



IMPROVING IN-PATIENT MENTAL HEALTH SERVICES FOR BLACK AND MINORITY ETHNIC PATIENTS

Recommendations to inform accreditation standards

Occasional Paper OP71

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AUTHORS

This report was written on behalf of the Royal College of Psychiatrists, the National Mental Health Development Unit and the National Mental Health Equalities Programme by:

Chris Fitch

Research Fellow, Policy Unit,
Royal College of Psychiatrists

Melba Wilson

National Programme Lead,
Delivering Race Equality
in Mental Health, National
Mental Health Development
Unit

Adrian Worrall

Head, College Centre for
Quality Improvement,
Royal College of Psychiatrists

FOREWORD

This report forms an important addition to ongoing and important discussions about improving care and treatment for people from Black and minority ethnic communities, and indeed all communities.

When we convened the expert panel we were concerned to have a full and frank discussion which went to the essence of how people provide services and how people receive services. Our starting point was that it is ultimately people and the quality of their relationships which has the biggest impact on service provision.

At the same time, we also wanted to ensure that any recommendations which emerged from the discussions took account of the day-to-day realities of the environment of acute mental health wards. The panel was clear that it needed to find the balance between aiming for the ideal and understanding that reaching it would require time, energy, thought and most of all commitment to make it happen. We think we achieved that balance.

We both feel very privileged to have been a part of this project. We are also incredibly proud of the work we did over those two days of panel discussion, and in subsequently developing this report for publication. Everyone involved gave an enormous amount of energy and time and we want to express our very deep thanks to the panel, who entered into the spirit of the task and entrusted us to remain true to the goals.

Particular thanks to Chris Fitch, who continually held the tension of the project, doing the day-to-day work that made this report a reality; to Rowena Daw (Head of Policy at the Royal College of Psychiatrists), who saw the vision and said let's make it happen; and to Adrian Worrall (Head of the College Centre for Quality Improvement), who recognised the synergies between the College's vision and the work of the Delivering Race Equality in Mental Healthcare programme.

Melba Wilson, National Programme Lead, Delivering Race Equality in Mental Health, National Mental Health Development Unit

Dinesh Bhugra, President, Royal College of Psychiatrists



SUMMARY

On 10 and 11 February 2009, an independent expert panel was held at the Royal College of Psychiatrists.

The panel was instigated by Professor Dinesh Bhugra (President RCPsych), and chaired by Melba Wilson (National and London Director, Delivering Race Equality in Mental Health Programme/National Mental Health Development Unit, England).

The aims and objectives of the panel were developed in close collaboration with the College Centre for Quality Improvement (CCQI). Project managers were consulted, and Adrian Worrall and Maureen McGeorge represented the CCQI on the panel.

This work was supported by the Royal College of Psychiatrists' Policy Unit (Chris Fitch and Rowena Daw).

The CCQI aims to create a new and enhanced role for clinicians and their professional bodies in raising standards. It is comprised of a number of improvement and accreditation projects focused on in-patient care. Each of the projects has its own set of standards to gauge achievement. Some of these standards are uniquely devised for that type of in-patient care, whereas others are commonly used across a number of projects.

For more information on the CCQI please visit www.rcpsych.ac.uk/ccqi

What did the panel do?

The panel reviewed the standards used by the CCQI in three in-patient accreditation networks which (directly or indirectly) relate to the care of Black and minority ethnic in-patients on acute mental health wards.

- The panel then made subsequent recommendations for:
 - improvements to existing standards;
 - issues to be formulated into new standards;
 - guidance or information that might accompany existing or new standards.
- This report (i) presents these recommendations; and (ii) invites the CCQI, network advisory boards and project managers to respond to these.

Which networks were reviewed?

The panel reviewed standards from three CCQI networks: adult in-patient services (the AIMS network); child and adolescent in-patient services (the QNIC network); and medium-secure forensic services (the QNFMHS network).

Why is this work important?

There are 4.6 million people from Black and minority ethnic¹ groups in the UK. Reported problems which members of these groups can face in relation to in-patient mental health service provision include: sociocultural difficulties (health beliefs and mistrust of services), systemic problems (lack of culturally competent practices in mental health services), economic issues, and individual barriers (denial of mental health problems).²

Research shows that BME groups are more likely than average to be admitted to mental health hospitals. Some BME groups also experience different pathways into acute care, and it is important to avoid aggregating all ethnic groups together where possible.³

¹ The term 'Black and minority ethnic' (BME) is defined in Delivering Race Equality (Department of Health, 2005) as referring to 'all people of minority ethnic status in England. It does not only refer to skin colour but to people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and East European migrants' (p. 11).

² Thornicroft GJ. Shunned: Discrimination Against People with Mental Illness. Oxford University Press, 2006.

³ Bhui K, Stansfeld S, Hull S, Priebe S, Mole F, Feder G. Ethnic variations in pathways to and use of specialist mental health services in the UK. Systematic review. British Journal of Psychiatry 2003;182:105-16.

- Since 2003, a number of policy directives have addressed the needs of BME in-patients. However, concerns remain about the care provided to BME in-patients.
- Consequently, the Royal College of Psychiatrists, the National Mental Health Development Unit and the CCQI agreed to collaborate on a review of CCQI accreditations standards. This was seen as a way to concretely improve provision for BME in-patients among services who are members of the CCQI networks, and for the CCQI to demonstrate what can be achieved.

What changes have resulted?

This report has been formally submitted to the CCQI. It has been agreed that the report's recommendations will be incorporated into a core set of universal standards that are currently being developed by the CCQI. These standards will apply to all CCQI networks.

How do I read this report?

The recommendations are presented in the following format:

- Recommendation heading
- A brief description of the issue
- Where relevant information is available, a description of how the CCQI is already addressing the issue
- A bulleted list of recommendations

Composition of expert panel

The expert panel was chaired by Melba Wilson (National Director, Delivering Race Equality in Mental Health Programme/ National Mental Health Development Unit, England).

Panel members included:

- Rizkar Amin (psychiatrist and Chair of RCPsych Transcultural Psychiatry Special Interest Group)
- Oyedeji Ayonrinde (psychiatrist, South London and Maudsley NHS Foundation Trust)
- Kam Bhui (psychiatrist and Research Lead, Queen Mary's School of Medicine and Dentistry)
- Godwin Calafato (carer consultant)
- Rowena Daw (Head of Policy, RCPsych)
- Tim Exworthy (psychiatrist and Chair of RCPsych Committee on Human Rights)
- Paul Grey (service user consultant)
- Maureen McGeorge (Programme Lead CCQI)
- Amarjeet Rebolo (carer consultant)
- Hari Sewell (Director of Health and Social Care Improvement, Camden & Islington NHS Foundation Trust)
- Annemarie Smith (carer consultant)
- Premila Trivedi (service user consultant)
- Marcel Vige (Diverse Minds, Mind)
- Sue Waterhouse (National Programme Lead, Gender Equality and Women's Mental Health Lead, London Development Centre)
- Adrian Worrall (Centre Head CCQI).

