BARRIERS TO APPROPRIATE MENTAL HEALTH CARE FOR BME COMMUNITIES: PSYCHIATRISTS' PERSPECTIVE

Iftikhar Ahmad, Rashda Tabassum

ABSTRACT

Objective: The aim of this study was to explore psychiatrists' understanding of the referral rates, perceived barriers to accessing mental health services by the black and ethnic minorities and identify any training needs.

Design: Cross sectional study.

Place and duration of study: The study was conducted across the Midlands and Staffordshire, including Walsall, Wolverhampton, Stafford and Stoke-on-Trent United Kingdom. Data was collected between November and December 2007.

Subjects and Methods: A questionnaire was developed to collect the relevant information. The questionnaire was short by design, to try to enhance the response rate. It was sent by post with an explanatory covering letter and a reply paid envelope for its return. The survey population consisted of psychiatrists, including SHOs, SAS doctors, and consultants working in these areas.

Results: The majority of respondents identified language barriers, social stigma and reluctance to use services as the main barriers to mental health services by the Black and ethnic minority (BME) community.

Conclusion: Stigma and Poor communication were found to be the main barrier in accessing services. Transcultural training is likely to help to address some of the issues identified.

Key words: Black and Ethnic Minorities (BME), Barriers, Stigma, Language, Access to Services

INTRODUCTION

Mental Health policy in the UK emphasises equality in care provision. The Human Rights Act 1998 and Race Relations (Amendment) Act 2000 place the responsibility to eradicate discriminatory procedures and practices on service providers. Despite this, the evidence suggests that people of black and Asian ethnicity have reduced access to and utilisation of services, but higher admission rates. Black patients in particular often access services late and in-crises. Perceptions of coercive treatment and adverse experience are widespread amongst these communities and create barriers to services. A report by the Healthcare Commission (2007) found that admission rates were lower than average among the white British, Indian and Chinese groups, and three or more times higher than average in black and white/black mixed groups. Black and white/black mixed groups were also significantly more likely than average to be admitted to hospital via the criminal justice system.

It is not clear whether this increase is due to a higher rate of mental illness amongst this population or an issue with mental health services. At least some of the increase is attributable to social disadvantages experienced by African-Caribbean people living in deprived inner cities. Social class, area of residence, parental separation, unemployment, and social isolation are socio-environmental factors in schizophrenia. Mallett et al found that African-Caribbean patients had higher rates of unemployment, more likely to live alone and experienced long periods of separation form their parents as a child[1]. Some patients from black and minority ethnic (BME) groups may be reluctant to consult their GP about psychological problems, less likely to have problems detected and less likely to receive active management[2].

Carpenter and Brockington reported higher admission rates for immigrant groups with schizophrenia, neuroses and personality disorder[3]. Immigrants had approximately twice the rate of admission compared to British-born patients. More recently, Bhui et al found

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strong evidence of increased admission rates for BME patients and some differences in referral pathways and primary care assessments[4]. Koffman et al found that black patients were more likely to be admitted to hospital under the Mental Health Act and less likely to be registered with a GP, adding to the issue of appropriate and timely referral to mental health services[5]. The authors called for increased racial awareness and staff training.

There is some variation in the evidence: Cochrane[6] and Nazroo[7] reported that Asians living in Britain have lower rates of mental illness than whites, whilst Harrison et al[8] and Goodwin[9] found rates of mental disorders similar to that of the indigenous population. These studies have generally used hospital admission rates as their prime data source. Some ethnic groups complain of more coercive treatment and adverse experience[10]. These perceptions on the part of ethnic groups are wide spread and put barriers to use of specialist mental health services.

The aim of this study was to explore psychiatrists' understanding of the referral rates, perceived barriers to accessing mental health services by the black and ethnic minorities and identify any training needs.

SUBJECTS AND METHODS

A questionnaire was developed to collect the relevant information. Where a time span was required, psychiatrists were asked to focus on the last calendar year to aid accurate recall of events. The information collected covered demographic details of the responding psychiatrist; the number of the referrals they have received for black and ethnic minority patients over the past year and whether they considered this to represent the true level of disturbance in this group; information about any perceived barrier to access to services that might in the psychiatrist's view preclude them from seeking referral to psychiatric services; details of the individual psychiatrist's training in trans-cultural psychiatry and their perception of the effectiveness of this training. Space was provided on the questionnaire for individual observations and qualitative comments. The questionnaire was short by design, to try to enhance the response rate. It was sent by post with an explanatory covering letter and a reply paid envelope for its return. The survey population consisted of doctors including SHOs, SAS doctors, and consultants from across the Midlands and Staffordshire, including Walsall, Wolverhampton, Stafford and Stoke-on-Trent. The letters were sent to 148 psychiatrists. A sample of questionnaire is attached as Appendix.

