Advancing Practice in Bedfordshire

Editorial Group: *Advancing Practice in Bedfordshire*

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Volume 5 (Number 1): *Contents*

Editorial: *promoting practice development*

by John Butler – Chair of Editorial Group

I am pleased to introduce the first edition of Volume 5 of Advancing Practice in Bedfordshire, which launches a specific theme of practice development as an approach to enhancing service and care provision that the editorial group hope to further develop in future issues. This theme is introduced by Debbie Buck in her paper on the introduction of Non-Medical Prescribing – one of the new ways of working for non-medical practitioners. Dr Iqbal Mohiuddin describes the findings of his audit of BME service-users in the Luton South West Community Mental Health Team, which has clear implications for future practice. Kelly Perkins, as part of completing her training in the use of psychosocial intervention, discusses the nature and impact of negative symptoms, providing an insight into the theory and highlighting the contemporary approaches to managing these difficult experiences. Daisy Bogg provides a short briefing on the recent developments in mental health legislation, upon which new educational programmes are beginning to be made available in preparing practitioners for implementing the required changes in practice. Bockarie Sesay provides an outline of his literature review relating to collaborative team-working, which was undertaken as part of his recently completed research, about which there will be more in the next issue.

Much of this work demonstrates or will lead onto practice development, which may be viewed as *a continuous process of improvement towards increased effectiveness in providing service-user centred care by enabling teams to develop knowledge and skills and to transform the culture and context of care* (see: Garbett & McCormack 2002/4). This process is best enabled and supported by facilitators who are committed to systematic and rigorous practices, which highlights the role of the Trust's recently established Practice Development Unit (from Feb 2008). This small dedicated team offers skilled facilitation and support in promoting practice development initiatives within teams and services, supporting such through educational ventures and monitoring the impact of initiatives through quality assurance activities and outcome measurement.

We hope that you find something here that stimulates your ideas for developing practice and moving forward in your team.

Exploring and overcoming the barriers to Non-Medical Prescribing

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Practice Development

Introduction and Background

The Cumberlege Report (1986) identified that community nurses were using a lot of time waiting for prescriptions to be written by General Practitioners once they had already identified their patients' needs (Courtney 2007). It was suggested that limited prescribing should be allowed for district nurses and health visitors, especially around long term conditions (Humphries 2002), in the context of a care plan. This was reviewed by June Crown in 1989, and test sites were set up to pilot nurse prescribing. In 1999, a further report from Crown was published which recommended that nurse prescribing be extended to other nurses in specialist roles, which was finally realised in 2001 (Courtney 2007).

In the local Trust, nurse prescribing commenced in 2003 - 2004 when four nurses completed an educational programme in that year. Since this time, a further seventeen nurses have completed the course and a prescribing lead role was established, in October 2006, to support non-medical prescribing. Supporting prescribers to ensure that they have access to the right mandatory training and updates to satisfy organisational requirements and helping them to overcome the barriers to prescribing is a well highlighted need (Hall 2005). However, setting up processes across a large organisation where the lead works only one day a week represents a challenge. This study was therefore undertaken to gain a basic understanding of the barriers to prescribing.

There has been limited research into the number of non-medical prescribers who are actually prescribing, especially with regard to mental health nurses and prescribing since its conception in 2001 (Courtney 2005). Within the field of mental health nurse prescribing, there has been a significant increase in the number of prescribers trained, but very little

research completed as to the success of incorporating prescribing into their roles and the difficulties they have faced in implementing this. Acceptance of this role for nurses has been mixed: although nurses are aware of the benefits of prescribing both for their practice and their patients, they often have reservations about both the training provided (Nolan 2000) or the need for roles to be reviewed to enable time for prescribing (McCann 2002). Research into patient views of nurse prescribing and their confidence in being treated by nurses within general medicine has been positive (Berry 2005).

Aims and Objectives

A management project was undertaken to explore the most helpful approaches in promoting change and introducing and embedding new roles within practice – in this case, non-medical prescribing. With the aim of working to overcome evident obstacles to the nurse prescribing role and promoting the use of prescribing skills, this involved considering the experience of current nurse prescribers within the Trust and, if now prescribing, considering what obstacles they have encountered and the supports they have been able to access and need.

Methodology

In providing a lead non medical prescribing role for the Trust, it is imperative to ensure good communication and sound knowledge in enabling teams to successfully implement the nurse prescribing role. There is also a need to monitor practice and to provide mandatory training, in assuring high quality practice and staff safety, as discussed within the NMC guidelines on nurse prescribing (NMC 2006).

The Department of Health recommends establishing peer supervision and providing mandatory training, both of which have been provided within the Trust in the form of two forums. However, attendance at these forums has been sporadic, although this is currently being addressed through local policy and practice development initiatives.

Considering the provision of training and the needs of the Trust's services, it is important to explore the barriers to non-medical prescribing practice. A specific questionnaire was therefore designed to explore current prescribing practice, barriers to prescribing and the ongoing development needs of non-medical prescribers within the Trust.

Designed to include questions informed by current practice and NMC Guidance (NMC 2006), the questionnaire was piloted for ensuring viability. Feedback on the pilot confirmed that the questionnaire was self-explanatory and easy to complete, such that it could be mailed to staff as a self-report questionnaire. An explanatory letter was enclosed to advise on confidentiality, and confirm the anonymised reporting of findings.

A questionnaire was forwarded to all 15 trained nurse prescribers in the Trust, eight of whom returned a completed questionnaire, of whom five were presently prescribing. Semi-structured interviews were subsequently conducted with the other seven nurse prescribers, only three of whom were prescribing. The findings are summarised below.

Findings

10 of the nurse prescribers completed their prescribing training in 2005; 3 in 2006; and one in 2004 & 2007 respectively.
As shown, most respondents completed their training in nurse prescribing when it was still in its infancy, and available free to both the organisation and the individual. The government agreed to open up nurse prescribing to other professional areas following a trial with district nurses and health visitors, and funding was initially made available for this (Courtney 2002). Within the Trust, a nurse prescribing conference was held in early 2005 to promote the training, and the number of staff applying for the course quickly increased. Many of the early prescribers had undertaken their training before practice support systems were in place, nominating themselves for the course. Bradley (2004) reported that those prescribers who accessed training before the organization had agreed a strategy often resulted in poor prescribing practice once qualified.

11/15 nurse prescribers reported having completed the Trust's additional mandatory training for nurse prescribers.
The Trust began sending staff on the nurse prescribing course with little support once they had qualified, which resulted in a reactionary development of support systems and little mandatory training being provided initially. Upon interviewing seven nurse prescribers, Lewis-Evans (2003) reported concerns about the availability of update training, to maintain their skills, and support from the organisation, that they felt they needed for satisfactorily fulfilling the role. The Trust has since been

addressing these issues by introducing mandatory peer supervision on a six weekly basis and by setting guidance for mandatory additional training. The majority of nurse prescribers in the Trust subsequently completed the Trust's mandatory training: a medication management course that focuses upon the use of psychotropic medication and practical concordance strategies; a course on physical health checks that includes history taking. The NMC (NMC 2006) has specified the development needs of nurse prescribers, which will be incorporated into the Trust's programme of mandatory training.

10/15 nurse prescribers reported having the support of their medical supervisor.
The support of medical supervisors has been sporadic, and early indicators highlighted a lack of medical support in some teams. In fact, upon commencing nurse prescribing within the Trust, a questionnaire was forwarded to the consultants. Though only six responded, concerns were expressed about the safety of prescribing practice in mental health. Jones (2004) highlighted the concerns of medical staff as cost implications and role depreciation. In the Trust, when the conference was initially advertised, there were no representatives from the medical staff. Since this time, education and support has been provided to consultants in achieving an acceptance of nurse prescribers within their teams. However, the lack of medical support still presents a major barrier for some teams. This will need to be a priority for the future in ensuring that nurse prescribing is embedded within the Trust.

12/13 nurse prescribers reported having the support of their manager to prescribe (2/15 responded as not applicable).
The majority of the prescribers who responded had experienced support from their managers to prescribe, although it would have been useful to have identified exactly what support they were receiving. McCann (2002) explored the implications of prescribing on twenty four nurses, highlighting the need for definitive role re-structuring and management support within the teams. Humphries (2000) identified another difficulty for the prescriber, as the need for time to complete the additional documentation that is required. Having a definite idea about how the nurse prescriber will be able to utilise this skill in each team, management support in attending forums and training, and time to complete the additional documentation,

would all need to be established in ensuring that future prescribers are enabled to implement their skills in practice.

12/15 nurse prescribers last attended the Trust's nurse prescribing forum in 2006, one in early 2007 and 2/15 stated that they had not yet attended.

The Trust's nurse prescribing forums are aimed at providing ongoing peer support and education by the Trust's pharmacist and interested consultants. This has been poorly attended since its conception, which may be linked to the prescriber's view of the Trust's desire to support and facilitate prescribing in their areas of practice. Hall (2005) identifies the organisation's responsibility in supporting and assisting those who have completed the course to prescribe and also to receive ongoing practice development training. Nolan (2001) identified the need for more training to be available both during and following nurse prescriber training. Though there is a general request for more training among the Trust's nurse prescribers, there is clearly a need to further explore the poor uptake of arranged forums.

7/14 nurse prescribers reported having experienced difficulties in setting up supplementary prescribing in practice.

The Trust's non medical prescribing lead will clearly need to ensure that there processes are implemented to ensure that all prescribers can access prescriptions pads, and gain access to a locked facility for their safe-keeping. Brookes (2007) focused upon the change management process in enabling prescribers to establish and deliver new skills – the Trust will need to be vigilant in identifying difficulties to establishing prescribing practice in ensuring the commencement of prescribing practice. Jones (2005) identified the need for organisations to be clear about their strategy for implementation, ensuring that areas where prescribing practice is progressing well is developed further and replicated within similar teams.

7/15 nurse prescribers confirmed that they were presently prescribing.

Respondents reported that prescribing is helped by having a supportive and committed team, a specific service role (such as prescribing within a memory clinic, depot or denzapine clinic), having the support of a medical supervisor, and through enhanced relationships with colleagues. A number of barriers were identified: pressure of work, an inability to agree a specific application, opposition from the consultant, being in a team manager role,

the reluctance of team-members to agree to nurse prescribing, a lack of self-confidence, a lack of support, and isolation from others who support the initiative.