SECTION ONE
STAFF SKILLS



1 DISCUSSING AND UNDERSTANDING THE NEEDS OF BME PATIENTS

If staff are able to understand how a patient perceives and makes sense of their own mental health problems, this can significantly help in delivering care and treatment which meets users' needs. However, as Bhui and Bhugra⁴ observe, achieving this understanding can be extremely challenging. This is because mental health workers and service users often do not share a common cultural background, which may mean they sometimes think and talk about mental illness in different ways. This can make discussions and assessments difficult (even where the worker and user speak the same language), as words can carry various meanings, and different ideas or 'models' about what mental illness means may be used.

There was a clear recommendation that the CCQI should develop standards which require staff to:

- explicitly ask service users about how they understand their own mental health problem in terms of their cultural background;
- use this information to improve the formulation and delivery of care and treatment;
- record this information in care plans, case notes and other documents;
- where appropriate, use clear and non-technical language when communicating important information⁵

In this section, the panel therefore propose recommendations for the CCQI to take on board. These should be read alongside the standards in Section 3 which specifically focus on initial and continuing patient assessment.

It is also recommended that the CCQI should review and adopt the content of recent publications on this issue, including the 'Cultural Competency Toolkit'.⁶

1.1 PATIENT ASSESSMENT: INCORPORATING CULTURAL FACTORS

What is the issue?

The CCQI should ensure that standards are put into place which will document whether patient assessment at the point of admission takes account of cultural factors, as well as the basic mental and physical needs of the patient. Following admission, any further patient assessments should also take account of cultural factors.

What does the CCQI already do?

From the CCQI standards that were reviewed, it was clear that existing standards already directed staff to include 'ethnicity' in patients' assessment and care planning.

However, cultural needs, for example, can include: language; particular concepts or ideas related to mental illness; religious observances; dress or modesty; food; practical care (such as skin care); health issues specific to that culture or community (e.g. sickle cell anaemia); practices related to family planning, birth or death; hygiene.⁷

⁴ Bhui K, Bhugra D. Communication with patients from other cultures: the place of explanatory models. *Advances in Psychiatric Treatment* 2004; **10**: 474–8.

⁵ Caution should always be exercised when communicating across perceived cultural or language barriers. For example, fluent English speakers from any cultural group may be insulted if addressed in slow and simple sentences.

⁶ West London Mental Health NHS Trust. Cultural Competency Toolkit. Good Practice in Ethnic Minority Healthcare. WLMH NHS Trust 2007.

⁷ In the WLMH NHS Trust Cultural Competency Toolkit other examples are also given for common ethnic and cultural groups. It is also observed that workers: ask patients about any cultural or religious practice which may be relevant to their care; do not make assumptions about patients on the basis of their ethnic minority group; be aware that there are as many differences as similarities within cultural and religious groups; remember that the service user is always the best source of information about their own culture or religion; keep in mind that spending some time asking service users about their culture or religion will often save time and resources at a later stage; be aware that there are sources of information, support and finance to assist you in providing appropriate care to patients from any ethnic minority group.

What did the panel recommend?

In general terms:

- 1.1.1** The CCQI should ensure that it is clear in either its standards or accompanying guidance (a) what is meant by cultural needs; (b) how this differs from ethnicity; and (c) the range of issues that need to be considered.
- 1.1.2** Evidence should exist that all staff are aware, and understand, what is meant by 'cultural need', and also know that different BME groups will verbalise distress and underlying mental conditions in different ways.
- 1.1.3** Evidence should exist that all assessments cover the cultural, mental and physical needs of the service user.
- 1.1.4** There should be evidence of cultural factors being taken into account by staff throughout the entire patient journey as well as at the point of admission.
- 1.1.5** There should be evidence that service users feel that their perspective on their situation and mental health problems is adequately explored, discussed, understood and recorded by ward staff.
- 1.1.6** Assessments should capture the cultural practices and routines that an individual follows in the community/outside of the in-patient setting.

1.2 PATIENT ASSESSMENT: INCORPORATING FAITH AND SPIRITUALITY

What is the issue?

Issues of faith, spirituality and religion are important considerations when thinking about a patient's 'culture' in general, and even more so in relation to BME groups where a range of beliefs may be held and practised by large numbers of patients.

What does the CCQI already do?

The CCQI has some standards which touch on this issue, including access to relevant faith-specific support through someone with an understanding of mental health issues. However, these could be elaborated and appended, with a more proactive emphasis on assessment and also involvement of faith organisations.

What did the panel recommend?

- 1.2.1** Every ward should have a system for dealing with faith/spirituality issues. This should be integrated into the care planning process and reflected in a standard.
- 1.2.2** A standard on the consideration of faith and spiritual needs as part of the admission/assessment process, and appropriate linkage to services in the community which can address any relevant need.
- 1.2.3** A standard which determines whether staff have the skills to explore spirituality or faith issues during the assessment process and, if so, whether they have the skills to enquire about, and deal with, conflicting beliefs to their own.
- 1.2.4** A standard which gauges the extent to which Chaplaincy or other religious staff are effectively engaged in ward-based work.⁸

⁸ Many members of the expert panel observed that chaplaincy staff played a spiritual and generally supportive role in many in-patient settings. It was explained that a lot of psychopathology on wards has a link to god/religion, or that people commonly invoke faith during their treatment (e.g. as a reason to refuse, or influence, treatment). The chaplain (and equally other religious staff) can be extremely useful in picking up on issues that the clinical team were not aware of. Furthermore, chaplains do not only talk about religious issues, but can open up discussion about issues which have not been raised before or with others. The AIMS standards do contain reference to chaplaincy, but this could be expanded within AIMS and extended to other CCQI networks.

1.2.5 A standard on whether the ward has external links and whether it also involves local faith or religious organisations in its work, including churches, mosques and other places of worship.

1.2.6 A standard which not only requires evidence of the recording of faith/religious background in patient notes, but also evidences how this knowledge is being used to shape care.⁹

1.3 STAFF TIME

What is the issue?

When working with patients from BME backgrounds, staff need to make sufficient time available for an individual to express and explain themselves fully. This is particularly evident for individuals whose primary language is not English, but also to ensure a full understanding of cultural norms and values.

There should be sufficient time for staff to work and talk – informally and formally – with service users, including those from BME backgrounds. This may include ‘protected time’ on the ward, where visits and other interruptions are discouraged, allowing staff to consistently spend time with patients.

What does the CCQI already do?

Among the CCQI standards that were reviewed, there were some standards on ‘staff accessibility’ in a number of the networks, and also standards relating to protected time and ‘first points of contact’ among staff. However, these could be improved upon.

What did the panel recommend?

1.3.1 A standard which demonstrates that a named nurse on a ward has spent time with a patient (rather than the patient being invited to spend time with the nurse), and has recognised and documented their history, personal strengths and interests.

1.3.2 A standard which demonstrates that a range of ward staff (including, but not limited to, doctors and nurses) are provided with the time and resources needed to engage with service users.

1.3.3 A standard which provides evidence of a practical mechanism or protected time to allow ward staff to engage with patients.

1.4 FORMAL AND INFORMAL MECHANISMS FOR COMMUNICATION

What is the issue?

It is important that ward staff are demonstrably confident in their ability to engage and interact with in-patients from a range of BME backgrounds.

