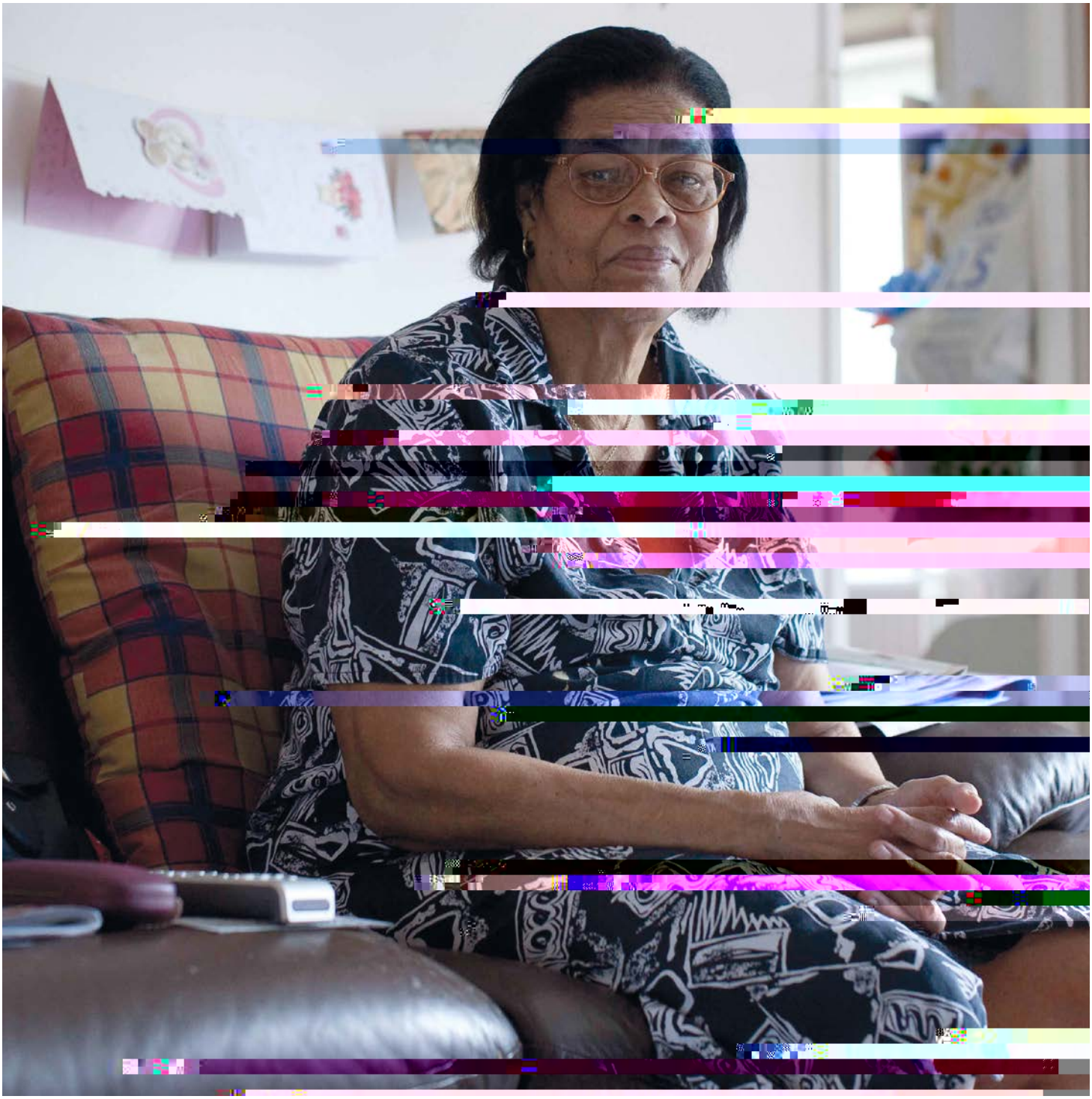

A **A**

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This small exploratory study took an audit approach and investigated current practice and policy by interviewing respondents from 11 Housing Associations (HAs) providing sheltered housing and extra–care support that are already serving tenants or lease holders with dementia from different ethnic backgrounds and received information from 15 more. A cross-section of HAs was identified to seek views and experiences of 1) generalist HAs providing for the whole community, 2) specialist HAs established primarily to meet the needs of specific minority ethnic groups (though now providing housing for people from the whole community), and 3) differently-sized HAs in different parts of the UK. Table 1 summarises the type and range of organisations selected for interview (undertaken in Spring 2015). The HAs were identified through a search of the internet and through interviews with experts and practitioners in the three related, sometimes overlapping, fields of housing, dementia care, and care for black and minority ethnic older people.