RESULTS

Out of 148 professionals 94 returned the questionnaire, so the overall response rate was 63.5 percent. Many respondents also took the time to add qualitative observations to their replies suggesting that the topic was found to be relevant and interesting to many of the participants. Most respondents were consultant psychiatrists as shown in figure 1:

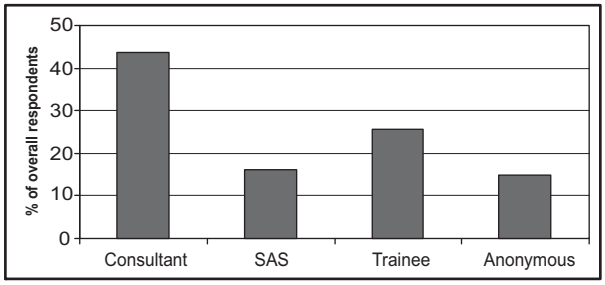

Fig. 1: Job title of respondents

Respondents were asked to state their ethnicity; this was an open question as opposed to selecting from a predetermined list. 37.2 percent of respondents classed themselves as Asian or British Asian and 26.6 percent as white. 27.7 percent chose not to answer this question, as shown in figure 2:

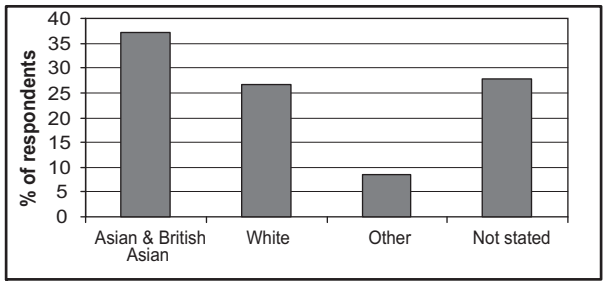

Fig. 2: Respondents by ethnicity.

Figure 3 shows that most of the psychiatrists (54.3%) have received less than ten referrals from GPs for patients from BME communities with psychological problems during the past year. 6.4% of these respondents have not received any referral from these communities while 25.5% have received from 10 to 25 referrals and 11.7% received more than 25 referrals:

Female patients also appear to be under-represented with 35 respondents stating that less than 10 percent of BME referrals are female patients.

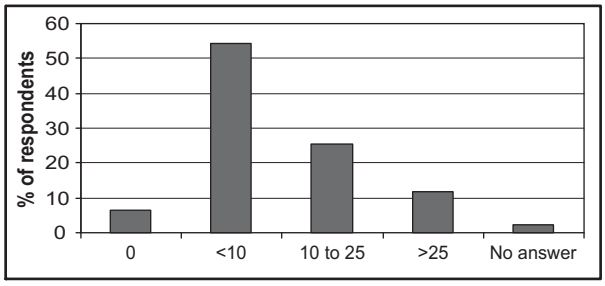

Fig. 3: Number of referrals of BME patients.

58.5% of psychiatrists think that the level of referrals received does not reflect the true level of psychiatric morbidity in the BME community and 61.7% thought that the referral rate under represented the true level of morbidity. None of the respondents felt that this was an over-representation of the true level (see figure 4).

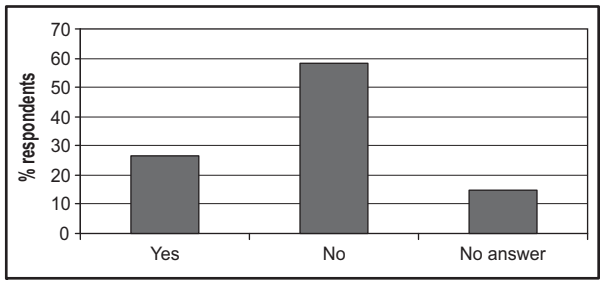

Fig. 4: Are these figures representative of the true levels?

Respondents were divided as to whether they felt that the referral rate reflected the level of psychological distress faced by patients, as shown in figure 5.

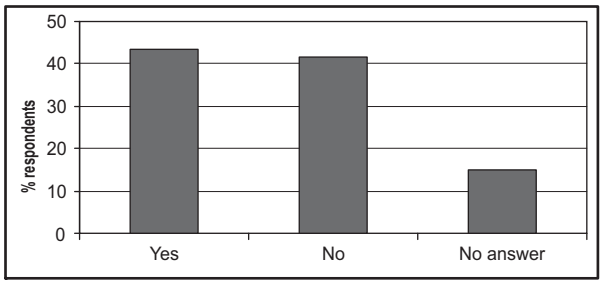

Fig. 5: Do the referrals reflect the true level of distress faced by patients?