Interaction and engagement need not always occur in the context of a formal meeting with a service user, or with, in the words of one panel member, ‘an assessment form in one hand and a pen in the other’. Instead, it should be evident that staff members are able to draw on a range of formal and informal mechanisms to engage with service users, and to explore, discuss, and understand differences and similarities between staff and service user backgrounds.

⁹ The role that religion plays in people’s coping strategies, and often as a basis for recovery, was noted. The panel recommended that standards should exist on recording faith/religion, and also how this knowledge was being used to inform clinical work.

What does the CCQI already do?

It was not clear from the review whether the CCQI take a measure (either from service user questionnaires or other tools) of the range of methods, settings or times in which staff engage with users.

What did the panel recommend?

1.4.1 Staff should be visibly comfortable and confident in communicating and engaging with service users from BME groups, and feel able and confident to structure and facilitate this communication.

1.5 USING CLEAR LANGUAGE AND CHECKING IT IS UNDERSTOOD

What is the issue?

Language and communication were repeatedly raised as critical elements of the provision or experience of good-quality care to BME in-patients. An emphasis was placed on the use of clear and straightforward language.

What does the CCQI already do?

From the CCQI standards that were reviewed, existing standards already made reference to avoiding 'jargon'. Other standards not reviewed by the panel (for example Adult Inpatient Standards for Older People (AIMS-OP)) had additional standards on communication which should be taken into consideration. Some standards existed on physical equipment relating to reasonable adjustments for disability, although it was not clear what degree of attention was given to communication needs.

What did the panel recommend?

In general terms:

1.5.1 The CCQI should review what standards on communication are currently employed across its various networks, and identify others that might be used across these networks.

1.5.2 The CCQI should review available Cultural Competency Toolkits to ensure that standards, accompanying guidance or good practice examples are given on how to improve discussion with some patients from BME backgrounds.

In relation to the standards:

1.5.3 Evidence should exist that staff use language which service users perceive as clear and jargon-free.

1.5.4 Evidence should exist that staff are able to ensure that users understand what is being said to them, and similarly staff understand what users are saying or explaining to them. This is critical in prescribing or clinical decision-making. Staff should work to ensure that informed consent is being given.

1.5.5 Evidence should exist that staff make reasonable adjustments for patients who have physical or mental disabilities to enable them to understand what they are being told, and to enter into discussion with service users about this.

1.6 WORKING WITH INTERPRETERS

What is the issue?

When working with BME patients, it is not uncommon to involve an interpreter. However, ward staff often do not have skills in working with interpreters. The panel recommended that the CCQI review and take on board practice recommendations detailed in the document 'Guidelines for working effectively with interpreters in mental health settings'.¹⁰

What does the CCQI already do?

This was not recorded in the notes of the expert panel.

10. Miletic T, Piu M, Minas H, Stankovska M, Stolk Y, Klimiolis S. Guidelines for Working Effectively with Interpreters In Mental Health Settings. Victorian Transcultural Psychiatry Unit, 2006.

What did the panel recommend?

- 1.6.1** There should be evidence that ward staff adequately take into consideration the needs and working practices of any interpreters who are present in line with the recommendations of Miletic.¹⁰
- 1.6.2** There needs to be a recognition in the standards that ward staff who speak the same language as a patient may occasionally act as an unofficial interpreter during formal assessments.

1.7 INVOLVEMENT OF USERS AND CARERS

What is the issue?

The recommendations given below (and elsewhere) by the panel are intended to ensure that user and carer involvement (from both BME and other groups) is more strongly represented in the standards, rather than a criticism of the existing standards.

What does the CCQI already do?

A number of standards on user and carer involvement already exist, and these were strongly appreciated by the panel. The use of advocates was also implicit in the standards, particularly in relation to Independent Mental Capacity Advocates (IMCAs) in the Mental Capacity Act and Independent Mental Health Advocates (IMHAs) in the Mental Health Act. However, while recognising this implicit reference, the panel wanted to see an explicit reference to advocates and BME service users.

What did the panel recommend?

- 1.7.1** There needs to be evidence that BME service users (and carers where appropriate) are involved/consulted by staff during the patient journey.

1.7.2 The standards should emphasise service users and carers having more of a voice and role in meetings (which are often dominated by clinicians).

1.7.3 Advocates should also be involved in the care planning process, including the organisation and running of meetings.

1.7.4 There should be evidence that an Equality Impact Assessment has been undertaken about all forms of service user involvement, and that any findings are acted upon.

1.8 THE ROLE OF ADVOCATES

What is the issue?

The standards might make a stronger reference to the role of advocates (and the inclusion of their views) when discussions are held with BME in-patients, and when decisions are made about their care.

What did the panel recommend?

- 1.8.1** Evidence exists that the role and views of advocates have been taken into account, where there is evidence that it is the wish of the service user to do so.

SECTION TWO
THE PATIENT JOURNEY



2 ADMISSION

2.1 INFORMATION FOR IN-PATIENTS

What is the issue?

Information for in-patients is urgently needed at the point of admission. However, language barriers and patient dissatisfaction can mean that BME in-patients do not read or place value on patient information leaflets. Consequently, steps need to be taken to ensure that information is accessible and available in different formats.

What does the CCQI already do?

From the CCQI standards that were reviewed, a range of standards were identified relating to information being provided on admission (or as soon as a patient was well enough). However, these do not take into account the importance of ensuring that information is accessible and available in different formats.

2.1.1 Information about the rights of the individual when on the in-patient ward needs to be made available to in-patients from a range of BME backgrounds in (i) an accessible form and (ii) on a recurring/repeated basis to ensure that they are fully aware of their rights.

2.1.2 Information about the operation and activities of the acute ward was provided: the panel felt a standard should exist to ensure all inpatients received accessible information about this.

2.2 TRANSITION FROM POLICE OR CRIMINAL JUSTICE SETTINGS

What is the issue?

The CCQI could do more work on its standards relating to the transition of patients from police or criminal justice settings, and general working relationships between these two agencies.

What does the CCQI already do?

AIMS and the CCQI's Violence Audit had relevant standards which could be adapted. Not all CCQI networks would deal with transition from criminal justice settings.

What did the panel recommend?

2.2.1 Development of a standard(s) about the transition from police or criminal justice settings to in-patient unit, and the potential for a non-uniformed person to accompany the individual.

2.2.2 The CCQI to consider the relationship between police and acute wards during Section 136 admissions in light of the Royal College of Psychiatrists' report.¹¹

2.2.3 The use of Section 136 of the Mental Health Act should be documented to ensure that data on patient ethnicity and gender are collected (as described in the College report¹¹).

¹¹ Royal College of Psychiatrists. Standards on the Use of Section 136 of the Mental Health Act 1983 (2007) (Version for England) (College report CR149). Royal College of Psychiatrists, 2008.

3 INITIAL ASSESSMENT AND CARE PLANNING

Core standards relating to assessment have already been described in Section 1. In this section, additional recommendations are made on the recording of information in assessment notes and care plans.

3.1 RECORDING OF CULTURAL INFORMATION

What is the issue?

Cultural information is not routinely or well recorded in care plans and patient notes.