Relating to some of the concerns expressed by Jones (2004), many of the nurse prescribers completed the course through their self-motivation rather than as part of a Trust strategy that considered where nurse prescribing could best be implemented. Sending managers to the course is clearly an expensive option, and as the role of managers has changed within the Trust, there has been a shift away from the clinical role with no opportunities to prescribe. Knowledge of the specific barriers encountered in each team will facilitate the development of an action-plan to overcome the barriers. Since this study, nurses who are interested in undertaking the course have been asked to attend a short interview to discuss their proposal for acquiring and using prescribing skills within their practice area.

12/15 nurse prescribers reported a wish to prescribe as part of their current role following course completion.

This was a very positive response and reflected the research conducted by Hall (2005), in spite of the evident barriers to practice. Bradley (2004) found that those prescribers who were able to utilise their prescribing skills in their current roles felt more positive about prescribing and the benefits it holds for their clients. The aim will therefore be to support and encourage nurse prescribers to identify a role within their areas and to encourage them to become more motivated about taking this forward. This will be easier if a role is clearly defined at the outset.

Respondents identified a number of requests for ongoing training to ensure safe practice: continued peer support (3 responses); specific professional development courses / updates (10) e.g. physical health care, pharmacology, legal issues, policy developments; advice on medications and cautions (2); support and commitment from the team (1); regular supervision (2).

This highlights the need for more formal mandatory training, and is reflected within the NMC Guidelines (NMC 2006).

Respondents identified a number of supports that they should have put in place before starting the course that would have facilitated implementation: reading around the subject (1 response); securing

support for implementation (4), from the consultant, manager and professional lead; talking to those who had completed the course (1); finding a course with a specific focus on mental health (1); establishing a role for prescribing within the practice area (1); reducing the caseload (1); considering the changing role of Team Manager (1); better understanding the role (1).

Supporting the consultants to understand the role will be important in ensuring future practice of nurse prescribing, and encouraging staff who wish to train as prescribers to thoroughly consider the role and its application within the practice area. As espoused by Courtney (2005), the introduction of the lead non-medical prescriber has enabled greater centralisation on who is prescribing and the sharing of good practice, whilst providing a much needed support and supervisory role for prescribing practice.

Conclusion

The number of people attending the course in the Trust has been sporadic since the outset, with no clear vision about how it was promoted, and how many should be supported onto the course. Bradley's (2004) conclusion was that nurse prescribing should be implemented using an organisation's strategy to see where it is working and replicating that practice. This involves setting up systems to monitor who is attending the course and how it can work in their clinical area as essential feedback on implementation and practice. Black (2007) highlights the need for everyone to be clear of their roles in a team with a clear strategy and aim to measure against. The role that the lead prescriber will play in developing nurse prescribing needs to be clear to the organisation, to enable the replication of good practice to develop.

The nurse prescribers who completed the course in the first two years were viewed by the Trust as champions for nurse prescribing, despite the generic feel of the original course and the lack of specific training during the course, such as physical health checks and mental health medication. Relevant additional courses were subsequently identified as mandatory training for all nurse prescribers in the Trust, and were written into the organisation's strategy, and the majority of staff have now completed this mandatory training. Templar (2005) makes it clear that an integral part of the manager's role is ensuring that the team or workforce has the right

skills for the job. The lead prescriber will need to ensure that required training is both clearly outlined and available when required.

As the support of a medical supervisor is mandatory for undertaking the course, some staff have overcome the problem of being unable to access such support from within their own team by approaching other teams, though this has caused some difficulties upon course completion. In response to the concerns expressed by medical officers, Jones (2006) suggests that nurses and consultants need to develop a different kind of relationship. In one of the Trust's Units, the consultant has expressed concern over their diminishing role if nurses started to prescribe as well. The lead must therefore develop good communication networks with this group, as described by Brookes (2007), and be able to discuss barriers and nurse prescribing needs within the Trust with this group of staff.

Management support for prescribers in their clinical areas has been viewed positively though, as nurse prescribing becomes embedded, the role of the Team Manager will need be to more open and robust. Brookes (2007) highlights the need for change management in the clinical environment to assist with the implementation of prescribing, specifically considering the culture of the team. Nurse prescribing can present a big cultural shift for some teams, especially where there are very strong medical interventions. Identifying the culture and making steps to change needs to be led by the team manager with support from the lead prescriber in the first instance. The lead must enable teams to manage this change (Black 2007) by providing support for managers and prescribers and having clear objectives for prescribing in these teams and the Trust as a whole.

Peer support and supervision is seen as an essential component of staff support for prescribing, but attendance remains ad hoc rather than being viewed as an essential component of personal development. Brookes (2007) emphasizes the need to maintain competency in prescribing by ensuring that the organisation provides, either individually or to a group, supervision which allows prescribers to reflect on prescribing practices. Set agendas are currently in place, though these will need to be reviewed in both forums to further reflect the needs of those prescribers attending. The lead will clearly need to encourage all the prescribers to talk about their needs and how they wish them to be met, whilst also supporting and

educating them. Promoting effective forums will require all the prescribers to participate and discuss the vision, and work together to break the barriers.

This study has highlighted the need for having a clear role for prescribing in the practice area before commencing the course, rather than leaving this to the end. Having a defined role for prescribing is essential if prescribing practice is to be embedded within Trust services, which must involve discussion with the team. Hall (2005) talked about nurses owning their prescribing and allowing them the space and time to develop a role, with the support of the organisation. The lead will need to work closely with those areas where barriers are more prominent, which will include working with consultants and teams to consider ways of enabling the implementation of skills by prescribers in the team. Templar (2007) identifies the need for the manager to continually look ahead and embrace change. The lead will need to be able to embrace change and support clinical areas in developing strategies that will advance prescribing practice.

It is worth noting the initiatives that have assisted the prescriber to prescribe in replicating such practice within other teams / services. This includes: having the support of the whole team; and, planning before commencing training. Jones (2005) found that identifying clinical areas where prescribing works well is helpful for replicating good practice in similar teams. In the Trust, nurse prescribing is more prevalent and successful in the community mental health teams and in-patient rehabilitation units, such that these areas now feature in the strategy for advancing nurse prescribing over the next couple of years. Doherty (2007) suggests looking to the manager to ensure that effective communication processes are in place and the organisation is aware of the strategy.

The majority of people who have completed the course have indicated that they would still like to use their prescribing skills – a very positive finding. Bradley (2004) talked about the nurse's confidence in their prescribing abilities as being higher when first completing the course, though falling if not going on to prescribe. In the Trust, motivation is still high, so the lead will need to target those who are not yet prescribing. Black (2007) emphasizes the need to motivate team members, which involves sharing the vision and working with everyone involved to achieve that vision.

Continued professional development is essential, which has so far primarily been achieved through the structure of peer forums within the Trust, where training events are organized and speakers are invited. Since the publication of the NMC Guidelines (NMC 2006), an annual mandatory update for all prescribers has been arranged by the lead, to ensure that nurse prescribers are updated. Regular medication information is passed through to nurse prescribers using the e-mail facility, and the Trust's quarterly newsletter, *Medicine Matters*, is distributed to the nurse prescribers.

Following this study, and as discussed by Jones (2005), it has been formally agreed that interviews will be held with all potential prescribers at which they will be asked to identify how prescribing would be used within their practice area, and confirming that they have the support of their line manager and consultant psychiatrist. The development of a lead nurse prescribing role for the Trust will help in supporting teams who are struggling to implement nurse prescribing and ensuring that those undertaking the course are able to gain support during their training by having an identified person to contact. The lead would need to be able to understand the roles of the prescribers within their own clinical areas and, as Templar (2007) highlights, be able to negotiate changes with all parties in developing practice.

Nurse prescribing will continue to develop within the Trust, and although it has been agreed to support and progress supplementary prescribing at the present time, there is discussion about establishing and supporting independent prescribing in specific areas of practice, such as the memory clinic and sensory service. Brookes (2007) highlights some of the benefits of independent prescribing for secondary services, especially when working closely with the primary care trusts – the community mental health teams in the Trust have been considering how best to develop close links with General Practitioners. The Trust's vision for the development of nurse prescribing must be shared within the organisation and with all nurse prescribers, in encouraging and advancing good practice.

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The nature and impact of negative symptoms of psychosis – a discussion

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Discussion Paper

Introduction

There is now general agreement that there are three groups of symptoms associated with a diagnosis of psychotic illness:

1. *Positive symptoms* – hallucinations, delusions, ideas of reference, passivity phenomenon such as thought insertion, withdrawal, broadcast.
2. *Negative symptoms* – social withdrawal, apathy, demotivated behaviour, flattened mood and a lack of pleasure or interest.
3. *Cognitive / disorganised symptoms* - disordered thinking leading to difficulty in forming thoughts, poor speech content and flow, poor concentration, poor memory and difficulties in learning, problem-solving and abstract thinking (Morrison et al 2004).

Negative and cognitive symptoms, which some would argue are inter-related (Stolar and Grant 2007, Milev et al 2005), appear to be overlooked as a treatment priority. Historically, little attention has been paid to negative or cognitive symptomatology in psychotic illness (Stolar and Grant 2007, Birchwood and Trower 2006). It has been argued that the emphasis on positive symptomatology may lie with both the under-reporting of negative symptoms, as they are nearer to usual behaviour, and the intolerant social reaction to positive symptomatology (Stolar 2004, Rector et al 2005).

It is clear that such symptoms represent a source of poorer outcomes in quality of life issues, such as relationships, social and vocational roles (Bromet et al 2005, Fowler et al 1998) and in some cases this may contribute to relapse and co-morbidity (Birchwood 2003, Kuipers 2006). For example, there may be an increased potential for the exacerbation and

entrenchment of delusional beliefs due to a lack of disconfirmation opportunities (Freeman 2007). Dam (2006) further highlights the correlation between depression, adaptation to psychotic experience (Fowler et al 1998) and suicide. Suicide rates of up to 10% have been found in those diagnosed with schizophrenia, over a 10 year follow up period (Bromet et al 2005). Other authors cite the spiral of social decline and an eroding of the personality that is so often witnessed in individuals with a diagnosis of psychotic illness, as mainly related to apathy, social withdrawal and poor interpersonal functioning – commonly referred to as negative symptoms (Milev et al 2005). The financial implication of these medication resistant symptoms is also well documented in terms of direct and indirect costs – for example: benefits claims, poly-pharmacy, hospital admissions and family burden (Mino et al 2007). However, the origins and maintenance factors implicated in these *symptoms,* if this is indeed the correct terminology (Fowler et al 1995, Beck - Sander 1998), are complex and less easily described or understood.