75.5% of psychiatrists think that there are barriers preventing people from BME communities accessing mental health services, as shown in figure 6.

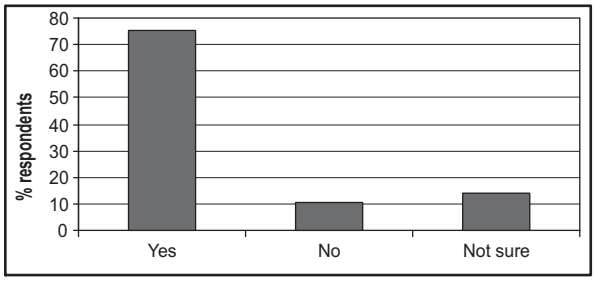

Fig. 6: Do you think there are barriers to referring BME patients?

Most of psychiatrists identified that language barriers, social stigma and reluctance to use services are the main barriers which result in under-utilisation of mental health services by the BME community. Other possible causes cited were ignorance of GPs about the cultural practices of BME communities, female patients being seen by male doctors, lack of awareness of services, ignorance about mental illness among ethnic minorities, cultural concepts of what constitutes mental illness, families' perception that services are racist, patients' failure to acknowledge psychological factors and the perception that services focus on the medical model (see figure 7. Note that some respondents selected more than one barrier).

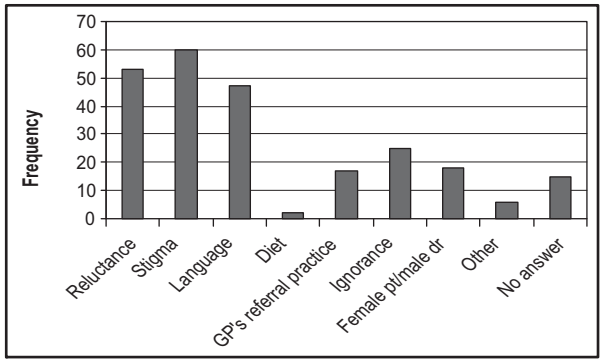

Fig. 7: Perceived barriers.

Most psychiatrists (59.6%) have not received any training to deal with patients from BME communities either as an undergraduate or postgraduate, although some of them (35%) mentioned attending lectures on a few occasions but no in depth training. See figure 8.

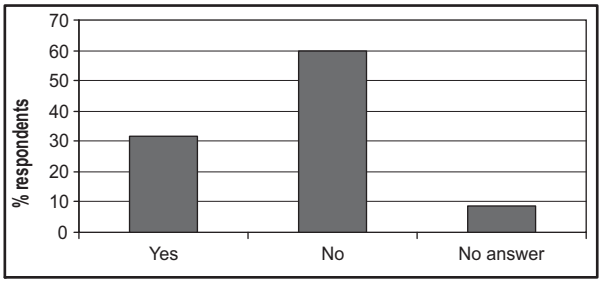

Fig. 8: Have youreceived training in transcultural psychiatry?

83% of psychiatrists highlighted the need for proper training in Transcultural psychiatry, while only 4.3% said that this was not necessary (see figure 9).

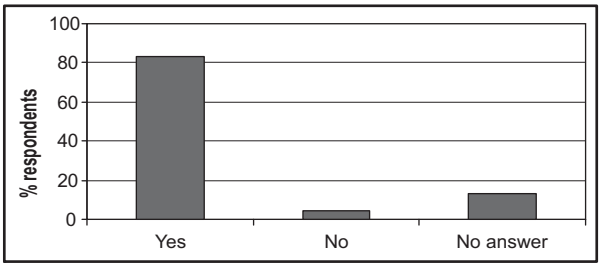

Fig. 9: Do you think psychiatrists would benefit from training?

DISCUSSION

To our knowledge, this is the first study to investigate the views of UK psychiatrists about the barriers to accessing mental health services by people from BME communities. Access to and engagement with different levels of mental health services could be explained by the "Goldberg and Huxley Model" which states that a patient needs to pass through a series of filters in order to reach specialist care. These filters range from appraisal in the community, presentation to and action by the general practitioner, involvement of psychiatric services at different levels from outpatient assessment to inpatient to forensic services, which the patient could reach either through the psychiatric services or through the criminal justice system[11].

It is generally agreed that black people are over represented in psychiatric hospitals and that their needs for psychiatric help are revealed through crisis services and assessment under the Mental Health Act more often than for their white counterparts. Black patients have more complex pathways to specialist services, seeing at least three carers before contact with specialist services[12], admissions are more likely to follow a domiciliary visit[13] and the police are more likely to be involved in the admission or readmission of black people[12,14,15]. Criminal justice agencies are involved in less than 20% of white British patient contacts compared to 35% of Afro-Caribbean and 40% of black African contacts.