What does the CCQI already do?

From the CCQI standards that were reviewed, it was not clear that the recording of cultural information had been considered in depth.

What did the panel recommend?

3.1.1 The documentation and recording of information about a patient should include (i) biological information and (ii) descriptions of the patient's social and cultural understanding and explanation of what is happening to them. These two pieces of information are equally important.

3.1.2 Evidence should be provided that care planning documentation records the service user's interpretation and understanding of proceedings.

3.2 LANGUAGE USED WHEN RECORDING CULTURAL INFORMATION

What is the issue?

There was a concern among the panel that the language used about BME in-patients in written assessments and care plans was formulaic. This primarily resulted in simplified and inaccurate notes, with a failure to capture the cultural background of the patient, or the cultural meanings and explanations they ascribed to their mental illness or distress.

What does the CCQI already do?

Learning disability standards included numerous standards on language which could potentially be adapted. In addition, the panel identified the following standards for consideration.

What did the panel recommend?

3.2.1 A standard on the type of language that is used in records and patient notes (moving away from negative or pejorative vocabulary that is used by staff when dealing with/documenting care). This could signal a greater willingness by staff to work with patients on a more equal basis.

3.2.2 There should be evidence that formulaic or standard phrases are not repeatedly used during practice/clinical note taking (for example 'lacks insight'). Such stock phrases will lose their meaning with over-use, do not convey information about the individual, can become 'checklists', and some service users may attempt to give the 'right' answer.

3.2.3 A standard which establishes the literacy levels of a service user is key before any written assessment or documentation should be requested from them/passed on to them.

3.3 PHYSICAL HEALTH ASSESSMENT

What did the panel recommend?

3.3.1 Family history of physical health risks to be identified and considered before prescribing commences (with specific reference to heart disease and diabetes).

3.4 OTHER CARE PLANNING ISSUES

What does the CCQI already do?

There are CCQI standards on the content of initial and continuing assessments. However, the panel felt that the categories listed in this could be misinterpreted or misunderstood as a 'tick box' or administrative exercise.

What did the panel recommend?

- 3.4.1** A standard which establishes that the perspective of the clinical team about diagnosis and/or care regime has been communicated early to the individual concerned, rather than only at the point of discharge.
- 3.4.2** Evidence is needed about the different routes and pathways into in-patient care that service users take. This should be recorded in assessment and accompanying notes in order to develop a richer cultural picture about the individual.
- 3.4.3** During care planning meetings, space and time needed to be specifically dedicated to BME service users' and carers' cultural needs, and also to allow service users to define their own outcomes.
- 3.4.4** Evidence should exist that the care planning process is holistic and deals with social, educational and employment issues.
- 3.4.5** A standard which provides evidence that care planning anticipates and addresses the different stages of recovery once the person is discharged/left the ward, and which builds in contact with agencies in the community that can facilitate this.

4 CONTINUING ASSESSMENT

4.1 CONTINUING ASSESSMENT

What is the issue?

Assessment and care planning should be a recurrent activity, rather than a one-off. This could be strengthened in the existing set of standards reviewed.

What does the CCQI already do?

Standards exist on patients being told how, if they wish, they can access their current records or receive a copy of their care plan.

What did the panel recommend?

- 4.1.1** Evidence should exist that service users were provided/offered the opportunity to review their own notes in collaboration with a staff member.
- 4.1.2** The panel noted that the implementation of care planning, and follow-through on the plan, can sometimes be poor for all in-patients. It would be useful if the standards could emphasise the importance of implementation.

5. MEDICATION

The prescribing of medication to in-patients from BME backgrounds is a vital issue that the CCQI needs to address in much more detail.

Pertinently, the CCQI is home to the National Prescribing Observatory for Mental Health (POMH), and the expert panel has requested that the CCQI works carefully and in consultation with the joint-heads of POMH-UK (Carol Patton and Tom Barnes) to address the recommendations in this report. The Delivering Race Equality in Mental Healthcare programme had also undertaken an audit of prescribing practice in relation to BME patients¹² and when results from this are published in 2010 these should also be taken into consideration by the CCQI.

5.1 THE IMPORTANCE OF CAREFUL PRESCRIBING

What is the issue?

There is a need for careful prescribing as research evidence suggests that some BME groups experience 'over-prescribing'.

What does the CCQI already do?

A number of standards relating to prescribing exist, but it was not clear from the expert panel's discussion to what extent the CCQI could make recommendations relating to clinical prescribing practice. This needs to be carefully considered by the CCQI. The CCQI reported that multiple standards exist on access to psychological therapies.

Basic medical assessment should pick up on family health risks; there is also a growing awareness of the need for

physical assessments. However, this should be explicitly referred to; this is worth re-emphasising given the particular prevalence of specific conditions within BME communities.

What did the panel recommend?

- 5.1.1 If clinically appropriate, there should be a period of observation without prescribing.¹³
- 5.1.2 Withdrawal and reduction from medication should be addressed by the standards, through reference to care plans.
- 5.1.3 The standards need to establish whether forms of treatment other than medication were offered to the patient (including, but not limited to, psychological therapies).
- 5.1.4 Family history of physical health risks to be identified and considered before prescribing commences (with specific reference to heart disease and diabetes).

5.2 EVIDENCE OF NEGOTIATION BETWEEN CLINICIANS AND USERS

What is the issue?

Negotiation over prescribing and medication is important for all service users, but has particular resonance for BME in-patients.

What does the CCQI already do?

A number of the CCQI networks have clear statements on positive risk-taking, and this could be extended to medication. Negotiation about medication is covered in some networks, with reference to 'joint decision making'. However, the CCQI should collect data on the extent to which this aspiration of negotiation or joint decision making happens in practice.

12 Connolly A, Taylor D, et al. Antipsychotic Prescribing in Black and White Hospitalized Patients: A Cross Sectional Study. South London & Maudsley Trust, Interim report July 2009. The aim of the project was to determine whether ethnicity of patients affects total dose of antipsychotic used (high dose (>100% of dose) antipsychotic use, total numbers of antipsychotics prescribed and type of antipsychotic used) after controlling for more than 20 factors affecting dose (e.g. age, weight). Ten sites were approached to provide data with only two unable to participate. Data on over 900 patients have been collected. Interim findings were no differences in any outcome by ethnicity, but that 'prescribed poly-pharmacy was significantly higher for blacks than whites'.

13 Sashidharan SP. Inside/Outside: Improving Mental Health Services for Black & Minority Ethnic Communities in England. National Institute for Mental Health in England, 2003.

What did the panel recommend?

- 5.2.1** There needs to be evidence (including, but not limited to, the clinical record) of negotiation between clinicians and users about their medication, and positive risk-taking needs to be evidenced as part of this.
- 5.2.2** There should be evidence that users have made an informed choice, rather than complied with clinicians' recommendations.
- 5.2.3** Where there is disagreement between staff, users and carers about prescribing this should be recorded in the clinical notes.
- 5.2.4** Evidence should exist that, during negotiation about medication, the clinician took into account the views of other staff members who know and regularly work with the patient. The rationale for this is that these staff members may know about how the individual best responds to medication.
- 5.2.5** Evidence that ward staff have been trained/educated to ask inpatients about whether they prefer some degree of symptomatology which allows for some form of personal recovery, as opposed to no symptoms and reduced social functioning/inclusion.