What are Negative Symptoms?
Although Bleuler and Kraepelin described emotional and social difficulties in their descriptions of schizophrenia (Beck and Rector 2005), Crow (1980, cited in Morrison et al 2004) introduced the concept of a cluster of symptoms specific to the diagnosis of schizophrenia:

- *flattening of affect* – blunted, unresponsive and / or a limited range of emotion;
- *alogia* – poverty of speech, limited verbal interaction and poverty of thought (this latter issue is debatable as there may be a thought but a lack of desire or sense of purpose to express the thought (Rector et al 2005, Stolar 2004);
- *anhedonia* – an inability to experience pleasure (although it has been argued that there may be an inability to initiate pleasure-inducing activities, individuals may still be able to enjoy these as well as anyone else once the activity is initiated (Rector et al 2005));
- *avolition* – a lack of will / motivation;
- *apathy* – a lack of interest;
- *asociality* – a lack of social interaction (Morrison et al 2004).

Although the presence of these features in association with psychosis is not disputed, the aetiology is widely debated (Fowler et al 1995, Stolar & Grant 2007). Indeed some authors argue for a move away from a discrete

diagnosis of schizophrenia, as it objectifies a heterogeneous range of experience, to one that is more sensitive to the subjective experience (Levin 2006).

Theories of Negative Symptoms
It is hypothesised that negative symptoms can be further subdivided into primary and secondary symptoms (Beck & Rector 2005).

Primary negative symptoms refer to the attitudes, beliefs and behaviours (or lack of) resulting from neurobiological and / or pathological processes (Morrison et al 2004).

Some studies have been offered as evidence of this theory, showing that those experiencing negative symptoms of schizrenia have enlarged ventricles in the brain (Rector et al 2005, Littrell et al 1997). Stolar (2004) hypothesises that resulting neurobiological disturbances or other anomalies in connectivity may cause disruption in various inter-related aspects of cognitive processing, which include memory, attention, and reward systems, as shown in Fig 1.1.

Fig 1.1 Implications of Inter-related Cognitive Processes
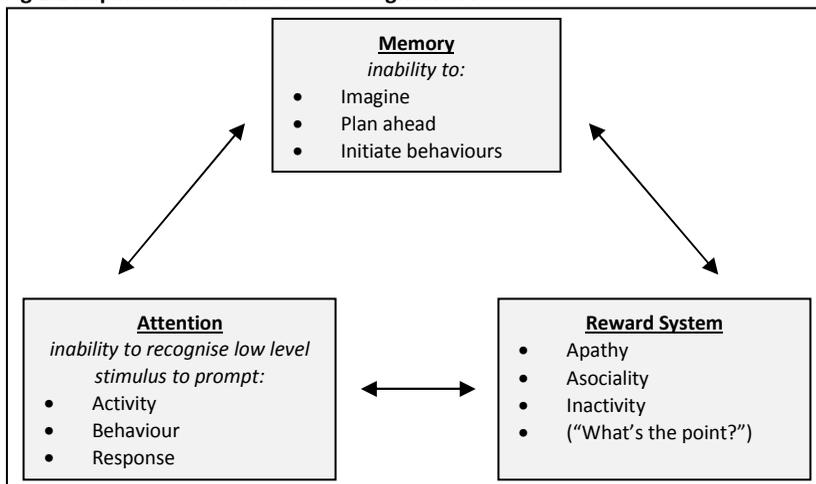
Milev et al (2005) demonstrated this inter-relationship, identifying a slower pupillary response, an indicator of information processing speed, in a letter

recognition task in individuals diagnosed with psychotic illness. They found that impaired information processing speed, which is linked to memory and attention, was predictive of poorer outcomes in terms of social, vocational and global psychological functioning. They also highlighted a link between a decreased level of cognitive functioning at first episode and progressive severity of negative symptoms over a seven year period. Although this provides evidence of impairment, it is not concrete evidence that these changes are directly caused by a disease process. It does however highlight the need for early and sustained intervention.

There is some suggestion that abnormal cell pruning in the womb or during adolescence may be responsible for poor connectivity (Morrison et al 2004) and may be a vulnerability factor for psychosis in the first instance, rather than a symptom of psychotic illness (Fowler et al 1998). Furthermore enlarged brain ventricles have been found in individuals with alcohol, depression and other disorders (Littrell et al 1997), such that the evidence, whilst convincing, is inconclusive.

Rector et al (2005) take a different view and propose a link between premorbid schizotypal and schizoid personality traits in those with a stable core of negative symptoms. They propose a continuum of experience and behaviour, *for example*, in those individuals with pre-morbid difficulties or a lack of interest with initiating, understanding and maintaining social relationships, which may be exacerbated by the experience of psychotic illness. They argue that 85% of outpatients with schizophrenia have a diagnosis of personality disorder, mainly of the afore-mentioned variety. However, these theories fail to explain negative symptoms in those with healthy pre-morbid functioning.

Secondary negative symptoms refer to the attitudes, behaviours and beliefs associated with (*or secondary to*) the experience of psychosis.

The impact of the experience of psychosis can be multi-faceted, from the treatment options to the personal and societal response, and can influence the recovery process (Birchwood et al 2006). For example, anti-psychotic medication generally works by blocking selected dopamine pathways (Farine 1994), which can mean an under-stimulation of the mesocortical pathway that affects frontal lobe executive functioning (Littrell et al 1997) – a global term for planning and co-ordinating activity. Further histamine

blockage by serotonin action can induce sedation and weight gain by increasing appetite (Farine 1994), which can lead to a lack of activity and social withdrawal, as described in Fig 1.1, compounded by tiredness and poor self esteem.

These issues can be further compounded by the widely described experience of shame and stigma associated with a diagnosis of psychotic illness (Birchwood et al 2006). Social rank theory suggests that we all have a desire to present ourselves as attractive to others (Gilbert 2000). Being marked by the self or others, particularly with something as taboo as a diagnosis of schizophrenia, can lead to opting out, avoidance and symptoms of social anxiety, which are similar in presentation to both depression and negative symptomatology (Gumley et al 2004, Dam 2006, Birchwood et al 2006).

Furthermore, trauma occurring either in response or as a trigger to psychosis (Calcott et al 2004) can influence memory. Indeed structural changes in the hippocampus (the area of the brain associated with memory, learning and contextual information processing) have been found to occur in (sexual abuse and combat) trauma victims (Morrison et al 2004). Calcott et al (2004) suggest that reliving distressing experience, which is a trademark of post traumatic stress that results from a perceived threat to life or integrity, experienced through hallucinations and delusions, can influence memory and affect. As mentioned earlier, memory difficulties impede an individual's ability to plan and initiate activity. The consequent lack of stimulation can induce a blunting of affect / numbness that is, again, characteristic in post trauma but interestingly virtually indistinguishable from negative symtomatology.

Furthermore, the experience of trauma can shatter pre-morbid core beliefs and assumptions of a sense of self efficacy and safety (Birchwood et al 2006). Trauma may also exacerbate existing beliefs and attitudes in terms of Schizotypal and Schizoid personality traits (Rector et al 2005) and the meanings attached to expressing wishes / desires, forming relationships and engaging in activities. Consequent diminished anticipation for pleasure and success can result in apparent apathy, avolition and indeed alogia (Gumley et al 2004, Beck and Rector 2002). Individuals may not see the point in engaging socially (Gumley et al 2004, Beck and Rector 2005).

Other authors have suggested that negative symptoms may actually be coping strategies for managing distressing residual positive symptoms (Birchwood 2003) or perhaps an avoidance of high expressed emotion in the family. However, what we do know is that these issues are exacerbated as the social decline resulting from negative symptomatology spirals (Milev et al 2005, Morrison et al 2004). As we have demonstrated, the causes are inter-related and complex and it would follow that treatment is also variable. Consequently it is difficult to be discrete about the cause and effect and it may be more useful to take a stress- vulnerability perspective (Zubin and Spring 1977).

Rationale and Evidence Base for CBTp for negative symptoms

Most studies of cognitive behavioural therapy for psychosis (CBTp) have tended to concentrate on interventions for the management of positive symptoms (Stolar 2004). The general theme of these studies appears to be favourable in terms of reduced distress and improved coping and subsequent impact on negative symptoms (Rector and Beck 2001, Haddock et al 2003, Sensky et al 2000, Granholm et al 2005, Wykes et al 2007) (Fig. 1.2). Furthermore the National Institute for Clinical Excellence (2003) indicates CBTp as a core treatment option for both positive and negative symptomatology.

Fig 1.2 Studies that include Outcomes on Negative Symptoms

Study	Experimental Group	Control Group	Outcome measure	Outcome
Sensky et al 2000	90 clients offered 20 x 45min sessions of CBT + RC i.e. medication	20 x 45 min sessions of befriending – neutral pleasant discussion + RC	CPRS, SANS, MADRS	at immediate follow-up all groups showed signif improvement; at 9/12 FU, signif improv for CBT group
Pinto et al 1999 (Wykes et al 2007)	19 clients offered 24 x 1 hr sessions of CBT + social skills training + RC	18 clients offered 24 x 1hr psycho-education, crisis management, advocacy (housing etc…) + RC	BPRS, SAPS, SANS	at immediate follow-up, signif improvement; at 6/12 FU, slippages in control group but experimental group remain improved
Daniels 1998 (Wykes et al 2007)	20 clients offered 16 x 50 min sessions twice weekly of	20 clients as a waiting list control – not specified	CGI, QOL,SANS, BPRS,GAF, PANSS	improved social competence, psychosocial & global functioning at

	group CBT + group process strategies			post treatment; some deterioration in control group
Haddock et al 2003	17 clients offered 29 sessions of individual CBT + motivational intervention & 15 carers offered 10-16 sessions of Behavioural Family Therapy + RC	18 clients offered RC & 18 carers offered a family support worker (advice and management)	GAF, PANSS, SFS, TLFB, client service receipt inventory, salary of therapist; GHQ, BDI, RCNS with carers	signif improv in positive symptoms over 12 but not 18 months, though GAF remained improved; no signif cost effectiveness found
Rector et al 2002	24 clients offered 20 x weekly sessions of CBT + enhanced RC	18 clients offered 20 x weekly sessions of enhanced RC (psycho-ed, meds management, housing, OT & crisis support)	PANSS, BDI	at 6 month follow up: 65% vs 62% improvement in +ve symptoms; 67% vs 31% improvement in –ve symptoms
Granholm et al 2005	37 older clients offered 24 x 2hr group therapy, CBT & social skills training + RC	39 clients offered RC	ILS, PBSA, PANSS HADRS, BCIS	improvement in general functioning and skills over control group but no change in +ve / -ve symptoms

Abbr: RC = routine care; CBT = cognitive behaviour therapy; OT = occupational therapy; CPRS = comprehensive psychiatric rating scale; SAPS = scale for assessment of positive symptoms; SANS = scale for assessment of negative symptoms; BPRS = brief psychiatric rating scale; GHQ = general health questionnaire; QOL = quality of life scale; CGI = clinical global improvement scale; HADRS = hospital anxiety and depression scale; GAF = global assessment of functioning scale; SFS = social functioning scale; BDI = Beck depression inventory; TLFB = time line follow back; ILS = independent living skills; PBSA = performance based skills assessment; BCIS = Beck cognitive insight scale.