As for patients from south Asian backgrounds, in a study in west London, specialist referral following primary care assessment appeared to be equally common among the two groups but hospital admission was more likely among south Asians following domiciliary visits[15,16].

Although several studies report various rates of referral for patients from BME communities, few have explored or identified the possible reasons for these results[15,17,18]. From the literature review, it appears that patients from BME communities are mainly utilising the services which are hospital based and under coercion of law rather than at the community or out patient levels. In the present study, 58.5% of psychiatrists thought that the referral rate did not reflect the morbidity in the BME community and most regarded the referral rate as an under-representation of the true psychiatric morbidity in the BME Community.

In a study in Birmingham, of all the ethnic groups with mental disorder, South Asians were the least likely to be referred to specialist care[19,20] although south Asians have also been shown to have the highest community rates of mental disorder and to be more frequent consulters of primary care[9]. Similarly, black people are more likely to be referred to specialist services[14,15]. The criminal justice agencies are involved in less than 20% of white British patient contacts compared to 35% of Afro-Caribbean and 40% of black African contacts. One possible explanation is that GPs have a lower likelihood of recognising a psychiatric problem in black people[15,16,20], thus confirming the perception of psychiatrists' of a barrier at primary care level. This should be explored further.

The overwhelming majority of respondents in this study (75.5%) thought that there are barriers preventing people from the BME communities accessing mental health services while only 10.6% thought there were no barriers. The majority identified that language barriers (n=47), social stigma (n=60) and reluctance to use services (n=53) as the main barriers to accessing mental health services.

Language is the essential tool to communicate and nowhere is this more apparent than in the situation where patient and doctor are separated by a language barrier. In today's multicultural society, especially in large cities, it is not uncommon to encounter such a situation. 50% of psychiatrists in the present study considered language to be one of the main barriers and this could affect various access points to mental health services. People from different cultural backgrounds express their emotions and distress in different ways and a language barrier could lead to misdiagnosis. A few studies in UK-based hospitals have concluded that the quality of communication tends to be poor[21,22]. Similarly, in a survey of 1000 professionals working in different psychiatric services in Australia, more than one-third reported having contact, at least on a weekly basis, with patients with whom effective communication was either limited or impossible because of a language barrier[23]. The use of interpreters has improved the situation but it has its own drawbacks and one has to be aware of these issues to utilise this resource efficiently[24]. For example, patients are less likely to ask questions about their care through an interpreter[25].

65% of psychiatrists in this survey considered stigma to be the primary barrier in accessing services for patients from BME communities. The stigma associated with mental illness is well recognised and still prevalent in the society. The stigma associated with mental illness is increasingly recognised as an important factor influencing access to mental health care by the general population. The Royal College of Psychiatrists has recognised the deleterious effects of discrimination and prejudice against people with mental illness and has attempted to address this with the Changing Minds campaign[26]. 63% of respondents highlighted stigma as one of the main barrier.

In the present study, 59.6% of psychiatrists stated they had not received any training during their career in dealing with patients from BME communities. In another study, 80% of psychiatric staff stated that their professional training prepared them "very little" or "not at all" for cross-cultural clinical work[23]. In the UK, a national training programme was proposed and published in *Inside Outside* (National Institute for Mental Health in En-

gland, 2003) which advocated mandatory training in cultural competencies for all professional staff working in mental health services. In the same year, the *David Bennett* enquiry made recommendations that training in cultural competencies should become a priority (Department of Health, 2003). Three years on, it appears that not much has changed and there appears to be no coherent approach to address these training needs.

As the study was carried out in only one region of the UK, the findings can not be generalised or extrapolated. However the findings from this study are similar to other studies looking at the same problem but from different angles. Additional research is needed to confirm the results of this study and further explore barriers to mental health care and associated training needs.

CONCLUSIONS

This is the first study in the UK to investigate the views of psychiatrists about the possible barriers to accessing mental health services for BME communities.

Stigma was found to be the main barrier in accessing services and is an issue not only for patients from BME communities but many patients with mental health problems.

Poor communication with patients impairs the clinician's ability to assess a patient comprehensively and language barriers are increasing with higher levels of immigration. Significant advances are needed in research and training towards overcoming language barriers. The interaction between patients from BME communities and primary care needs to be explored further.

Training in transcultural psychiatry is likely to improve the quality of services for patients from the BME communities and appropriate use of interpreters may help to overcome language barriers. Addressing stigma is a challenge for those working in mental health and society at large.

DECLARATION OF INTEREST

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