Some generalist HAs provide specific supported living or home care schemes for minority groups adding to their portfolio of services beyond the provision of accommodation. Others offer both private (owner occupied or leasehold) and social housing (rented by tenants). The material used here relates solely to the social housing parts of their operations but could be transferable. Visits were also made to two HA sheltered units in London. We were not able to include accounts of end users' (tenants') perspectives – this would be a useful area of future study, as would the opinions of family members.

However, details of over 100 HAs were explored, using internet search of HAs and bodies representing HAs specialising in services for ethnic minority groups to inform the sample of HAs contacted. The illustrative examples provided in this report were drawn from England and Scotland.

Exploratory conversations were held with over 20 HAs, of whom ten were finally identified who met the criteria and who brought relevant comments and experiences to the study, and one further HA was included as it brought another perspective. We are grateful to all respondents for their interest and time – more than one person was spoken to in many of the HAs – at head office and service levels.

In this report we use the term tenant (rather than customer or resident which are sometimes used). We refer to housing units to reflect the many forms of accommodation provided by HAs. The term ‘Extra-care housing’ is used to refer to accessible self-contained apartments/flats with options to rent or buy on a shared ownership basis and where social care can be provided as an ‘extra’ service to tenants. ‘Sheltered housing’ is used to mean purpose built or adapted housing, with access to an alarm or warden system. We use the term ‘black and minority ethnic’ to refer to people from different ethnic groups other than White British (others may use terms such as black, Asian and ethnic minorities). We use the term older people although some respondents use the term ‘elder’. We did not restrict ‘older people’ to any specific age group but in the main respondents referred to older people as being aged over 60 years. Finally, in speaking of dementia we mean the general term referring to syndromes covering loss of abilities, such as abilities to self-care and memory problems, associated with cognitive impairment, sometan pH40(l)11.72.1(a)51yB1.81(a),S4g73(f)18.2(e)6(rr)17.sul(rm t(r)16.3(o)3.6(m d)10.5(i)6.8(f)-21.4(f)18.2(e)6(r)17.7(e)6(n)16.8(t e)15.3(t)1.9(h)6.5(n)7.1(i)

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The overriding finding is that while all the HAs are developing their understanding of dementia, and have policies in place relating to equalities and diversity, none have yet fully integrated the three strands of housing, dementia care and cultural or ethnicity related needs and preferences, nor the impacts of racism and disadvantage. We found many similarities in both policy and practice between the different HAs in relation to tenants with dementia and offers of housing to older people from varied backgrounds. Differences appeared to be in the degree of integrating understandings and knowledge of dementia and of cultural or ethnic diversity. However, some HAs were apprehensive about how to manage dementia if their focus had previously been on addressing needs related to ethnic or cultural identities or discrimination or disadvantages. All but one of the HAs had or were developing dementia strategies, and were training their staff to understand and recognise dementia. The challenge lies in integrating experience and good practice.

C[illegible]:

- All respondents stated that their policy would be to enable tenants – with dementia or without – to stay in their own home for as long as possible, but in some circumstances tenants would be moved to a new housing provider or another unit of accommodation.
- Overall, HAs try to meet individual needs – the word person-centred (commonly used in social care) was not used specifically but a similar ethos was espoused.
- Most acknowledged their staff should know more about dementia and many HAs reported they had started dementia awareness training.
- Substantial adaptations to tenants' homes tend to follow professional assessment of need – but new units are increasingly designed for disability and some for dementia-related assistance. There was no general agreement about what specific adaptations might be needed to cover dementia-related needs, but a fear of expense was universally expressed.
- Specific design features related to cultural preferences and requirements may meet dementia-related needs but knowledge of how this works in practice is anecdotal.
- All HAs have policies on safeguarding and security and did not see these as needing particular modification.

I

- HAs offer (and continue) tenancies or licences to people with mild dementia – indeed some are not aware of the presence of dementia at the time of someone moving in, because the dementia may not be have been diagnosed, or clearly identifiable. The consequences of policy encouragement of earlier dementia diagnosis have not been generally considered.
- Tenants are able do what they like to their homes within reason – but, at times, safety considerations may mean that a modification is refused. The notion of 'reasonableness' appears to be negotiable.
- All HAs were aware of working with cultural difference as a training imperative and all had Equality & Diversity policies addressing all forms of disadvantage, including race and ethnicity.
- Levels of dementia awareness and skills among staff varied. Somf(g)-04Dd.5(v(e)6F(n)16.

Many HAs have been at the forefront of developing services to meet the needs of changing communities. HA1 has developed a specialism in meeting the

Other HAs are developing a specialism in dementia care. HA3, for example, provides services for different groups, ranging from people who have been homeless and rough sleepers to residential care for people with complex needs, such as acquired brain injury, learning or physical disabilities, and people with dementia. It undertakes housing management, while another provider undertakes care services. It also supports older people who want to continue to live at home (home care). Further it runs a Home Improvement Agency to support older or disabled people if they need a repair or adaptation in their home.