Although generally positive, the studies above incorporated varied interventions under the umbrella of CBTp. Consequently it is difficult to state with certainty the elements of CBTp that were effective for negative symptomatology. However, Wykes et al (2007) and Rector and Beck (2001) have reviewed several studies of CBTp that included those targeting social functioning, social anxiety and negative symptomatology. The factors identified for success with negative symptoms are: shared goals; psycho-education techniques; compliance; and, behavioural strategies. A further

study by Massari and Hallam (2003) identified the fundamental characteristics as humanistic and collaborative.

Although there does not appear to be a specific model of CBT for negative symptoms, it is generally agreed that therapy should be formulation focused (Morrison et al 2004, Rector et al 2002) but with the following general principles in mind:
1. to reduce distress and disability;
2. to reduce emotional disturbance;
3. to increase active participation of the client in managing self, risk and social implications (Fowler et al 1995).

There is also general agreement that the behavioural features of CBT, including homework, are most beneficial for negative symptomatology (Rector and Beck 2001, Jacobson et al 2001). In keeping with this philosophy, activity scheduling, which includes mastery and pleasure ratings (Beck and Rector 2005) is used to:
o   monitor current activities and beliefs;
o   begin to address inactivity by scheduling pleasurable and meaningful activities (Jacobson et al 2001) and rating the extent to which these are completed and enjoyed;
o   breaking tasks into smaller manageable and repeated tasks (Milev et al 2005).

Conclusion

In conclusion, the debates surrounding the aetiology of psychosis are endless. There is general agreement that psychotic illness is not a discrete disease process and many authors now accept theories based on several inter-related factors (Zubin and Spring 1977, Calcott et al 2004, Fowler et al 1995). From this standpoint, it seems sensible to conclude that the same is true for the causes and effects of primary and secondary negative symptoms in relation to psychotic illness. Consequently, it may be more useful to take a more holistic and person-centred approach when attempting to understand and support individuals in managing these *symptoms.*

At present the philosophy of cognitive behavioural intervention seems most appropriate as it encourages the client to explore their current situation and identify personally meaningful areas for change, and collaborate on the method of the change process and the pace at which

the change will occur. This would appear to be most important for regaining a sense of control and purpose for those whose illness may have externalised, in actual or perceived terms, a significant proportion of their locus of control.

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The Mental Health Act 2007 – *a short update*

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B r i e f i n g   P a p e r

Introduction

After nine years of controversy and two failed attempts, the reform of the Mental Health Act 1983 has finally been drawn to a close. On 19th July 2007 the final version of the mental health bill received royal assent and was passed into English law as the Mental Health Act 2007. The final version of the reformed legislation was a significant compromise by a government, who had started the process nearly a decade ago with the intention to introduce a whole range of new powers, and whose final version includes one new community order, new roles and several changes of definitions or conditions.

The Act itself was largely agreed with the Mental Health Alliance (a coalition of many professional and service user groups), who issued a statement:

"Alliance members and supporters have achieved some hard-won improvements to the Mental Health Act. The right to advocacy and the new safeguards for children are genuine steps forward. But the overall verdict of Alliance members is that the 2007 Act is a disappointment. Progressive measures such as giving people greater choice and rights to services have been omitted."
(*http://www.mentalhealthalliance.org.uk/news/prfinalreport.html*)

Summary of the Changes

The amendments overall are an improvement on the 1983 Act, with several practical difficulties being addressed and further alignment with the Human Rights Act 1998.

1. **Definition of Mental Disorder:** a single definition applies throughout the Act, and abolishes references to categories of disorder.
2. **Criteria for Detention:** it introduces an "appropriate medical treatment" test which will apply to all the longer-term powers of

detention. As a result, it will not be possible for patients to be compulsorily detained or their detention continued unless medical treatment which is appropriate to the patient's mental disorder and all other circumstances of the case is available to that patient.

3. **Professional Roles:** it is broadening the group of practitioners who can take on the functions currently performed by the Approved Social Worker (ASW) and Responsible Medical Officer (RMO).

4. **Nearest Relative (NR):** it gives to patients the right to make an application to displace their NR and enables County Courts to displace a NR where there are reasonable grounds for doing so. The provisions for determining the NR will be amended to include civil partners amongst the list of relatives.

5. **Supervised Community Treatment (SCT):** introduced for patients following a period of detention in hospital. It is expected that this will allow a small number of patients with a mental disorder to live in the community whilst subject to certain conditions under the 1983 Act, to ensure they continue with the medical treatment that they need.

6. **Mental Health Review Tribunal (MHRT):** it introduces an order-making power to reduce the time before a case has to be referred to the MHRT by the hospital managers. It also introduces a single Tribunal for England, with the one in Wales continuing.

7. **Age Appropriate Services:** it requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs).

8. **Advocacy:** it places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates.

9. **Electro-convulsive Therapy:** it introduces new safeguards for patients.

In addition, the changes to the Mental Capacity Act (MCA) provide for procedures to authorise the **deprivation of liberty** of a person resident in a hospital or care home who lacks capacity to consent. The MCA principles of supporting a person to make a decision when possible, and acting at all times in the person's best interests and in the least restrictive manner, will apply to all decision-making in operating the procedures.

What will this mean in practice?

A work programme is being rolled out across the service over the coming months, with full implementation to be completed by October 2008. A number of changes have already occurred, with civil partnership now recognised as a spousal relationship and the Approved Mental Health Practitioner (AMHP) training being approved for commencement next year.

Professional roles will be a significant aspect of the new legislation, with nursing, psychology and occupational therapy colleagues able to access and train to undertake the AMHP role, and appropriate professionals able to be appointed as the responsible clinician which will replace the responsible medical practitioner role.

Further Information:

A full training plan is being developed and will be available to staff early in 2008, with a number of mandatory requirements for both practice staff and managers – further details will be published via the Trust's intranet or WBT Manager (electronic training booking & recording system).

For queries relating to professional roles, please contact:
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Publications, guidance and information is being posted on the Trust's intranet site as it becomes available – please visit the Trust's intranet site and follow the links: Trust intranet>social care>mental health act 2007.

Department of Health: www.dh.gov.uk
Mental Health Alliance: www.mentalhealthalliance.org.uk

Collaboration between the Crisis Resolution and Home Treatment Team and Community Mental Health Teams: a review of the literature

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Literature Review

Introduction & Background

Care for individuals with mental illness has evolved over the last 50 years following the closure of large asylums (institutional care), to care in the community. Since the 1950s, many government policies in England and Wales have focused on reducing hospital beds, with the rationale that 'care in the community' enables individuals with mental illness to live independently in their own homes (Tyrer et al 1998). The Department of Health (DH 1990) predicted that this model of care would increase opportunities for people with severe and enduring mental illness to achieve their full potential, while at the same time allowing them choice.

Community Mental Health Teams (CMHTs) were developed to deliver community care (Bouras 1986, Bennette 1991), being viewed as a 'vision, a social process, a health resource, a group of professionals, a unit of management' (Moss 1994). Moss' view of a community mental health team is not restricted to a 'team', but to a wide range of activities that take place in the community away from the mental hospital. This view is echoed in Moss' comments that 'community mental health teams replace mental hospitals, and creates aspirations for service users and their families on the one hand, and health care professionals' on the other.

Nevertheless, community care as represented by CMHTs has been the subject of controversy, with some commentators believing that the model is a failure (DH 1998, Boateng 1998, Leff 2001) due to an increase in homelessness among the mentally ill (Shelter 2001, Timms and Fry 1989), and violence and homicides committed against the public by some individuals with mental illness (Taylor and Gumm 1999). On the other

hand, success stories about community care have not been well-publicised. For example, in the 1950s there were more than 150,000 beds in long-stay mental hospitals, which reduced to less than 30,000 by 1998, and this was predicted to decrease even further (Shepherd 1998). Furthermore, between 1978 and 2001, only 14 out of 130 psychiatric hospitals remained open (Leff 2000). Nevertheless, homelessness of and homicides by individuals with mental illness have over-shadowed the success stories, and by their own recognition and admittance, governments have echoed the media outcry of the failure of community care – with a loss of confidence in the model by the public.

In 1997, the Department of Health recommended that for a successful community care system, accommodation, work and employment, and specialist community teams (with small protected case loads and extended hours of operation, with the capacity to deliver intensive support) needed to be in place (DH 1997). Furthermore, the National Service Framework for Mental Health (NSF) included a recommendation for the establishment of specialist community mental health teams, that included: Crisis Resolution (home treatment) Teams, offering an alternative to in-patient admission; Assertive Outreach Teams, providing intensive support in the community to patients with complex health and social needs who might drift out of care; and, Early Intervention Teams, providing services to young people who have developed a severe mental illness for the first time (DH 1999).

It was intended that the establishment of these specialist teams would strengthen community care and regain public confidence, and thus reduce the pressure for acute psychiatric beds (DH 2000). However, there appeared to be a lack of guidance as to how professionals in the CMHTs and specialist community teams would work effectively together.

The Mental Health Policy Implementation Guide for community mental health teams (DH 2002) suggested that all stakeholders within the 'whole system' of community care should aspire to flexible and close working relationships in localities. More specific to the CMHTs and Crisis Resolution Teams, recommendations were made for close liaison and links between these teams. Clearly, managing a whole system requires joint working, which in turn necessitates collaboration – in this case between CMHTs and the new community specialist teams such as the Crisis Resolution and Home Treatment Teams (CRHT) (Kennedy et al 2005). There are however

important implications of joint / collaborative working where teams cross boundaries, balancing areas for open co-operation versus conflict, which may be a consequence of variations in commissioning, statutory responsibilities, occupational cultures and management arrangements (Lankshear 2003).