5.3 ADVANCE DIRECTIVES IN PRESCRIBING

What is the issue?

Advance directives¹⁴ about prescribing choices should be taken into consideration. The CCQI have been asked to provide a written response on how advance directives might be accommodated.

What did the panel recommend?

- 5.3.1** Evidence should exist on whether advance directives were discussed with the user, offered as an option to the user, or rejected by the user.

- 5.3.2** The expert panel asked the CCQI to work with the Prescribing Observatory for Mental Health to identify a practical mechanism for using advance directives in specific relation to prescribing decisions.

5.4 LENGTH OF TIME ON MEDICATION

What is the issue?

In-patients (both from BME groups and other patient constituencies) could be on the same medication for a considerable amount of time, without review or revision. It was recognised that a standard on the length of time an in-patient had been on medication might be difficult to collect evidence for. However, the CCQI was asked to work with the Prescribing Observatory to address this.

What does the CCQI already do?

It was not clear to what extent the CCQI could address this issue, given the short period of time that in-patients are on wards.

What did the panel recommend?

- 5.4.1** The CCQI to develop a standard which provides evidence on the length of time an inpatient has been on medication.

5.5 CAPACITY, MEDICATION, AND PRESCRIBING DECISIONS

What is the issue?

Decisions around medication and prescribing need to take into account the mental capacity of the patient to enter into such discussions, understand what is being proposed, weigh up their decision and communicate their preferences.¹⁵ This may not always be happening in relation to patients from BME communities, particularly taking into account language and other cultural issues related to communication.

¹⁴ Advance directives are a method of making a person's views known if he or she should become mentally incapable of giving consent to treatment, or making informed choices about treatment, at some future time.

¹⁵ As described in the relevant mental capacity legislation.

What does the CCQI already do?

The CCQI recognised that a standard should be added in light of the Mental Capacity Act. It also noted that this may relate to compliance and second opinion appointed doctors.

What did the panel recommend?

5.5.1 Evidence needs to exist that an assessment has been undertaken on whether an individual has the capacity to understand and make decisions relating to the prescribing of medication.

5.6 SOCIAL EXPERIENCE OF PRESCRIBING

What is the issue?

The 'social experience' of prescribing refers to the interaction, discussion and negotiation between clinical staff and in-patients, as well as the lived experience of being on medication.

What does the CCQI already do?

The CCQI covers subjective perceptions of staff and users in their audit tools, although it was not clear to what extent this related to this issue.

What did the panel recommend?

5.6.1 The CCQI standards should demonstrate that the subjective experiences of users and staff in relation to the prescription of medication have been adequately captured.

5.7 FEAR OF PRESCRIBING

What is the issue?

There is a fear of being prescribed medication among some BME groups. This is related to the length of time someone could be on medication, and the rationale for giving the medication to the individual.

Relevant background and wider

documentation to this key issue is provided in 'Breaking the Circles of Fear'¹⁶ which reported that fear often stopped Black people from African and Caribbean communities from engaging with mental health services; that mainstream services were experienced as inhumane, unhelpful and inappropriate; and that problematic care pathways of this group of service users influenced the type and outcome of treatment and the willingness of their communities to engage with mainstream services.

What does the CCQI already do?

There are some CCQI standards on patients accessing information leaflets about the side-effects of medication. However, it would be useful for the CCQI to specifically recognise the fear of prescribing and medication among some BME communities.

What did the panel recommend?

5.7.1 The CCQI standards need to explicitly recognise and refer to the fear of prescribing and medication among BME communities.

5.7.2 Evidence should exist that staff have taken steps to recognise and address such fear.

5.7.3 A standard should exist which documents whether patient information on medication side-effects is available to all in-patients, and whether users access, read and value this information.

6. ACTIVITIES, THERAPIES AND LINKS

6.1 WARD ACTIVITIES AND THERAPIES

What is the issue?

The ward environment has a significant influence on patient recovery, safety and experience. This includes culturally appropriate activities provided by staff on the ward.

What did the panel recommend?

6.1.1 A standard on the provision of culturally appropriate activities on the ward, including activities outside of the regular working day (9am–5pm), the provision of activities by community groups and the avoidance of any major occupational therapy assessment before activities.

6.1.2 Culturally appropriate activities to be provided on a daily basis, at weekends and also in the evenings.

6.2. EXTERNAL ACTIVITIES & THERAPIES

What is the issue?

The ward environment has a significant influence on patient recovery, safety and experience. This includes culturally appropriate activities provided by external organisations.

What does the CCQI already do?

Some CCQI networks made reference to some level of activities, but not specifically to BME groups or organisations.

What did the panel recommend?

6.2.1 Standards need to be developed which provide evidence that wards are actively linking with, and involving, the BME community and voluntary groups in the development of a patient's care plan.

6.2.2 There should be evidence that external agency staff who engage with the in-patient ward have the skills and knowledge to do so effectively. This could take the form of a user-informed skills audit of such staff.

6.2.3 Evidence exists on whether the ward has external links with local organisations and churches, mosques and other places of worship.

6.2.4 A standard which provides evidence that external faith/spirituality organisations are being engaged with.

6.3 OTHER LINKS WITH EXTERNAL ORGANISATIONS

What is the issue?

The CCQI standards should make clear and explicit reference to links with external agencies which either represent or work with BME communities.

What does the CCQI already do?

Some CCQI networks made reference to patients being supported and encouraged to access local organisations, or to have weekly outreach visits. This was not uniform, nor did it specifically mention BME organisations or groups.

What did the panel recommend?

6.3.1 There needs to be evidence of links being made with external agencies – including BME organisations – to promote restoration of a sense of personal identity.

6.3.2 A standard which provides evidence that care planning anticipates and addresses the different stages of recovery once the person is discharged/left the ward, and which builds in contact with agencies in the community that can facilitate this.

7. DISCHARGE

7.1 DISCHARGE

What is the issue?

The discharge process was identified as a point at which communication and planning could often encounter difficulties.

What did the panel recommend?

- 7.1.1** A standard which establishes that the perspective of the clinical team about care has been communicated early to the individual concerned, rather than only at the point of discharge (where people can learn for the first time about their diagnosis).
- 7.1.2** A standard which establishes whether discharge care planning takes into account both the short- and longer-term needs and care of the service user. This will require staff to carefully consider how the transition/handover is managed.

8. WARD ENVIRONMENT: VIOLENCE, ABUSE AND OTHER ISSUES

This section focuses on the ward environment and, in particular, issues of violence and abuse. The recommendations are not intended to imply that all staff are not already addressing these concerns or effectively dealing with them. However, they are offered from the perspective of clinicians, service users, carers, and policy makers and reflect their current and ongoing concern around these issues, and the potential for the CCQI to further address them.

8.1 WORKING IN DIFFICULT SITUATIONS

What is the issue?

There was a perception among BME groups that staff could often find it challenging to communicate and interact with them, particularly in situations of heightened tension/potential violence.

What did the panel recommend?