HA3 accepts tenants with mild dementia in its sheltered accommodation scheme. It was previously commissioned to provide a round the clock resident warden service, but this is now just a support function, and this in turn has been reduced on cost grounds. Additional housing management is funded from the HA service charge, which is paid for through local authority housing benefit for those on low income. This HA runs a supported living scheme for African-Caribbean older people and comments on its experience of trying to be 'in tune' with what is needed:

> *'Our approach is to make sure that the community exercises its voice and has all their environmental requirements. We involve family and friends. There are different social activities, such as domino nights. In our mixed communities we celebrate a range of cultural events. We always recruit staff from local communities and related backgrounds. If we don't have this it's difficult to be in tune. The direction of travel in adult social care is*

Many HAs are developing dementia strategies or statements of intent. HA4, for example, is currently reviewing its housing stock and support. Its main business has been sheltered housing but it is developing more Extra-care housing, mostly by re-designating some of its current stock, and creating some common facilities in recognition of Iningut i,n bu17.7(e h13(i)7.1(1T(t)17.wETq0y)-15(42)7.1(2.17o)3l
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Formed over 30 years ago HA10 was established predominantly to provide quality homes and housing services for the local Chinese community. It provides bilingual services to enable Chinese speakers to access services and facilities generally available to the wider community. About half its tenants are Chinese speaking, and similar numbers of staff speak Chinese. Other tenants are mostly from other South East Asian backgrounds. Cultural awareness and accessibility are visibly expressed through the building architecture which was designed to meet particular requirements, e.g. there is a Chinese style archway into the building, dragon motifs and the colours used are mostly red, gold and green ('lucky' colours) – thus people's front doors are red and green, window frames are green. The colour black is not used because this is said to be unlucky. Such adaptations will likely be appropriate for people with dementia. Other tailored services cover a range of social and leisure events on offer, e.g. Tai Chi, films, translation services, and bilingual speakers that may be helpful to people who have lost abilities to speak or understand English

In its general retirement housing the on-site staff (Monday-Friday) are thought likely to be the first people to recognise if a tenant is becoming frail, or unable to cope. It is their role to raise concerns with the family or local authority adult services.

E D C

Some Extra-care housing schemes have substantial experience of providing services to diverse tenant groups. One HA5 scheme described itself as designed to accommodate a range of health conditions, both physical and mental, having improved the buildings' physical design with level access, grab rails, varied colour schemes, and so on. This scheme recruits staff with the relevant language and support skills for Asian older people; and tTmm(e)6(r p)-2(e)-3.1/t sk2(o)s s2.7(l9.3((k)0.9(i)

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Indeed, should a tenant need something substantially different or have 'extreme' dementia, it would probably suggest the tenant moves to another HA or elsewhere which could better accommodate their needs:

> *'We are looking at each case on a case-by-case basis. If we can be flexible on a small scale we don't have a problem. We're willing to go the extra or mile or two. We don't take people with extreme dementia and if someone required substantial adaptations we'd need to pass on'.*

While not always clearly articulated, other HAs also raised the question of managing difficult symptoms of dementia and the problems this may bring to the housing community.

For some, such symptoms are managed within services if these include specialist dementia units. HA8, for example, provides sheltered housing and Extra-care schemes. Mo(e)-3.1 1.m(u1(c)5.(n)7((m)8.mt[(E)-2.8(x)-7.6(t)2.4(r)17.2(a)4(-)-6

In 2005 HA11 developed an Older People's Services Project with another HA as part a shared equalities and diversity commitment to older people. It provides, among other things, support and guidance on more general age-related issues such as dementia or coping with loneliness and isolation. Following initial activities it has attracted funding from the Big Lottery. The project continues by reaching out to disadvantaged older black and minority ethnic people in its locality. HA11 has been developing a programme for black and minority ethnic older people and housing for some time. Most recently, with grant and charitable funding, it has developed a programme of awareness training about dementia, with input from Stirling University. It works closely with older people and feels it has won trust from local communities because, 'they are not about consulting but feeding back also'. It is starting on a healthy living awareness programme with the black and minority ethnic community, working closely with

- What is the scope when undertaking HA refurbishments to consider principles of dementia design?
- Is there consistency in meeting dementia-related needs and cultural needs between the two sides of a HA business?
- Are training and skills development on Equalities reflective of dementia? Are dementia awareness and skills training reflective of religious and ethnicity diversity?
- How are people living in general needs HA who develop dementia able to keep close to their community (shops, temple, or similar)? What are the local supportive factors?
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