In spite of the many problems that joint / collaborative working can provoke, such collaboration in health and social care teams can benefit service users through the implementation of an integrated care pathway (ICP) (Scottish Office 1997, Kitchener et al 1996).

In the local Health and Social Care Partnership Trust, two Crisis Resolution and Home Treatment Teams (CRHT) work alongside existing Community Mental Health Teams. Both types of service teams provide a service to the same patient population.

In March 2006, the Luton-based CRHT and local CMHTs participated in a team building day, from which a number of difficulties were highlighted: a lack of interface / joint working, joint planning and shared care; a lack of respect of professional opinion between teams; a large number of referrals by CMHTs to CRHT during the last hour on Fridays; and, instances of accusing each other of being unhelpful. On a more positive note, it was agreed that the teams needed to continue to: work in partnership; and, continue to make service users and their families feel satisfied.

In preparing and undertaking a research study to further explore the interface between these two teams, *a summary of which will be presented in a follow-up paper*, a review of some of the key literature was undertaken.

Literature Review

Community Mental Health Teams (CMHT)
CMHTs are considered and expected to provide the core of specialist mental health services in England (DH 1999: 47), but with the introduction of new models of mental health services that include Assertive Outreach Teams, CRHTs and Early Intervention Teams (DH 1999), roles and responsibilities have become complicated (Thornicroft et al 1999). These

different community teams are expected to function in an integrated way (Carpenter and Barnes 2001), though it is evident that using an integrated approach to care is associated with high levels of stress and burn-out among community-based mental health staff (Leary and Brown 1995, Prosser et al 1996, 1999), leading some commentators to question the sustenance of community care (Wykes et al 1997). Nonetheless, CMHTs are considered to provide a useful function in many areas.

A meta-analysis evaluating the effects of CMHT management in the UK found a correlation between CMHT management and reduction in suicide among those with severe mental illness (Tyrer et al 1998). The authors further associated CMHT care with an avoidance of hospital admission and a shorter duration of hospital stay where hospitalisation was not avoided. Their conclusions are drawn from the results of randomised controlled trials in a systematic review of five studies: three studies from London, UK (Merson et al 1992, Burns et al 1993a & 1993b, Tyrer et al 1998), one from Australia (Hoult et al 1981) and one from Canada (Fenton et al 1979). The outcome measure relating to suicide can be a source of criticism: in fact, the number of deaths in the studies was small and further studies were recommended to determine whether these findings were robust (Simmonds et al 2001). In spite of this critical view of the findings of Tyrer et al (1998), the positive outcome measures are consistent with those of Simmonds et al (2001).

These findings are not however shared by other researchers / authors. Key empirical evidence suggests problems with CMHT care, and notable criticisms include the following: random case allocation rather than being needs-led; integrated care planning and joint work rarely being conducted; and, poor inter-agency work (Paxton 1995, Galvin & McCarthy 1994, Onyett & Ford 1996). In terms of process, these authors take the view that CMHT management is flawed and is consistent with Clark's (1999) report on inter-professional working in London, which highlighted conflicts, unclear roles of CMHT staff, and motivation being generated by status and self-interest rather than team commitment.

Further support of the criticisms of CMHTs is evident in Norman and Peck's (1999) work in the UK. They draw a correlation between CMHT work and poor inter-professional / multi- agency working. Using discussion groups of senior mental health managers in a conference setting, they highlighted

problems within CMHTs: a loss of faith by mental health care professionals in the system within which they work; strong adherence to uni-professional cultures; an absence of a strong and shared philosophy of community mental health services; and, mistrust of managerial solutions to the problems of inter-professional working. The strength of Norman and Peck's (1999) study is their method of data collection, which involved discussion groups to generate data. However, they are criticised because their groups did not involve staff from grass roots, as suggested in a government document (DH 1995), which indicates that senior management solutions or government policy alone do not encourage inter-professional collaboration, but would need the involvement of all staff concerned.

Crisis Resolution and Home Treatment Teams (CRHT)

Crisis is considered as 'a breakdown of an individual's normal coping mechanism, which may be developmental, situational or a result of severe trauma' (Rosen 1997). This view of crisis is recognized by Schnyder (1997) who has developed a seven-point psychiatric crisis intervention model. Though descriptive, the model's relevance is that it maps out the actions to be taken through identified stages:

o establishing contact;
o problem analysis;
o problem definition;
o goal definition;
o working on the problem;
o termination;
o follow-up.

Schnyder's model has been criticised for its descriptive nature, though it could be useful for clinicians who are new to crisis service provision. Nevertheless, Schnyder's model is consistent with, and supported by, Roberts (1990) crisis model, which clearly identified the type of interventions to be undertaken at different stages.

The Sainsbury Centre for Mental Health (2001) in the UK present the CRHT as a specialist community mental health team, with a focus on individuals with a mental illness who present in crisis. While the Centre's material is descriptive in nature, it is valuable in that it sets out guidelines for Trusts who are intending to establish crisis intervention services. The guidelines

suggest that, if implemented properly, crisis services can prevent hospitalisation or shorten bed days where admission cannot be avoided.

These views are consistent with the findings of Johnson et al (2005), who through their study of 260 participants in the Inner London Borough of Islington, comparing an intervention by a crisis service with a generic community mental health team, found a strong association between crisis intervention service and client satisfaction, but not so for the generic community mental health team intervention – the control group in their study. These findings are celebrated in other studies by Johnson et al (2005) and Joy et al (2006). In a systematic review of five randomized controlled trials, a further association was shown between CRHT intervention and the prevention of deaths by suicide (Joy et al 2006).

A study by Harrison and Traill (2004) in the North-West of England, using a postal survey of Consultant Psychiatrists, revealed that of the three recently established service teams, Crisis Resolution Teams over-shadowed Assertive Outreach and Early Intervention Teams in preventing hospital admission. Nevertheless, Harrison and Traill (2004) can be criticised for not exploring the negative effects of the new services, and especially the Crisis Resolution Service which most consultant psychiatrists favoured. Instead, a general concern is expressed that the new specialist services are being developed at the expense of existing teams.

In spite of these positive outcomes, there does not appear to have been any study comparing how staff in CRHTs relate with staff from other teams / agencies.

Collaboration between CRHTs and CMHTs
Though the CRHT and CMHTs in the Trust provide home-based services for individuals who present a different phase and severity of mental illness, their team management structures differ, and they may best be regarded as different in their individual aims and approaches to care. The type of collaboration between these teams can thus be regarded as 'inter-agency', which refers to 'relationships between different organisations / agencies with their own cultures, manifested in their policies and procedures, but all within the whole system' (Biggs 2005: 187). This view of collaboration is different from that which is required in multidisciplinary teams, with the latter referring to cooperation within a team.

The Mental Health Policy Implementation Guide (DH 2001) described the remit of the various teams providing a service in the community for adults of working age. This guideline recognises and stresses the important role that CMHTs (or primary care liaison teams) will continue to perform (DH 2001: 6), recognises that a change in one service will have an impact upon another (ibid: 7), and encourages all teams to break barriers in adopting a whole systems approach to working (ibid: 7). However, the roles of the newer service elements or CMHT were perhaps not fully clarified. Nevertheless, the guideline does highlight the role that Local Implementation Teams (LITs) are expected to play. The guideline is very specific in emphasising the importance of a liaison and link with not only the CRHT, but also the other newer specialist community teams. Of particular importance is the recommendation that 'mutually agreed and documented responsibilities, liaison procedures and in particular transfer procedure need to be in place when Crisis Resolution and other new specialist teams are established'. However, this guideline did not draw attention to the challenges of collaboration.

The Department of Health produced a specific guideline on working in partnership, which emphasises the importance of joint working among key stakeholders in care provision, and highlights the principles of whole systems working, which are that (DH 2000): the needs of the community are paramount, and so the priorities must be based on the benefits to the entire community and not any single organisation, with all partners needing to agree the goals and objectives; no organisation can opt out; and, practical goals and objectives should be set which will benefit all partners. The guideline further gives an account of the fundamental elements to successful joint work, which include:

o   policy and goal setting;
o   accountability, referring to the management arrangements that underpin delivery of the local agenda;
o   networking and alliances, referring to the means by which change is achieved and commitment to action on joint initiatives is generated;
o   culture and learning, referring to the way in which the local community embraces joint working and learns from local and national initiatives;
o   the appropriate use of all local resources; and,
o   skills and competencies.

It was highlighted that successful joint working can be achieved through: open communication and mutual respect for each organisation; a participative approach which encourages each party to contribute; good relationships; the development of a learning climate; and, a review and dissemination of experiences from local initiatives.

This guideline not only highlights the principles of whole systems working, but also presents the challenges: the difficulties in agreeing a set of priorities which benefits the community as a whole; the difficulties in establishing accountability arrangements across a number of organisations; and, the legacy of separate systems and departments.

Kennedy et al (2005) reported on the success of a 'whole system'. Although anecdotal, this paper drew upon the experience of a North London Trust in involving personnel and teams within the Trust to overcome the problems of bed occupancy on acute psychiatric wards whilst avoiding out-of-area placements for service users. A success story, this demonstrated that, if well organised, the vision of the whole system can be achieved.

Partnership / Joint Working and Collaboration
Partnerships are designed and deemed to facilitate the negotiation and delivery of public programmes cutting across the boundaries of fragmented organisations. Therefore, the integration of mental health services is a key policy objective that aims to increase quality and efficiency of care (Skelcher 2000, Freeman and Peck 2006, Rees et al 2004). Partnership is 'an umbrella term covering a multitude of arrangements between public, private and voluntary agencies and service users (Home Office 1999, Bratby 1999). It is believed that such partnerships and service integration are beneficial to service users, carers, staff and the organisations / teams which enter partnership relationships.

A study by Freeman and Peck (2006) in England explored the impact of integrated provision on service users, carers, teams and staff, using a multi-method approach in a county-wide study in Hertfordshire from 2002 – 2004. The results revealed: a stronger association between inter-team collaboration and user and carer satisfaction with the whole system; role clarity and job satisfaction among staff in the teams; and, inter-year comparisons indicated moderate to good levels of achievements, with

scores for 2004 showing slight improvements on those for 2002. This study not only focused on the positive outcomes of partnership but also reported on some of the difficulties teams encounter when they enter partnership relationships. The positive outcomes were consistent with the findings of Rees at al (2004), who investigated the experiences and views of Integrated Care Pathway (ICP) implementation in CMHTs in Scotland. Using a qualitative method (individual and group interviews) to explore professional views of joint working in CMHTs and the role of an ICP, it emerged that joint working was associated with positive outcomes, and they identified the need to share roles, responsibilities and information. It emerged that joint working can benefit service users by offering them a single point of access into a streamlined service. However, Renholm et al (2002) pointed out that few studies have assessed the impact of ICPs on joint working, communication and collaboration within multidisciplinary teams, and those studies which do so have shown inconsistent results.

