Knowledgeshare

Reviews

Counselling Victims of Warfare: person-centred dialogues

Richard Bryant-Jeffries

Radcliffe Publishing: Oxford, ISBN 1-85775-721-1, 2005, 208 pp

The author of this text has worked as a person-centred counsellor/therapist for more than a decade, and this book, covering a difficult area for those offering counselling services, forms one of a series on 'living therapies'. Clearly designed as a teaching text, the aim of the author is to present and describe an approach to person-centred counselling in an accessible format that can be used by both experienced counsellors, and those still developing their skills.

The author's commitment to this approach is evident throughout the text, which is divided into two main sections, with an introductory chapter providing a useful summary of key points in person-centred counselling, its history, and the rationale supporting his choice. In contrast to many such texts, the information is provided through the use of two contrasting case studies. The first is of a female victim of war, and the second of a member of the armed forces who now has to live with memories of what he saw, and what he did. As the title suggests, each is presented in the form of a dialogue between counsellor and client, with inserted comments when key issues and dilemmas arise. Supervision sessions are also included using the same format, and at the end of each session discussion points and questions are listed.

It is rare that one is given such insight into the processes and interactions that occur during counselling. Although fictitious, the dialogues have been thoroughly researched with organisations and individuals involved with counselling and supporting victims of warfare. The materials presented are distressing to read, and the dilemmas faced by the two counsellors demonstrate the difficulties and costs of such emotive and sensitive issues to both counsellor and client.

Overall, this is a thought-provoking book which provides an opportunity for those reading it to reflect on their own views and perspectives as they consider how the two dialogues progress. Readers who have little knowledge of person-centred counselling will find that the format used will help increase their awareness and understanding as the ongoing dialogues reveal both the strengths and limitations of this type of counselling.

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Counselling for Progressive Disability: person-centred dialogues

Richard Bryant-Jeffreries

Radcliffe Publishing: Oxford, ISBN: 1-85775-898-6, 2004, 170 pp

This book addresses an increasingly important and necessary area of counselling. There is little within counselling and psychotherapy literature concerning the issues around progressive illness and disability. It is also encouraging to see a recent publication from a person-centred perspective.

The book is structured around a series of two fictionalised client–counsellor encounters. Each case deals with the psychological and emotional impact and adjustment concerns of progressive disability. Each example is presented in a session-by-session format and I particularly liked the inclusion of clinical supervision sessions as an essential part of the therapeutic process. For me, this reinforces the fact that the therapeutic relationship is in reality a triad (client–counsellor–supervisor) rather than the usual occlusive representation of a dyad. While the session-by-session format gives an 'in-the-room' or experiential perspective, it does reinforce the view that counselling is not an 'observer sport'. However, I found the sheer amount of verbatim narrative unrelenting and tedious. While there was respite in the regular text boxes that drew attention to discussion points, I found myself wanting more reflection and contextualisation by the author.

While there was little detail given about the clients, there was even less about the counsellor. I was curious about where clients were seen, how the counsellor received his referrals, whether these were typical or atypical of his case load and whether there were specific difficulties encountered with this client group.

The main body of the text was overly subjective and could have benefited from a greater degree of objectivity. The fictionalised cases, while highlighting important central concerns, also seemed to lack a sense of

spontaneous authenticity. Here, I found the subjective or 'virtual' approach was interesting both in terms of its content and what questions it provoked. The main question I was left with was how the person-centred approach had become so resolutely uncritical. In the current climate of evidence-based practice there was no reference to research, either supportive or critical. This I find an enduring mystery. Rogers, while valuing being an engaged and congruent therapist, also set great store on the research process.

As both a practitioner and educator I am always pleased to see more person-centred literature. However, I would also appreciate a more balanced, critical and research-based dimension to leaven this overly subjective book.