- 8.1.1** A standard on staff perceptions and training in relation to cultural perceptions of hostile or threatening behaviour should be established.
- 8.1.2** The CCQI should develop a standard on how clinicians could manage fear of potential violence and respond in a proportionate way, taking into account cultural factors/perceptions.
- 8.1.3** A standard on support and training should be established to enable staff to consider their risk management and assessment in relation to violence.

8.2 PROVIDING INFORMATION ON VIOLENCE

What is the issue?

The CCQI to assess whether patient information packs/leaflets should make reference to (i) the fact that violent events do sometimes take place on in-patient wards, and (ii) the likely response of ward staff to such events.

What does the CCQI already do?

As wards often produce their own information packs the potential exists to include information on violent incidents, although any reference to violence would have to be carefully worded.

What did the panel recommend?

8.2.1 A standard should be established about the content of patient information packs, including information relating to violent incidents.

8.3 AUDIT OF VIOLENCE

What is the issue?

Standards which establish a measure of the violent behaviour on the ward – in order to assess how well wider policies or strategies are working – would be welcomed.

What does the CCQI already do?

In some wards there are systems in place to ensure that post-incident support and review are available and take place. This includes staff, patients, carers and family, and other patients or visitors who witnessed the incident.

What did the panel recommend?

8.3.1 Standards which audit violence levels on acute wards, and which differentiate between forms of violence (racial, sexual etc.) are needed and should be regularly reviewed by the trust board.

8.3.2 A standard which encourages staff – following an incident – to identify and document the behaviour preceding that incident, so that an understanding can be developed about the factors involved.

8.4 DEBRIEFING

What is the issue?

Debriefing after incidents of violence can be helpful to the ward team.

What did the panel recommend?

8.4.1 Evidence that after any incident of violence a debriefing session took place (perhaps involving the identification of factors contributing to violence).

8.5 ABUSE

What is the issue?

Abuse should be a key consideration in the standards. On many wards there is a mutual code of conduct for ward behaviour that patients are advised about, and that staff also have a professional responsibility to always take reports of abuse seriously. However, this issue should be explicitly recognised in the standards, as opposed to being implicitly assumed.

What did the panel recommend?

8.5.1 There should be evidence that staff take reports of abuse seriously; challenge inappropriate behaviour; and that discussions are held about why this hostility/abuse is being expressed.

8.5.2 A standard that victims of abuse should not be expected to 'stay in their room' in order to avoid the perpetrator.

8.5.3 A standard that clear ward procedures for handling racial abuse exist, and which describes how these will be acted on.

8.5.4 There should be evidence that the consequences of engaging in racial abuse have been communicated to all users and carers on the ward.

8.6 SEXUAL SAFETY

What is the issue?

Sexual safety should be a key consideration in the standards. On many wards there is a mutual code of conduct for ward behaviour that patients are advised about, and that staff also have a professional responsibility to always take reports of abuse seriously. However, this issue should be explicitly recognised in the standards, as opposed to being implicitly assumed.

What did the panel recommend?

8.6.1 A standard which demonstrates that staff take reports of sexual abuse/violence seriously; challenge inappropriate behaviour; and that discussions are held about why this hostility/abuse is being expressed.

8.6.2 A standard that victims of sexual abuse/violence should not be expected to 'stay in their room' in order to avoid the perpetrator.

8.6.3 A standard that clear ward procedures for handling sexual abuse/violence exist, which describes how these will be acted on.

8.6.4 A standard on making clear to service users and carers the consequences of engaging in sexual abuse/violence.

8.7 CONTROL AND RESTRAINT

What is the issue?

National guidance from the Department of Health on training standards for control and restraint has now been published. Wider guidance on control and restraint techniques is also available.¹⁷

What does the CCQI already do?

Standards exist in some CCQI networks on rapid tranquilisation, physical intervention or seclusion, including the actions taken and any outcomes.

What did the panel recommend?

8.7.1 Existing standards on control and restraint should be reviewed in light of this guidance.

8.7.2 There should be evidence that violent incidents are audited, including the identification of staff involved, in order to establish a rolling description of events.

8.7.3 The CCQI to consider how standards could be developed to address issues of rapid tranquillisation and use of psychiatric intensive care units.

8.8 PERCEPTIONS OF RISK IN RELATION TO BME GROUPS

What is the issue?

There were differing perceptions among staff about the risk presented by BME groups.

What did the panel recommend?

8.8.1 Evidence that staff are able to openly talk about, and reflect upon, how they define risk in relation to particular BME groups.

8.9 NURSE STATION

What is the issue?

A complaint that is commonly voiced by service users is a lack of response/recognition when approaching the nursing station/office. Although some patient information packs may explain what staff are doing in such stations, many service users often perceive they are being ignored.

¹⁷ National Institute for Clinical Excellence. Violence: The Short-term Management of Disturbed/Violent Behaviour in Psychiatric In-patient Settings and Emergency Departments. NICE, 2005.

What did the panel recommend?

8.9.1 A standard which addresses the accessibility of ward staff, including those working in the nursing station.

8.10 ACCESS TO STAFF

What is the issue?

The accessibility of ward staff is important. Service users and carers often feel they cannot get sufficient time with staff members.

What did the panel recommend?

8.10.1 'Access to staff' is already part of the AIMS standards, reflecting previous work undertaken at the College Research and Training Unit on the National Audit of Violence. These relevant standards should be added across all networks.

8.11 WARD ENVIRONMENT

What is the issue?

The ward environment has a significant influence on patient safety. This was partially covered in the existing standards, but could be strengthened in relation to three sets of standards.

What did the panel recommend?

8.11.1 A standard on the cultural safety of the ward environment – this could take the form of a positive statement of how the ward is being made, and kept, safe.

8.11.2 A standard about managing the ward environment and atmosphere – this is not necessarily just about BME groups, but about changing staff practice to reflect the importance of safety for staff as well as patients.

8.11.3 A standard on the provision of culturally appropriate activities on the ward, including activities outside of the regular working day (9am–5pm), the provision of activities by community groups, and the avoidance of any major occupational therapy assessment before activities.

8.12 MIXED-GENDER WARDS

What is the issue?

Women from BME groups may have particular cultural beliefs and norms about mixed-gender care.

What did the panel recommend?

8.12.1 A standard on the care and treatment of women from particular cultural backgrounds into mixed-gender settings.

8.13 SECLUSION/SUPERVISED CONFINEMENT

What is the issue?

Although seclusion does occur on in-patient wards, there is concern about reports of individuals being confined to their room on the ward, but this not officially being recorded/defined as seclusion or supervised confinement.

What did the panel recommend?

8.13.1 Evidence should be provided that staff have made efforts to avoid and actively identify situations where individuals are confined to their rooms, but where this is not officially termed as seclusion.

9. ETHNICITY DATA COLLECTION

9.1 DATA

What is the issue?

Improvements have been called for in the collection of data on patient ethnicity by government and voluntary sector reports. Such improvements in collected data will help inform the development of appropriate services and interventions.

What did the panel recommend?