Impact of Multi-disciplinary and Inter-agency Collaboration

Most policy initiatives in health and social care in the UK have focused on collaborative working and indicate that to sustain high quality care, integration among health care professionals is a necessity (DH 1999, 2001, 2002).

Collaboration is considered a 'partnership in which power, knowledge and expertise of each member or team is acknowledged and valued in the work towards a shared goal' (Stichler 1995: 54). Tschanneh (2004) adds that 'collaboration also involves individuals with varying backgrounds and expertise communicating effectively with one another in a non-hierarchical fashion, as together they are able to search for solutions that cannot be determined with an individual's limited scope of knowledge'. It is perceived that collaboration among health and social care professionals in various settings results in positive outcomes for service users and professionals involved in those collaborative endeavors (Aiken 2002, Vahey et al 2004).

Higgins (1999) studied the relationship between nurses' perception of collaboration and negative patient outcomes. It emerged that when nurses reported the absence of collaboration around decision making for patients, the predicted risk of poor patient outcomes was 16%, whereas when nurses reported full collaboration, the patient predicted risk for negative

outcome was only 5%. Baggs et al (1999) found similar results when assessing the relationship between the decision to transfer patients and patient mortality and morbidity. Many will argue that though a correlation is drawn between collaboration and positive patient outcomes, creating an environment that supports collaboration has yet to be explored.

It is reported that for collaboration to occur in the work environment, individuals and the whole system must support team-work (Borman et al 1997, Hudson 2006a, 2006b). Hudson (2006a, 2006b) concluded that the input of stakeholders at every level of the organisation would need to be deployed in achieving collaboration but warned that tensions and conflicts were also bi-products of collaborative ventures, echoing the findings of Jehn et al (1999), that 'work-group success does not only depend on the group's ability to do the task but also on its ability to manage its own interactions effectively, including cooperation, communication, and coordination of its collective efforts'.

Successful intra-team and interagency collaboration can be guided by using a well defined model, which Bronstein's (2003) meta-analysis of the social work literature in the USA claims to constitute:

o *interdependence* – 'an interpersonal process through which members from different disciplines or teams contribute to a common goal' (Berg-Weger and Schneider 1998: 698);

o *newly created professional activities*, that 'are identifiable structures built by collaborator endeavors that do not replicate those of individual professionals or teams' (Kagan 1992, Mathessich and Monsey 1992);

o *flexibility* – deliberate occurrence of role-blurring so as to reach a productive compromise in the face of disagreement and the alteration of role (Toseland et al 1986, Abramson and Mizrahi 1986);

o *collective ownership of goals* – 'shared responsibility in the process of reaching identified goals, including joint design, definition, development and achievement of goals' (Bruner 1991, Mathessich and Monsey 1992); and,

o *reflection on process* – for collaborators to review and evaluate their working relationship (Billups 1987, Soler and Shauffer 1993).

So far, joint working and inter-agency collaboration have been found to be beneficial though conflicts do occur. Turnbull (1999) reported on a multi-

disciplinary conference held in Wales, which explored the interface between community mental health services and primary care, criminal justice services and drug and alcohol services. Reports from these workshops suggested: a lack of role clarity between teams; a power struggle within and between teams; poor communication between teams due to the differing cultures and backgrounds of the agencies involved; difficulties encountered by specialist mental health teams locating certain service users; and, funding and commissioning differences. The report recommended that successful joint working can be achieved through joint multi-disciplinary education, joint funding and professional dialogue. Whilst the conference raised vital issues on multi-agency working, some of the solutions suggested appear unrealistic and difficult to achieve. Nevertheless, the suggestions in Turnbull's (1999) report were upheld by Norman and Peck (1999), as discussed earlier. It was therefore suggested that both managerial and grass root staff solutions to problems within and between teams would need to be considered.

Conflict in Collaborating Teams

It is very evident that individuals and teams in collaborative ventures have expectations which might not be similar to the values and perceptions of those in other teams who are supposed to collaborate, and as a result conflicts emerge. Boulding (1962) defines conflicts as 'a situation of competition in which the parties are aware of the incompatibility of potential future positions and in which each party wishes to occupy a position which is incompatible with the wishes of the other' (cited: Capozzoli 1999). The reasons for the differences that occur in multi-disciplinary teams range from the world-view (Ovretveit 1995), professional identity (Norman and Peck 1999), educational background (Miller et al 2001), jealousy and protectionism (Ovretveit et al 1997). Research evidence suggests that conflict can be both beneficial and dysfunctional to teams.

Lankshear (2003) studied the factors influencing client allocation within community mental health teams in England, making the correlation that conflicts are present when teams in a whole system collaborate. However, Lankshear pointed out that the type of conflict resolution strategy adopted (e.g. isolation, homogenization, fraternisation, negotiation and manipulation) would determine the outcome.

Conclusion

In summary, the literature has revealed that inter-agency collaboration is essential for collaborating teams and service users, and although this can lead to conflicts, such can be minimised by the adoption of appropriate intervention strategies. It is suggested that inter-agency and any resultant conflicts cannot be achieved by government policy alone (DH 1995), rather it requires the active participation of staff who are closely involved, with solutions being found through multi-professional consensus and dialogue (Norman and Peck 1999).

In planning and undertaking a research study, it was proposed to use a theoretical perspective, based upon the empirical and anecdotal evidence presented in the literature, hypothesising that problems do exist between the CRHTs and CMHTs within the Trust, and that these problems may have an impact on team performance, the staff and the common client group that both service teams serve.

The basis of this hypothesis is that in the Trust, the CMHTs and CRHT provide services for the same client group, which indicates that both service teams interact, and there are inevitably tendencies for conflicts / problems or issues to arise, as strongly suggested by the literature. In reality, at the team building day involving CRHT and CMHT team-members, it emerged that there was lack of collaboration between the two service teams. However, the nature and extent of this problem was not thoroughly explored, though suggestions were aired for these teams to collaborate more closely. A research study was therefore planned and undertaken to further explore this issue and investigate whether or not any achievements have been gained. *A summary of this research study will be presented in a follow-up paper.*

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Exploring the Characteristics and Needs of Black & Ethnic Minority Service-Users in a Community Mental Health Team

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Service Audit

Introduction

The multi-disciplinary Luton South West Community Mental Health Team (CMHT) provides mental health and social care for adults aged 16 to 65 years old, who live within a densely populated area of Luton. In fact, Luton has a relatively high population density of 42.5 residents per hectare, compared to 2.8 for the East of England and 3.4 for England and Wales, with higher than average numbers of people from black and minority ethnic (BME) groups when compared to that nationally: local census data (LBC 2001) confirms the total population of Luton as 184,356, with BME groups representing 35% of this, as compared with 12.5% for England and Wales; of these, some 118,916 of Luton residents are of working age, representing 64.5% of the total population (see Table 1).

Table 1: No. of Working Age People by Ethnic Group (LBC 2001)

Ethnicity	Number of working age people in Luton	% of working age population of Luton
White British	77,389	65.1
Pakistani	10,140	8.5
White Irish	6,073	5.1
Indian	5,411	4.6
Black Caribbean	5,364	4.5
Bangladeshi	4,496	3.8
White Other	3,114	2.6
Black African	2,337	2.0
Asian Other	1,010	0.9
Chinese	889	0.8
White / Black Caribbean	750	0.6
Black Other	497	0.4

Other	492	0.4
White/Asian	391	0.3
Mixed: Other	380	0.3
White / Black African	183	0.2

As shown in Table 2, the total estimated population of the Luton SW area is 48,870 people, representing 26.5% of the total population of Luton, of whom 62.3% (30,484) are of working age, which is slightly lower than that for the whole of Luton. More importantly, the Luton SW area appears to have higher than average numbers of working age people from BME groups when compared to the whole of Luton, and especially from the Pakistani, Black Caribbean, Bangladeshi and Indian ethnic groups.

Table 2: Estimated No. of Working Age People by Ethnic Group for Luton SW

Ethnicity	% of working age population of Luton	Estimated no. of working age people in LSW area	% of working age population of LSW area
White British	65.1	17,228	56.5
Pakistani	8.5	4,109	13.5
Black Caribbean	4.5	1,804	5.9
Bangladeshi	3.8	1,551	5.1
Indian	4.6	1,523	5.0
White Irish	5.1	1,261	4.1
Black African	2.6	600	2.0
White Other	2.6	617	2.0
White / Black Caribbean	0.6	518	1.7
Asian Other	0.9	365	1.2
White / Asian	0.3	206	0.7
Black Other	0.4	184	0.6
Mixed: Other	0.3	164	0.5
Other	0.4	151	0.5
Chinese	0.8	121	0.4
White / Black African	0.2	82	0.3

Furthermore, the area covered by the Luton SW CMHT includes some of the lower socio-economic wards in Luton: Dallow and Biscot wards have the highest levels of multiple deprivation, with rankings of 477 and 521 respectively out of 8,414 wards nationally (where 1 = the most deprived

area) (Office of National Statistics 2000). These two wards represent approximately 19.6% of the Luton SW area. There is an uneven spread of Luton ward rankings, with 14 of the 16 Luton wards being in the top 50% of deprived wards, of which 8 Luton wards are in the top 25% of deprived wards nationally.

A high proportion of the team's service-users appear to be from an ethnic background other than White British. Many also appear to be have literacy problems with regard to English and are unemployed. The team's service-user group experiences a wide variety of mental health problems that are often quite severe in degree and nature, and tend to have more complex mental health and social care needs.

Aim
It was decided to conduct a retrospective audit of all Luton SW CMHT service-users of non-White British ethnic origin, in establishing a database of BME service-users that would facilitate meaningful analysis and team audit activity.

Objectives
A number of key objectives were agreed for this audit activity:
o   to identify factors that may be associated with mental illness in BME service-users;
o   to make meaningful observations and form recommendations regarding clinical practice, management and service provision;
o   to repeat this audit for all Luton SW CMHT service-users of White British origin in making relevant comparisons;
o   to establish and maintain two complete and active service-user databases that could be used to aid future service audit.