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Racism in the Irish Experience

Steve Garner

This is an interesting but flawed attempt to explain the dynamics of racism in Ireland. Its starting point is the pioneering anti-racist analyses of Robbie McVeigh (e.g. 1992). While endorsing most of McVeigh's explanations for Irish racism, namely diffusion of UK racism, Irish people's participation in colonialism, racism in the Irish emigrant community and endogenous anti-traveller racism, Garner makes two criticisms. First, that McVeigh's work lacks sufficient historical detail to provide a nuanced account. To his credit, Garner provides much of that detail, especially in his treatment of the 'racing' of the Irish in the 16th and 17th centuries, and in his examination of the experience of the Irish in the Caribbean and the USA. However, it is in his second criticism, that McVeigh has failed to place Irish nationalism at the core of Irish racism, where Garner comes unstuck. According to Garner, not only has nationalism contributed significantly to racism, it has also hampered critical examination of that contribution, and 'McVeigh's work is rooted in his nationalist politics' (1992, p. 24). The problem with this line of attack is that McVeigh is not a nationalist; he is a republican. Unfortunately, Garner appears unaware of the difference. In contradistinction to nationalism's narrow concentration on the nation and those deemed fit to be part of it, republicanism's avowed ideology of liberty, equality and solidarity pushes it towards claims of both domestic inclusion and international solidarity. By collapsing all strands of the struggle to extricate Ireland from British colonialism into barren nationalism, Garner ends up providing us with yet another revisionist caricature of that struggle, while failing to develop our understanding of Irish racism much further.

Despite the regressive role Garner wishes to give republicans, a different story keeps bubbling to the surface. Thus we get brief mentions of the internationalism, anti-racism and anti-sectarianism of republicans over a period of two centuries, stretching from the French revolutionary-inspired United Irishmen in the late 18th century, through the 19th century with Robert Emmett and Thomas Davis, and into the 20th century with executed leaders of the 1916 Easter Rising such as James Connolly, Thomas McDonagh and Roger Casement. Yet, all of these are portrayed either as exceptions or as failures in order to maintain the thesis that nationalism, of which republicanism is seen as an undifferentiated part, has been a significant generator of racist ideas and practices.

When it comes to the 21st century, Garner is on even shakier ground, having to concede that republicans currently adhere to the ideologies of 'internationalism and multiculturalism', but attempting to claim (despite all the examples cited above) that this is a late conversion, adding the following bizarre sentence: 'Beyond the rhetoric of murals proclaiming parallel international struggles with the Palestinians and black Americans, there has been support for an anti-racist nationalism from a quarter that, according to the logic of this chapter, we might least expect to see it' (Adams, 2000 p. 220). While one cannot fail to admire Garner's chutzpah, his admission that his theory is incapable of explaining the facts drives the final nail into the coffin of his argument.

This is all a great pity. There are important issues buried in here that are pertinent to all societies which have emerged, or are emerging from national liberation struggles. These relate to the tendency for the colonised to construct positive versions of colonisers' racialised assertions of difference, and the danger that these valorised descriptors may in turn be implicated in an exclusive self-identity, at a cost to those who are excluded. When translated onto the political stage, this becomes a tension between those wishing to prioritise the interests of those whom they see as their own, and those who see their predicament as part of a global struggle. While Garner points to the infectious potential of colonisers' racism, he does not recognise the different political responses to this potential.

The other point of departure from McVeigh's analysis is Garner's decision to exclude sectarianism from his treatment. This is astounding – here we have an ethnic division that is so bitter it has led to the murder of hundreds of people simply on the grounds of their ethnic identity (sectarian affiliation being a proxy for that identity). It is difficult to overestimate the savagery involved – one might think of the Shankill

butchers who roamed Catholic areas of Belfast at night, kidnapping lone victims from the streets, hanging them up on meat hooks and torturing them to death using butchers' implements. An ideology that provides cover for that sort of activity must surely be of pertinence when considering the specificities of racism in the Irish experience. Its omission without explanation is simply baffling.

To conclude, where Garner has attempted to add empirical flesh to the theoretical bones of McVeigh's analyses, he has done a service to those wishing to understand racism in the Irish experience. However, in his attempts to push theory on beyond McVeigh, he has served to cloud rather than illuminate this important issue.