- 9.1.1** The CCQI standards should place a premium on the collection and recording of routine data throughout the patient journey, with in-patient ethnicity clearly documented.
- 9.1.2** Evidence that care planning documentation does record the service user's interpretation and understanding of proceedings.
- 9.1.3** A standard which ascertains the quality of record-keeping and data-recording at the ward level about ethnicity and cultural/social needs.
- 9.1.4** Evidence that the different routes and pathways into in-patient care that service users take are recorded and reflected in care plans. This should make reference to community mental health team admissions.
- 9.1.5** A standard which documents in the care planning record the life and routines that an individual follows in the community/outside of the in-patient setting.
- 9.1.6** There should be evidence of data collection on detained BME in-patients.
- 9.1.7** There should be evidence that any aggregated BME data on in-patient activity is fed back to ward staff.
- 9.1.8** A standard on data collection in relation to BME in-patients' access to mental health review tribunals.

9.2 IN-PATIENT WARDS AND POLICE

What is the issue?

There is potential for standards to be developed which improve working relationships between in-patient ward staff and the police. The Violence Audit had standards on this issue which should be drawn upon.

What does the CCQI already do?

In most trusts, there should be an information-sharing protocol that all staff ought to be aware of, and this should be publicised to visitors and patients. All staff should also adhere to Department of Health guidance on confidentiality, protection and use of patient information.

What did the panel recommend?

- 9.2.1** A standard which focuses on proactive communication and confidentiality – for example, sharing information with police on a 'need to know' basis, or the simple fact that if police bring a person on to a ward, this immediately marks the patient out as different.

10. OTHER ISSUES

10.1 SELF-CARE

What is the issue?

BME groups often have different self-care needs (e.g. black skin can be more dry and susceptible to pressure sores, and may require cream or lotion to be applied every day). An understanding of how different BME groups attend to self-care is therefore critical.

This issue is partially dealt with as part of Quality Network for Forensic Mental Health Services set of standards for women.

What does the CCQI already do?

There are some CCQI standards on patients accessing individual care needs, including ethnic and gender-specific requirements. However, it was not clear how this was measured, or how effective a measure this was.

What did the panel recommend?

10.1.1 There should be evidence that patients' self-care regimes are adequately documented and, within reason, responded to (e.g. particular skin cream, combs).

10.2 RELATIONSHIP BETWEEN IN-PATIENT WARDS AND AMBULANCE STAFF

What is the issue?

There is potential for standards to be developed based on the relationship between the in-patient ward and ambulance services/staff.

What did the panel recommend?

10.2.1 The CCQI to consider the relationship between the ambulance service and in-patient wards, and to formulate standards which address best practice in this relationship.

10.4 LEGAL

What is the issue?

Legal access and representation are key considerations in the mental healthcare of many BME in-patients.

Recommendations

10.4.1 A standard which aims for BME in-patients to have improved access to solicitors.

10.4.2 A standard on improved legal representation at mental health review tribunals for BME patients (taking into account literacy issues).

10.5 RECOVERY

What is the issue?

Recovery is where individuals actively build a meaningful life for themselves, either while continuing to experience mental health problems or following a period of poor mental health. It also involves the intended consequence of the skilful application of medicine, nursing and social care on a specific illness.

In relation to care planning, it should be emphasised that approaches to recovery should be creative and empowering, as opposed to following a bureaucratic or 'tick box' approach.

Recommendation

10.5.1 A standard which demonstrates that the concept of recovery is treated seriously, and that sufficient resources have been provided to encourage a creative and empowering approach to supporting service users.

10.6 DEFINITION OF RECOVERY

What is the issue?

The CCQI guidelines need a much clearer definition of recovery. The following were suggested, but it was recognised that these would need further development:

'Recovery is where individuals actively build a meaningful life for themselves, either while continuing to experience mental health problems or following a period of poor mental health. It also involves the intended consequence of the skilful application of medicine, nursing and social care on a specific illness.'

'Recovery involves: "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."'¹⁸

What did the panel recommend?

10.6.1 The CCQI to review the suggested definitions of recovery and to then adopt a clear and universal definition across each network's standards.

10.7 RECOVERY AND TREATMENT PLANS

What is the issue?

The joint completion of a recovery and treatment (RAT) plan could be beneficial in capturing information about service user preferences and outcomes. A RAT plan is a generic term that was used to signify the recording of such information, as opposed to a specific information form.

10.7.1 There should be evidence that a structured process has been followed to document a user's objectives, preferences and outcomes for recovery.

10.8 STAFF

What is the issue?

Staff might be encouraged – through the addition of a standard – to creatively work with service users to identify key goals for recovery.

What does the CCQI already do?

This was the essence of assessment and is implicitly covered in CCQI standards. However, this should be more explicit.

What did the panel recommend?

10.8.1 A standard which establishes that each care worker/coordinator identifies with the service user at least one goal for recovery and an implementation plan to achieve this. This should be addressed as part of the care planning process.

10.9 IDENTITY

What is the issue?

The definition and application of 'recovery' in the CCQI standards to include a recognition that personal identity is critical.

What did the panel recommend?

10.9.1 The CCQI definition of recovery to emphasise that for many BME and other patients that recovery is not just relief from symptoms, but also a personal state of identity. Critically, some people will prefer some degree of symptomatology which allows for other aspects of personal recovery.

10.10 OUTCOMES

What is the issue?

During the care planning process, recovery should reflect objectives and outcomes defined by the service user.

¹⁸ Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal* 1993; **16**: 11–23.

What did the panel recommend?

10.10.1 A standard which demonstrates that care planning has taken into account objectives and outcomes defined by the service user.

10.10.2 A standard which demonstrates that recovery is individual-led, rather than wholly service-led or staff-defined.

10.11 POWER

What is the issue?

A number of observations were made about power relations between service users and staff. These are listed below. It is recognised that translating them into quantifiable standards may be difficult, although the collection of data about service user perspectives may offer one route. The proposed standard on restrictive measures refers equally to a feeling of safety, as well as the measures themselves.

What do the CCQI already do?

Standards exist on clinical staff receiving training, support and supervision from experienced senior practitioners in providing one-to-one therapeutic contact. However, there is no explicit reference in relation to engagement with users and carers and issues of power and dynamics.

What did the panel recommend?

10.11.1 A standard about how decisions are made, which takes into account hierarchy of power. Particularly important in terms of multidisciplinary teams.

10.11.2 The CCQI to consider establishing standards which address issues of power and dynamics within the therapeutic relationship.

10.11.3 Evidence on whether restrictive measures are put in place – including locked wards and measures to stop people coming in/onto the ward.

10.12 DIFFERENCES BETWEEN CCQI NETWORK STANDARDS

What is the issue?

There are some differences between the standards contained in different networks – there is a need to ensure that good practice in one network is also adopted in others. An example was given of the QNIC guidance on forced medication being applied across the networks.

What did the panel recommend?

10.12.1 The CCQI should undertake a review to ensure that good practice and standards in relation to BME in-patients are shared across all networks.

10.13 STAFF SKILLS

What is the issue?

Three key points were raised (see below). Staff do not have to know about all religious groups in-depth, but instead should have the generic skills base to explore and discuss faith and spirituality issues with a range of patients.

What did the panel recommend?