Methodology
With the assistance of the team administrator and IT department, a confidential database was established for the Luton SW CMHT service-user group that included a range of socio-demographic *(for example: name, date of birth, address, ethnicity, language, employment status)* and clinical *(for example: diagnosis, CPA level of care, treatment with medication)* data fields. This database is maintained securely and is only accessible to members of the Luton SW CMHT.

This database was analysed in exploring the characteristics of the team service-user group against ethnic background.

Summary of Findings
A summary of the key findings is presented, which relates to information that was available in January 2007.

Gender
A total of 369 service-users were receiving care from the Luton SW CMHT, of whom 50% (n=185) were from an ethnic minority other than White British. Of the BME sub-group, 52.9% were male (n=98) and 47.1% female (n=87).

Age Groups
The majority of BME service-users (92.9%, n=172) were aged 18-60 years with 76.7% (n=142) being aged 18-50 years. None of the service-users were under 18 years old and only 2.2% (n=4) were over 65 years old.

Diagnoses
Almost half of BME service-users (44.9%, n=83) had an F20-29 diagnosis (schizophrenia, schizotypal and delusional disorders): 29.2% (n=54) of BME service-users had a diagnosis of schizophrenia, 4.9% (n=9) had a diagnosis of acute and transient psychotic episode and 7.6% (n=14) had a diagnosis of schizoaffective disorder.

Almost a quarter (24.9%, n=46) of BME service-users had an F30-39 diagnosis (mood disorders): 8% (n=14) had a diagnosis of bipolar affective disorder and 16% (n=30) had a diagnosis of depression. A further 22.2% (n=41) of BME service-users had an F40-48 diagnosis (neurotic, stress-related & somatoform disorders): 7.6% (n=14) had a diagnosis of mixed anxiety and depressive disorder, 3.2% (n=6) had a diagnosis of obsessive compulsive disorder, 3.2% (n=6) had a diagnosis of post-traumatic stress disorder and 5.4% (n=10) had a diagnosis of adjustment disorder. Only 1.1% (n=2) had a diagnosis of somatoform disorder.

A small number of BME service-users (7.6%, n=14) had more than one ICD-10 diagnosis, of whom 3.2% (n=6) had a F10-19 secondary diagnosis ('dual diagnosis') and 4.3% (n=8) had another secondary diagnosis.

Level of Care
Only 17.3% (n=32) of BME service-users were receiving Enhanced CPA (Care Programme Approach) care.

Prescribed Medication
The majority **(**86.5%, n=160) of service-users were prescribed regular oral medication only, whereas only 5.4% (n=10) were prescribed regular intramuscular (depot) medication only. 9.2% (n=17) were prescribed both regular oral and regular depot medication. 7% (n=13) were not prescribed any medication, whilst 15.7% (n=29) were prescribed as required (PRN) medication – and most commonly procyclidine, zopiclone or diazepam. Only one person was prescribed only PRN medication.

Ethnicity
Over a third (35.1%) of BME service-users were of Pakistani origin, and over two-thirds were of Pakistani, Bangladeshi and Black Caribbean origin. Indian, White Irish and Black African service-users together made up over one-fifth (21.1%) of the ethnic minority service-user group, with the White Other group representing over a quarter (27.6%). There were relatively few White / Black Caribbean, Black Other and Asian Other service-users, and none of the service-users were White / Black African, White / Asian, Mixed Other, Chinese or of an Other Ethnic Group.

Language
78.9% (n=146) of BME service-users spoke English as their main language, though many could speak another language ('mother tongue'). 47% (n=87) of BME service-users who spoke English as their main language were male (representing 52.9% of the group), as compared with 31.9% (n=59) who were female (representing 47.1% of the group). 10.1% (n=20) spoke Bengali and 5.9% (n=11) spoke Urdu as their main language, and could not speak English. The other languages that were spoken included: Punjabi (1.1%), Gujarati (1.1%), Hindi (0.5%), Albanian (0.5%) and Russian (0.5%).

Employment
87.6% (n=162) of BME service-users were unemployed: 44.3% (n=82) for females and 43.2% (n=80) for males. Of the remaining service-users, 8.6% (n=16) were employed full-time, part-time or voluntarily; 2.2% (n=4) were students; and, 1.6% (n=3) were retired.

Discussion of Findings

The BME service-user group represented 50% of the Luton SW CMHT caseload, thus appearing to be over-represented when compared to the data for the whole of Luton and the estimated population data for the Luton SW area.

White British adults of working age in the Luton SW area represented 56.5% of the total group, as compared with 43.5% for BME working age adults. The Luton SW BME service-user group therefore does appear to be over-represented when compared to the estimated working age population figures for the Luton SW area. There appears to be an over-representation of Pakistani, Bangladeshi, Black Caribbean, Black African and White Other ethnic minority groups: this was more than double for the Pakistani and Bangladeshi ethnic groups when compared to working age population figures for Luton as a whole (see Table 3).

Table 3: % of Working Age People by Ethnic Group
compared with estimates for the Luton South West area

Ethnicity	% of working age population of Luton	% of estimated working age population of Luton SW area	BME groups as % of Luton SW area
White British	65.1	56.5	50.0
Pakistani	8.5	13.5	17.6
Bangladeshi	3.8	5.1	8.1
Black Caribbean	4.5	5.9	7.9
Indian	4.6	5.0	3.8
White Irish	5.1	4.1	3.5
Black African	2.0	2.0	3.3
White Other	2.6	2.0	3.3
White / Black Caribbean	0.6	1.7	1.4
Black Other	0.4	0.6	0.8
Asian Other	0.9	1.2	0.5
White / Black African	0.2	0.3	0
White / Asian	0.3	0.7	0
Mixed: Other	0.3	0.5	0
Chinese	0.8	0.4	0
Other	0.4	0.5	0

It is possible that the population may have significantly changed in the last six years and the census data may not be completely accurate due to certain groups not being accounted for – *for example*, asylum seekers and illegal immigrants. Nevertheless this census data remains the most accurate and most recent that is currently available.

There is significant evidence to suggest that BME communities do not tend to access mental health services due to fears of stigmatisation and discrimination, which may suggest that the findings reported within this paper are an under-estimate of the actual number of people from BME groups with mental health problems.

The BME group appeared to have relatively high rates of F20-29 (schizophrenia, schizotypal and delusional disorders) diagnoses, which represented nearly half of all BME service-users. This includes service-users of the Luton Early Intervention Team who were referred back to the Luton SW CMHT upon the (temporary) decommissioning of that service in Sept. 2006.

The available evidence suggests that members of all ethnic minority groups are more likely to develop a psychotic illness. The personal and social pressures of belonging to any ethnic minority group in the UK are important determinants in the excess of psychotic disorders found. The UK AESOP (Aetiology and Ethnicity of Schizophrenia and Other Psychoses) study found that ethnic minority groups were at increased risk for all psychotic illnesses when compared with the White British population, though Black-Caribbean and Black African populations appear to be at especially high risk for both schizophrenia and mania (Fearon et al 2006).

The Black Caribbean group (which forms only 5.7% of the Luton SW service-user group) represented over 25% of the BME group with an F20-29 diagnosis, with over two-thirds (72.4%) of this ethnic group having a diagnosis of a psychotic illness. The Black African group (which forms only 1.6% of the Luton SW service-user group) represented 7.2% of the BME group, with 50% of this ethnic group having a psychotic illness. However, the Pakistani group represented the greatest number of service-users with a psychotic illness: forming 37.3% of the BME group (8.4% of the Luton SW service-user group), with 47.7% having an F20-29 diagnosis. The Bangladeshi group also appeared to be over-represented: forming 15.7%

of the BME group (3.4% of the Luton SW service-user group), with 43.3% having a psychotic illness. These four ethnic groups together represented 85.5% of the BME group with an F20-29 diagnosis. Mood disorders and neurotic, stress-related and somatoform disorders represented 12.5% and 11.1% of the Luton SW group respectively. There were relatively low rates of organic disorders, behavioural syndromes associated with physiological disturbances and physical factors, and disorders of personality and behaviour, each representing less than 1% of the Luton SW group.

BME service-users receiving enhanced CPA care represented just 8.7% of the Luton SW group, which seems surprisingly low, though this may suggest that a higher proportion of BME service-users are being better maintained with medication and appropriate CMHT support and are subsequently able to live more independently. This may also be a reflection of the amount of support they may be receiving from family members.

BME service-users represented 43.3% of the Luton SW group who were prescribed regular oral medication only, 2.7% for those prescribed regular intramuscular (depot) medication, 4.6% for those prescribed both regular oral and regular depot medication, and 3.5% for those who were not prescribed medication.

The largest non-White ethnic group for Luton SW was the Pakistani group (17.6%), then the Bangladeshi group (8.1%) and Black Caribbean group (7.9%). The Indian (3.8%), White Irish (3.5%), Black African (3.3%) and White Other (3.3%) groups each formed less than 4% of the Luton SW group. BME service-users who could speak English represented 39.6% of the Luton SW group, although 88% of BME males were able to speak English as compared with 67.7% of BME females. Those speaking only Bengali / Sylheti represented 5.4% of the Luton SW group and those speaking only Urdu represented 3%.

Unemployed BME service-users represented 43.9% of the Luton SW group, with no apparent differences for gender. BME service-users in full-time, part-time or voluntary employment represented only 4.3% of the Luton SW group, with students representing 1.1% and retired BME service-users representing 1%.

Conclusions and Recommendations

In view of the numbers of service-users from each ethnic minority group, there is clearly a need for appropriate ethnic and culture sensitive mental health service provision for BME communities, similar to that for White British communities. This provision would need to cater for similar numbers of males and females from BME communities and be gender-sensitive.

Separate or Integrated Services: the debate

There may well be a case for a separate service for BME groups due to their apparent over-representation as service-users. In fact, there has been an interesting debate about whether there should be separate psychiatric services for ethnic minorities (Bhui & Sashidaran 2003).

Stating the case for separate services, Bhui et al (2005) have argued that:

o   the evidence demonstrates racial, ethnic and cultural inequalities of access to specialist psychiatric care, and differential assessment and management practices;

o   in spite of contributing more on taxes than they consume in benefits, immigrants to the UK and their children still cannot expect at least equal benefit as citizens from a national system of mental health care;

o   professionals are still not fully equipped with the conceptual and skills knowledge to offer equity in assessment and management of mental distress in distinct cultural groups;

o   specialist services for specific ethnic groups have flourished mainly within the voluntary sector;

o   recent service developments in general psychiatry have not been evaluated in BME groups, even though they are over-represented as mental health service users;

o   the strength of specialist services lies in the mandate from service users and the commitment from the voluntary sector and those practitioners interested in culturally competent care provision;

o   existing services as a whole do not offer a system of care in which BME groups can expect to receive the least coercive treatment, and nor do they guarantee that cherished cultural, spiritual and religious beliefs are even known by professionals, let alone accommodated into care plans;

o   the statutory sector is increasingly containing, pursuing, detaining, and managing risk, rather than offering an alternative – voluntary

engagement through building relationships which aid recovery and instil hope;
o   in addition to an inability to address important institutionalised cultural issues, there are also gaps in service provision and in the training and continuing professional development of practitioners;
o   culturally informed staff focus on personal contact and relationship-building in the context of culturally congruent thinking;
o   the arguments against specialist services are often economic.