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Short reports

Migrants living with HIV/AIDS in Finland and Ireland: identifying good practice in social and health care

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We are currently exploring how the historical, political, social and geographical context has shaped the policy making and practices of social and healthcare support for migrants living with HIV/AIDS, by comparing the cases of Finland and Ireland. Both countries have a number of similarities. They share the cultural and historical experience of emigration, poverty, and domination by neighbouring countries, while developing distinct social and healthcare systems. Immigration has been a relatively new phenomenon in these nations, prompting new demands on collective notions of solidarity and belonging, particularly in terms of social rights inclusion. While there have been extensive studies of multicultural nations with long traditions of immigration, there has been little research on the social and healthcare response of peripheral countries with newly emerging migrant communities.

Both Finland and Ireland have seen the concentration of migrants in urban centres in the last decade. Different political and welfare cultures, as well as economies, have an impact on the diverse opportunities and challenges facing migrants living with HIV in these two countries. Moreover, the impact of globalisation has also fragmented national cultures so that the urban/rural divide can often be seen as the more decisive factor with regard to access to appropriate social and healthcare services. Migrants comprise diverse communities, with different nationalities and resident statuses as well as levels of social rights, which affects access to care and health disparities. By examining the relationship of the urban/rural divide to the social and health outcomes of migrants living with HIV/AIDS, this study seeks to identify the important factors that enhance or diminish good practice.

The research questions are:

- what areas have migrants moved to in Finland and Ireland? What characterises these areas and what role do migrants play as stakeholders in local issues? How do HIV epidemiological statistics and services correspond with migrants and their residential areas? Are there variations between the different urban and rural areas of Ireland and Finland, and if so, what explains these differences?
- how has social and health policy in Finland and Ireland developed to meet (or ignore) the needs of migrants living with HIV? What is the relationship between Finnish and Irish immigration policy and social and healthcare policy, specifically in regard to HIV/AIDS?
- what kinds of practices have developed to meet the needs of migrants living with HIV/AIDS in Finland and Ireland? What kinds of variations can be seen in practices in different residential areas? What accounts for these discrepancies?

Using a qualitative approach, this research project analyses social and health policy development in each country from the start of the AIDS epidemic, in connection with increasing immigration. The data are drawn from policy documents, epidemiological information, and other written sources, such as community-based organisations' reports, newspaper articles, etc. Practice is explored methodologically through a textual analysis of reports as well as interviews of professionals and clients. It is anticipated that the findings will be submitted for publication in the next few months. For further information about the project please contact us at the email addresses given below.

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The determinants of patient satisfaction in ethnically diverse communities. Report from an ongoing project in Newham, London

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Project objective

To assess the determinants of patient satisfaction in ethnically diverse communities.

Background

Newham, in East London, is one of the most diverse, culturally rich communities in the country, with many small white, Asian and African communities of varying backgrounds making up the local population of around 260 000 people. Amongst NHS patients in Newham, according to surveys conducted by Picker Europe, the patients least likely to rate services as very good or excellent are Asian patients, of whom only 38% did so, compared with 50% of black patients and 59% of white patients. Research by MORI, the market research and opinion polling organisation, also shows a close correlation between levels of diversity and levels of satisfaction, with the most diverse communities being the least satisfied with health service providers. A partnership of three organisations in Newham's NHS commissioned MORI to carry out focus group studies with patients and healthcare practitioners to investigate the differing levels of satisfaction amongst these groups.

Settings and participants

The study was approved by a research ethics committee and was peer reviewed by academic and private sector reviewers. Fieldwork took place in community venues in the early evening over two weeks. Eight focus groups took place in total: three groups of between five and seven participants took place with allied health professionals, nurses and doctors of mixed grades and background; five groups of between seven and nine participants took place with patients, with researchers of matched ethnicity and language. Patient participants were selected by two methods: a poster recruitment campaign in the primary care trust and acute trust and by random selection from a database of patients who had been referred for a routine care episode within the last three months. Health professionals were recruited from a pool of allied health professionals and hospital and general practice doctors and nurses. Each participant was taken through a simple telephone screening procedure to eliminate disproportionality of clinical area; age, grade and experience, reported serious untoward incidents (SUIs); language spoken and sex.

