettes'.

- A meal organised by an association promoting integration in a South-Lille district which has a high density of people from North Africa. The objective was to promote their cultural and culinary tradition.

In recent years, Lille has made a tentative approach to tackling the issues of elders of foreign origin, and now with the support of SEEM there is the intention to co-ordinate and develop the work of the different providers and to strengthen effective models of service.

6.5. Gothenburg / Gunnared

Due partly to its focus on offering person-centred services, and the small numbers of elders in each of the many different minority ethnic groups, Gothenburg's experience in developing and providing social services specifically for BME elders is limited and it wishes to learn from the other cities in the SEEM project.
Examples of best practice consist of four activities delivering services for BME elders in Gunnared (one of the 16 districts of Gothenburg):

- *Ilta Tähti - Aftonstjärnan (The Evening Star),* a day-centre for Finnish elders. It was set up in 1994 and has about 200 members. Aftonstjärnan is open Monday- Friday, 9-3.

- *Oliven (The Olive),* a meeting point for older immigrants providing information and network services.

- *Hälsodisken (Health Information Center) in Gårdsten,* an information centre set up to promote health. Five "Culture-interpreters" provide services in Arabic, Kurdish, Persian, Somali, Cantonese, Mandarin, Serbian, Croatian and Bosnian.

- *Finnish group dwelling "Rauhala"* which is integrated into a bigger "old people's home". The staff speak Finnish. Finnish food and cultural and leisure activities are offered.

Gunnared has been developing approaches on a small scale, and this has been relatively difficult due to the small number of older people in each minortiy ethnic group.

6.6. Strategies to Open up and Develop Appropriate Services for BME Elders

To summarise, the following strategies are being applied across the four cities to open up and develop appropriate social services for BME elders:

- **'Outreach'social work,** getting in touch with BME elders at their community centres and not waiting for them to come to mainstream service providers**.**

- **Information for BME elders,** making sure that BME elders are informed about existing social services.

- **Translation and interpretation services,** providing professional translation and interpretation services for BME elders when offering social or health services.

- **Advocacy:** actively supporting BME elders to express their needs and demands to health and social care providers. Not speaking for them but helping them to speak for themselves.

- **Conducting studies and working with universities:** using universities and other specialist consultants to conduct studies on the life situation on BME elders, their needs and demands.

- **Evaluation of existing services,** to see how far they meet the needs of all elders and especially BME elders.

- **Recruitment of BME staff,** to try to match the composition of the health and social care workforce to that of local BME communities.

- **Monitoring the ethnicity of staff and of service users** to become aware of demands and gaps.

- **Development work with BME organisations,** giving support to BME groups to strengthen self help potential, to give advice, information and support.

- **Cultural awareness training** for all care staff, on different cultures and on how to ensure that services are delivered in a culturally appropriate way.

7. The Way Forward – Recommendations

7.1. For the same reasons that it is not possible to transfer *solutions* from one country to another, it is also difficult to address the *issues* at the level of individual governments.

7.2. However, SEEM partners have agreed on a number of recommendations which address different levels of policy and service delivery and which are more abstract and general than the particular approaches in each of the cities.

7.3. Recommendations are aimed not at the level of national governments, but at a practical (commissioning and provision) level and at the overarching level of the EU.

Planning and Commissioning Services for Elders at a Local Level

- **In planning services:**

  - **Make sure the specific needs of BME elders are addressed** in the local planning documents for elders' health and social care, bearing in mind that different BME groups are themselves very diverse and have different needs

  - **Ensure BME elders are effectively involved and consulted** in planning and development of their services

  - **Improve links to and partnerships with** local BME communities and their organisations

  - **Commission research** regarding the needs of BME elders

  - **Co-operate with other service providers** to make sure the needs of BME elders are met

  - **Be open and committed to changing** existing policies, procedures and conventions, in order to accommodate different ways of working and different needs

  - **Be flexible**, to balance being experimental with understanding and responding to practical needs

  - **Evaluate** services and set clear targets that are regularly monitored

  - **Monitor** ethnicity of staff and service users

- **In planning and providing services, address the issues of:**
  - **Social isolation**
  - **Low income levels**
  - **Community safety - racist harassment and fear of crime**
  - **Accessible and affordable transport**
- **Provide access to culturally appropriate health and social care by:**
  - **Supporting and developing the infrastructure of the BME voluntary sector** to enable organisations to become sustainable providers
  - **Providing appropriate information** on services for BME elders, their families and carers
  - **Stimulating uptake, knowledge and information** through a range of outreach and other mechanisms which utilise formal and informal networks
  - Provide access to information, support and respite care for **BME carers**
  - Ensuring the availability of **suitable, affordable, warm and safe housing** within or near an elder's own community
  - Ensuring the availability of **appropriate residential nursing care and respite care**
  - Providing support services for BME **carers**.
- **In terms of health and social care staff:**
  - Provide **education and training for care staff** on the cultures and needs of BME elders
  - **Develop clear career paths,** development opportunities and additional support for BME staff.

Recommendations Regarding the European Union

- Continue to address the topic of BME elders
- Enable further exchanges of good practice between member states
- Enable further exchanges between academic and research organisations
- Enable further exchanges between service providers
- Commission international comparative studies
- Publish recommendations for member states

Monitor the EU guideline concerning equal opportunities regardless of race or ethnic origin (guideline 2000/43/EC of the Council from 29.6.2000, article 3c).

Please note

A list of the sources used for the SEEM Final Report is included in Dr Vera Gerling's SEEM (Phase 1) Final Report which is available at www.leeds.gov.uk/seem