10.13.1 A standard which determines whether staff have the skills to explore spirituality or faith issues during the assessment process, and if so, whether they have the skills to enquire about, and deal with, conflicting beliefs.

10.13.2 A standard on whether information about a user's faith or spirituality is entered into care planning.

10.13.3 A standard which provides evidence that external faith/spirituality organisations are being engaged with.

10.14 TRUST BOARD RECEIVES REPORTS ON VIOLENCE LEVELS

What is the issue?

CCQI standards apply at the ward level, rather than the organisational level. However, particular ward data might be communicated to the Trust Board, so that they are aware of activity at the ward level.

What did the panel recommend?

10.14.1 The Trust Board should receive reports on violence levels on wards.

10.15 PATIENT NOTES

What is the issue?

The panel identified a range of issues on patient notes including the following recommendations.

What did the panel recommend?

10.15.1 Evidence exists that service users were provided/offered opportunity to review their own notes.

10.15.2 Evidence exists on whether the Care Quality Commission had reviewed patient notes, and whether it had positively rated note-keeping.

10.15.3 Evidence exists on the extent to which cultural information is being recorded/retained in patient notes, and what information is being left out.

10.16 HUMAN RIGHTS

What is the issue?

The human rights of patients on acute psychiatric wards is critical and requires addressing. The panel felt many aspects of their discussion touched upon human rights issues in relation to BME and other groups. However, there were other issues not considered and the CCQI should undertake a review of their standards in relation to human rights.

What did the panel recommend?

10.16.1 The CCQI to review and take on board recommendations contained in the Department of Health training package on human rights.

10.17 DIGNITY AND RESPECT

What is the issue?

Treating service users and carers with dignity and respect is a central part of in-patient service provision. The CCQI should review the Department of Health's Dignity in Care campaign.¹⁹

What did the panel recommend?

10.17.1 Development of a standard which demonstrates that dignity and respect form a key part of all care planning, and that staff are aware of this.

SECTION THREE
STAFF NEEDS



11. EDUCATION, TRAINING & SUPPORT FOR STAFF

The importance of staff skills and knowledge is reflected across the existing CCQI standards. However, there is little reference to the competencies that staff need when working and engaging with BME in-patients. In this section, we describe the need for evidence to be provided that staff possess these key skills.

11.1 TRAINING: CULTURAL COMPETENCE?

What is the issue?

The ability for staff to understand, communicate with, and effectively interact with, people across cultures is known as 'cultural competency'. This was identified as a key challenge.

What does the CCQI already do?

Training standards are featured throughout the CCQI networks. However, few make explicit and detailed reference to cultural competence.

What did the panel recommend?

- 11.1.1** There should be evidence that all psychiatrists and ward staff have received training in cultural competency.^{20, 21}
- 11.1.2** Evidence should exist that psychiatrists and other staff members working on in-patient wards have received training about, and direct educational engagement with, the wider ethnic and social groups that in-patients often come from.
- 11.1.3** Evidence should exist that changes in ward practice and policy have followed on from the training of staff in cultural competency skills. Monitoring will be needed to assess this impact.

11.1.4 There should be at least one person on the ward who has received training in culturally competent assessment and interviewing techniques.²⁰

11.1.5 The CCQI to explore the potential for staff training on 'mini-ethnography'.²²

11.2 STAFF TRAINING: RISK AND VIOLENCE

What is the issue?

Training in respect of violence is key, particularly in relation to the regular review of ward policies (and their implementation) regarding violent incidents. There is a perception among BME groups that staff often find it challenging to communicate and interact with them, particularly in situations of heightened tension/potential violence.

What does the CCQI already do?

Outside of the CCQI, all staff who work in a clinical environment will receive training in the management of violence and de-escalation techniques. However, it was not clear to what extent this incorporated BME-specific concerns (as listed below). Additionally, the CCQI should make reference to these concerns, as standards or accompanying guidance.

What did the panel recommend?

- 11.2.1** A standard which demonstrates that staff training has taken place in respect of cultural factors, BME groups and violent incidents.
- 11.2.2** Evidence that where training and support for staff has occurred, this has included/resulted in a review of ward policies and their implementation.
- 11.2.3** A standard on staff perceptions and training in relation to cultural perceptions of hostile or threatening behaviour.

²⁰ In short, cultural competence refers to an individual's ability to interact effectively with people of different cultures. The demonstration of cultural competence is therefore reflected in an ability to understand, communicate with, and effectively interact with people across cultures.

²¹ This should include the Delivering Race Equality training programme, which is based on a capability approach, includes user involvement, and starts from staff needs.

²² 'Mini-ethnography' is a method of exploring the individual's world view and perspective using tailored interview and observational techniques. This technique is described in more detail in Bhui K, Bhugra D. Communication with patients from other cultures: the place of explanatory models. *Advances in Psychiatric Treatment* 2004; 10: 474-8.

11.2.4 The CCQI to develop a standard on how clinicians could manage fear of potential violence and respond in a proportionate way, taking into account cultural factors/perceptions.

11.2.5 A standard on support and training to enable staff to consider their risk management and assessment in relation to violence.

11.3 TRAINING: SERVICE USER INVOLVEMENT

What is the issue?

Service user involvement in cultural competence training is an integral part of the standards.

What does the CCQI already do?

This is covered in a number of areas, but could be strengthened. In some trusts financial or other support for service users and carers might be provided by an internal training unit, rather than being the responsibility of the ward itself.

What did the panel recommend?

Involving service users and carers in training is the remit and the responsibility of the trust/training unit rather than the ward, but it is an important recommendation to include within this report.

11.3.1 Users and carers from BME groups which reflect the local population are involved in training on cultural competency.

11.3.2 Service users and carers from BME groups who are involved in training programmes should receive adequate financial support or payment.

11.3.3 A standard on support provided to service users during training, as involvement can be demanding.

11.3.4 A standard on how local external user groups could become involved in training, rather than just users on the ward.

11.4 SUPERVISION

What is the issue?

Team training or team supervision is just as important an issue as training to individuals.

What does the CCQI already do?

Some CCQI standards refer to ward-based reflective practice or staff support groups to discuss clinical work. There is a need for specific and proactive reference to these practices/groups addressing issues which affect BME service users.

What did the panel recommend?

11.4.1 Evidence that team training (rather than just individual training) has taken place, with space and time being allocated to allow individuals to discuss, reflect upon and learn about issues of cultural diversity. This could include protected time for open discussion about aspects which are particularly challenging or potentially uncomfortable for staff members to engage with.

11.5 OTHER

What is the issue?

The panel identified a need for staff to be better supported and explore their own issues and concerns around working with BME in-patients.

What did the panel recommend?

11.5.1 Systemic training/models need to be adopted with input into care, which is able to mitigate the jading effect of staff being exposed continuously to people experiencing their most challenging phases of mental health problems. This could focus on aspects of recovery; nuances of communication; and/or protected spaces to enable greater time for staff reflection on/exploration of their own concerns or issues in relation to the ward environment.

11.5.2 Evidence on whether accredited training is being offered to staff. The provision of training to staff is a positive step – however, it is important that such training is of a particular standard, or even potentially accredited.

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Registered office: 17 Belgrave Square, London SW1X 8PG

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