Of the five patient focus groups, two took place with Asian participants, two with African-Caribbean participants and one with white participants. The two groups with Asian participants were split by the age ranges 20–40 years and 40–55 years, and the two with African-Caribbean patients were split by the age ranges 20–35 years and 40–55 years, a variance which came about through the screening process. A topic guide was designed for use with patients and professionals based on studies of patient satisfaction conducted by Picker Europe in 2002 and MORI researchers.

Results

All groups reported high levels of satisfaction with the cultural competency of staff, quality of post-operative care, levels of cleanliness, and described medical and clinical specialists as highly regarded. All groups also reported perceiving a consistent level of service provision across all communities regardless of ethnicity. The same groups also reported that they believed there were not enough staff; those who were available were always busy; nurses seemed overworked and indifferent. They also reported long waiting times, some wards being dirty, delays and cancellations and poor pain management.

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Conference reports

Meeting the Challenges of Health Research with Minority Groups

Support Unit for Minority Ethnic Health Research's (SUMEHR) inaugural conference at Friends House, Euston Road, London, 16 November 2005

This report provides an introduction to the Support Unit for Minority Ethnic Health Research (SUMEHR) and a summary of the proceedings of the SUMEHR half-day conference. The unit was established in August 2005 through a partnership between the North East London Consortium for Research and Development (NELCRAD) and North Central London Research Consortium (NoCLoR). Our conference, 'Meeting the challenges ...' set out to sketch in some of the broad but crucial issues facing health researchers working with minority ethnic groups, to highlight and celebrate the diversity of the research in this area and to hopefully build on this by encouraging communication between researchers, moving towards the formation of research networks around themes in minority health research. Attendance exceeded 100: 48 from primary care trusts, 21 from academic units, 13 from the voluntary sector, 11 from the community, 5 from mental health trusts and 6 'other'. SUMEHR encouraged registrations from a wide range of backgrounds. One objective of the unit is to promote the participation of communities and community representatives within the research process, and we were delighted that the event was able to contribute to this dialogue. The conference was principally targeted at those working in North East and North Central London.

Dr Keith Meadows, Associate Director of NELCRAD, opened the conference, giving some background to the development of SUMEHR and outlining future aims and objectives. The unit aims to provide a practical facilitative role for researchers, including supporting those experienced in health research but unfamiliar with working with minority ethnic communities. Challenges include the recruitment of 'hard-to-reach' groups into research projects, and the best way to work with community representatives. Dr Meadows introduced and welcomed Professor Waqar Ahmad, Assistant Vice-Chancellor and Director Middlesex Research, the chair for the afternoon. Professor Ahmad is a social policy analyst and sociologist of health with a long-standing interest in questions around ethnicity and health.

Having set the scene for the afternoon's proceedings, Professor Trisha Greenhalgh (Unit for Evidence-Based Practice and Policy, University College London) was invited to give the opening plenary, 'Researching ethnic issues in health care'. Professor Greenhalgh argued that 'ethnicity' should not be studied in isolation. Rather than emphasise the differences between populations, research should more positively focus on how common needs are differently exacerbated or constrained by multiple factors that include social, economic, cultural and psychological forces. What is often understood as 'ethnicity' is more usefully recognised as the complex interaction of conditions of multiple jeopardy in relation to health inequalities. The need to take account of this wider context means that applied designs and action research are often more relevant and successful than experimental, randomised trials.

Professor Greenhalgh's talk set the tone for the afternoon's discussions, in particular by introducing the idea of multiple levels of diversity and the need for collaborative approaches. Discussion continued through a set of four parallel sessions, with three presentations in each. These were grouped under the headings 'Theoretical and methodological challenges', 'Perceptions and partnerships to improve services', 'Health needs and behaviour' and 'Translation issues', and were chaired by Professor Paul Wallace, Dr Jane Anderson, Dr Sue Proctor and Dr Chris Griffiths respectively. Sessions gave the opportunity for speakers to present ongoing or recently completed research projects. For those in the early stages, this opened the possibility for delegates to engage in discussions on appropriate research design. However, in all cases participants were encouraged to focus on specific methodological challenges, as well as the practical implications these had for their research, sharing experiences, advice and best practice. The work presented ranged from a study on Somali women's perceptions of cervical screening (Ana Ileyassoff), to the problems of obtaining consent from non-English-speaking families (Sarah Jonas), to an examination of the concepts of 'ethnicity' and 'race' in health and healthcare monitoring (John Eversley) (for a full list, including abstracts and transcripts, see the website listed below). One presentation, led by Amber Linell, 'Encouraging community participation in identifying health needs and access to services for the Bangladeshi community in West Euston', included time for questions and answers from one of their specially trained community researchers (through a translator), enabling delegates to explore both sides of the research process, but also to engage directly with the issues of cross-cultural research.