They suggest that three UK events promise improvement:
o   mental health policy emphasises equity in care provision;
o   NHS Trusts (the providers of care) are named within the Race Relations (Amendment) Act 2000, which makes them liable if their services are discriminatory; and
o   the Royal College of Psychiatrists has instigated an inquiry into institutionalised racism within College structures.

On the other-hand, Sashidaran (2003) has argued that the separateness of 'cultures' and the emphasis on 'differences' between White and non-White continues to be a major preoccupation within Europe. The idea of cultural differentiation is animated by the continuing legacy and vocabulary of the 'race' discourse of an earlier era and is augmented by the new racism concerning asylum-seekers and refugees. The idea of separate services for different ethnic groups is based on the premise that the mental health needs of minority ethnic groups are somehow different from those of others. There is hardly any evidence to support this and some of the most dramatic and persistent ethnic inequalities are found in mental health. The major disparities in the service experience and outcome between majority and minority ethnic groups are more likely a product of institutional factors, embedded in our professional practice and driven by the culture and history of western psychiatry.

It is argued that the solution for the current problems must involve the mainstream of psychiatric practice rather than marginal initiatives that emphasise the further segregation of minority needs. Culture and culturally informed or capable services are important in all aspects of psychiatry and not just in relation to minority ethnic groups (i.e. the White British group). By setting up services that emphasise the significance of culture only in relation to ethnic minorities we not only bleach culture out

of the mainstream but also, indirectly, suggest that culture is a problem or disability that requires specialised and often moderating interventions.

Creating specialised services for minority groups which emphasise the centrality of culture would mean recreating the discredited and ultimately colonial discourse of transcultural psychiatry. Such marginal attempts to create new services for British people of African and South Asian heritage will allow the mainstream of our services and those working within it to continue turning a blind eye to the needs of our multicultural society. The lessons to be learnt are therefore not about separate developments for Black people or South Asians but how to make our services in general culturally capable in responding to the needs of all cultural groups, both Black and White. However, this cannot be achieved without addressing the central issue of institutional racism. If there is a serious attempt to plan and deliver our services with a commitment to tackling institutional racism, then the needs of minority (and majority) groups will begin to be addressed. Working in partnership with patients to create both objective and subjective inclusion is necessary for a mental health service to be accessible and appropriate for everyone. There is a continued need for voluntary engagement through building rapport and relationships which aid recovery and instill hope, ideally in a culturally-congruent manner.

A Need for Diversity Training
There is a continued need for diversity training for all mental health professionals and practitioners so that they may be fully equipped with the knowledge and skills to offer equity in the assessment and management of mental distress in distinct cultural groups. There is a need for appropriate training and continuing professional development for practitioners and all those involved in the provision of mental health, which will help in challenging and tackling any institutional racism that may still exist.

There may be a need to audit whether patients from BME groups can expect to receive the least coercive treatment options – not necessarily a formal admission to hospital. Professionals need to be aware of patients' cherished cultural, spiritual and religious beliefs, which need to be subsequently accommodated into patients' care plans in line with Commission for Social Care Inspection (CSCI) outcome recommendations (improved health and wellbeing, freedom from discrimination and harassment). Our mental health services in general need to be culturally capable in responding to the needs of all cultural groups.

Considerations for Referral and the Care Pathway

The apparent over-representation of F20-29 (schizophrenia, schizotypal and delusional disorders) diagnoses amongst BME service-users suggests a need for vigilance for these types of severe and enduring mental illnesses, particularly amongst Pakistani, Black Caribbean, Bangladeshi and Black African ethnic groups. There is also a need for appropriate referral, as early as possible, to the Early Intervention Service (EI) in promoting the best treatment outcomes for newly diagnosed patients. This would also suggest a continued need to ensure that the EI Service is culture and ethnic sensitive.

It is possible that, due to the apparent reluctance of BME groups to access mental health services due to fears of stigmatisation and discrimination, they are more likely to present in crisis when they, and their families, can no longer cope on their own. This suggests that the Crisis Resolution / Home Treatment Team (CRHT) as well as potential referring agencies, would need to be vigilant, particularly amongst the afore-mentioned ethnic groups, in a continued culture and ethnic sensitive manner. The least coercive treatment option should also be sought though it may well be too late for informal interventions at home by the time BME service-users present or are referred to mental health services. Subsequent referrals to the EI Service would be needed and some may need to be referred to the Assertive Outreach Team (AOT), which again would need to continue to be ethnic and culture sensitive.

Considerations for Public Health & Education

There may be certain cultural practices and traditions which may increase the risk of mental (and physical) illness e.g. consanguineous marriage, which may need to be sensitively challenged as possible public health issues, requiring appropriate psycho-education.

Considering the needs of non-English speaking service-users

Although the majority of BME service-users could speak English, there is still a clear need for continued sensitive and appropriate interpretation services to allow for the thorough assessment and management of BME service-users whom cannot speak English. Evidence suggests that perceived racial or ethnic discrimination (race, religion or language) is strongly associated with common mental disorders. Hence, locally, the Milton Keynes Language Service is a valuable and necessary resource.

Interpreting services are also often provided by CMHT practitioners whom are bilingual, *for example*, in Bengali, Urdu or Punjabi. This has probably allowed the Trust to make significant financial savings. Nevertheless, interpreting services still remain a significant cost and responsibility for the Trust. Perhaps controversial, it could be argued that encouraging respective BME service-users to learn to speak English could become a cost-effective measure for the Trust. Any money saved could then potentially be re-invested in other resources for BME service-users. There may even be a need for appropriate training of mental health practitioners to be able to teach English as a foreign language (TEFL).

This audit does not suggest an obvious link between the inability to speak English and the presence of mental illness, although it clearly shows that all BME service-users who were unable to speak English were also unemployed. This provides a further argument for encouraging BME service-users to learn to speak English, as this would most likely significantly improve their future employment prospects. This would probably help their subsequent social recovery and inclusion. It may be hypothesized that their inability to speak English contributes to further social isolation. Evidence has suggested that secure employment increases the likelihood of recovery, whilst unemployment can lead to social isolation and low self-esteem, as well as having a potentially adverse effect on subsequent employment patterns.

There appeared to be some significant ethnic and gender differences in BME service-users who could not speak English: more likely to be female and of Bangladeshi or Pakistani origin. This would suggest the need to perhaps target these groups sensitively and appropriately, especially as this may involve challenging certain cultural beliefs and norms. Perhaps there needs to be further encouragement and support of these groups to learn English through one of the many free learning resources that are available in Luton.

Providing Support into Employment
There were high rates of unemployment suggesting the continued need for close working with voluntary and employment support services to encourage and facilitate social inclusion – for example, with Luton MIND, Ashanti, Roshni and D4. Recent research suggests that employment rates among people with schizophrenia are higher in Germany than in the UK.

Data from the European Schizophrenia Cohort Study's two-year investigation show employment rates of 12.9% in the UK compared to 30.3% in Germany (Marwaha 2007). The most common jobs were cleaning, labouring and skilled trades, such as plumbing and metalwork. More people in Germany were engaged in sheltered or voluntary work. The Luton SW BME employment rates are much lower than that for the UK. Luton overall also has employment rates lower than the national average. This would suggest the continued need for close links with employment support schemes, such as ACE Enterprises, in providing occupational therapeutic intervention, closer links with potential training providers and educational services.

Priorities of the National Programme
The NIMHE Black and Minority Ethnic Mental Health (BME MH) programme aims to improve the mental health care of all people of Black and minority ethnic status. Its aims are to:
o   enhance the quality of life, challenge exclusion through improved mental health services and health outcomes;
o   develop appropriate training and support to staff to deliver culturally competent services, with confidence;
o   enhance or build capacity within black and minority communities and the voluntary sector to deal with mental health and mental ill health;
o   to ensure compliance with Statutory obligations (Race Relations [Amendment] Act 2000, Human Rights Act 1998).

The focus of the BME MH Programme is Delivering Race Equality (DRE) in Mental Health Care. This is a five year action plan for achieving equality and tackling discrimination in mental health services in England. Its three key aims are: equality of access; equality of experience; equality of outcomes. The outcomes that are forecast for this programme are shown in *Box 1*.

Next Steps
1. Having developed a specific database of BME service-users for the CMHT, this will need to be maintained and regularly updated by CMHT members.
2. The conclusions and recommendations need to be disseminated to the various agencies involved, to include the Locality Director, GPs, CMHT, CRHT, EI, AOT, Acute Units, local ethnic community support groups

(Ashanti & Roshni), D4, ACE Enterprises, local educational institutions, Luton MIND and voluntary organisations, whom could all effectively assist in their implementation.

3. Existing links with other agencies within and outside the Trust need to be strengthened, and new links perhaps need to be made and encouraged. This will need to continue to be based on effective and appropriate communication between all agencies involved.

4. This audit activity now needs to be repeated for the White British group of Luton SW service-users in facilitating appropriate comparison and analysis.

5. As highlighted, a number of areas require further investigation: the low numbers of BME service-users receiving enhanced CPA care, with a comparison being made with the White British service-user group; the continuing support needs of the small number of service-users who are not prescribed medication.

Box 1: Delivering Race Equality – expected outcomes

By 2010, mental health services should be categorised by:
o   less fear of mental health services among BME communities and service-users;
o   increased satisfaction with services;
o   a reduction in the rate of admission of people from BME communities to psychiatric in-patient units;
o   a reduction in the disproportionate rates of compulsory detention of BME service-users in inpatient units;
o   fewer violent incidents that are secondary to inadequate treatment of mental illness;
o   a reduction in the use of seclusion in BME groups;
o   the prevention of deaths in mental health services following physical intervention;
o   more BME service users reaching self-reported states of recovery;
o   a reduction in the ethnic disparities found in prison populations;
o   a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;
o   a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services;
o   a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

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