Following the parallel sessions, Professor Gene Feder's (Health Care Research Unit, Queen Mary's School of Medicine and Dentistry) plenary, 'Research on health and health care of ethnic minority groups: mistakes worth avoiding', provided a rich account of research initiatives in which he had collaborated. Instead of 'mistakes worth avoiding', Professor Feder

expertly demonstrated the many ways in which the limitations in a project's design may lead to new research opportunities, revealing unforeseen outcomes as well as exposing initial errors in theory or method which may then be improved upon. Examples included not recognising the ethnicities of the majority white population. Professor Feder also stressed the importance of taking account of his own 'identity' (male, white, Jewish) as it related to his research subjects, and how these identities (researcher and researched) are often flexible and changeable. This talk led into a lively debate, chaired by Professor Ahmad, with questions from delegates as well as feedback from the parallel sessions. These discussions moved onto issues of racism, funding opportunities for applied work and the policy agenda.

The conference received strong positive feedback (all delegates rated the general content from good to excellent). We plan to build on this support and, while continuing to work closely with our stakeholders, to use this to highlight the lack of an evidence base for dealing with ethnicity in primary care. We welcome any feedback, comments and suggestions about how to develop the unit's aims and best continue supporting health research with minority groups.

For more information on the keynote presentations, the parallel session presentations and conference feedback please go to: www.nelcrad.nhs.uk and follow the links for SUMEHR and the SUMEHR Conference. For any further information on SUMEHR contact Enrico Panizzo: enrico.panizzo@thpct.nhs.uk.

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The Crisis in Black Mental Health Care: how can this be resolved?

Cholmondeley Rooms, House of Lords, London,
31 January 2006

This seminar, hosted by Baroness Lola Young of Hornsey, was organised by Matilda MacAttram, Lead on Mental Health at The 1990 Trust, with the aim of raising awareness among members of the House of Lords and MPs of the trust's campaign against the draft Mental Health Bill 2004. It attracted over 100 participants including peers, MPs, chairs and chief executives of mental health trusts from across the UK, as well as representatives from leading mental health charities, human rights groups, major church denominations and human rights activists.

The first speaker, Dr Richard Stone, member of the David Bennett Inquiry Team, recalled that the stereotype of black people being 'dangerous' was found to have influenced practices in mental institutions way back in 1993, when the inquiry into the death of Orville Blackwood at Broadmoor Hospital was published. But nothing seems to have changed. When David Bennett, a black patient in a secure unit, had been involved in a fracas with a white patient, it was the former who was transferred to another ward. The situation degenerated until David Bennett was restrained by up to five nurses who held him face downwards until he stopped breathing. No attempt was made to resuscitate him. Dr Stone argued that the draft Mental Health Bill does nothing to protect black and minority ethnic (BME) people from this type of treatment and the injustices and inequalities in the mental health system.

Mr Chinyere Inyama, legal member of the Mental Health Review Tribunal, criticised the draft bill for taking away some of the safeguards against wrongful detention available in the current Mental Health Act. It proposes to replace the Mental Health Review Tribunal with a tribunal that may, in some instances, consist merely of one legal person. Also, the currently available right of the nearest relative to prevent detention will be lost if the bill becomes law. He quoted recent cases, which indicated that the interpretation of the current law is being changed by judges in line with the ethos envisaged in the draft bill. A recent judgement was that a patient may continue to be sectioned even if there is no requirement to attend hospital at all. Another judgement was that hospitals need not implement everything in the code of practice. He concluded that the draft Mental Health Bill requires extensive rewriting to protect and safeguard the rights of patients.

Barrister Mr David Neita, who works as an advocate for African-Caribbean service users, spoke of his experience of working with patients in hospitals by establishing communication through poetry and other means. He stated that psychiatrists were often surprised by the extent to which he establishes rapport with patients who they consider 'psychotic' and beyond rapport. He believes that many black people are considered 'psychotic' because they are not given the opportunity to establish meaningful communication. Legislation should reflect a variety of ways in which people with mental health problems can be helped, and not just the narrow views within psychiatry.

Lee Jasper (Chair of the African Caribbean Mental Health Commission) referred to the recent 'Count me in' survey of people in mental health facilities. Black African-Caribbean people, compared to white people, are 44% more likely to be sectioned, at least 25% more likely to be detained, and 70% less likely to be referred by their general practitioner (GP) for counselling. He expressed disappointment with the government's failure to accept that institutional racism is driving these figures. He suggested that the figures may well be similar to those that had existed in apartheid South

Africa. He believes that rewriting of the Mental Health Bill should not be done without the full involvement of African-Caribbean communities.

Professor Suman Fernando (University of Kent and London Metropolitan University) spoke of the culture clash and racism that occurs when psychiatry, based on value systems and worldviews that are western in origin, is used in a multicultural society. He criticised the wide definition of mental disorder and the emphasis on 'substantial risk' to others being proposed in the bill as the basis for sectioning, as this could result in people with what society considers odd ideas or unusual behaviour being liable to sectioning if they are judged to be 'dangerous'. Professor Fernando's view was that if the bill becomes law, current racial and cultural injustices would be exacerbated and extended.

Reverend Mathew Ashimolowo, Senior Pastor at Kingsway International Christian Centre, one of Europe's largest churches with a 12 000-strong congregation every Sunday, was the final speaker. He suggested that both the judicial system and mental health system are racially discriminatory. There is over-representation of black youth in prison, and stop and search actions by the police, and an under-representation of black people as high court judges and magistrates. Misdiagnosis of black people as 'schizophrenic' is a major problem. Mental health services fail to work with black communities, where the Church is one of the greatest sources of strength. Instead of pushing through what is an intrinsically racist Mental Health Bill, he argued that the government should look to innovative ways of tackling this issue.

All the speakers were unified in their opposition to the Mental Health Bill 2004 on the grounds that it will worsen current racial inequalities in the mental health system. A lively discussion took place in a session chaired by Dr Kwame McKenzie (Senior Lecturer at Royal Free and University College Medical School). It was generally agreed that government should be asked to allow an input from BME organisations into the rewriting of the bill.

In summary, the meeting highlighted the dangers inherent in the Mental Health Bill for BME communities. Also it provided an opportunity for peers and MPs to hear the voices of BME communities and for health authorities to be apprised of the concerns of BME communities about the inequalities in mental health services.

For more information see: http://healthweb.blink.org.uk or contact Matilda MacAttram: matildam@blink.org.uk

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Bradford City Teaching Primary Care Trust: Race for Health appreciation visit – diabetes and its impact on South East Asian communities

Midland Hotel, Bradford, UK, 22 February 2005

Bradford is a diverse city, multicultural, multireligious and multilingual. While the NHS in Bradford is committed to meeting the health needs of all the communities it serves, black and minority ethnic (BME) communities are noticeably at risk of differential health outcomes, and disproportionately more likely to suffer from certain chronic illnesses when compared with the indigenous white population. The challenge to address these inequalities in partnership with all those that can make a positive difference is a core priority for Bradford's Health and Social Care Partnership. The Race for Health Programme (RfHP) selected Bradford as one of 13 sites participating in a transformational change programme that aims to tackle inequality as experienced by BME patients. The programme aims to develop high-quality patient-centred care that increases patient choice, reduces health inequalities and improves health outcomes for BME communities.

In Bradford the RfHP concentrates its energy on the apparent disparity the prevalence of diabetes has on South East Asian communities. The purpose of the programme at a local level is to reduce health inequalities and improve health outcomes by providing culturally, religiously and practically sensitive services, which represent the needs of the diverse communities. The factors which provide impetus for the primary care trust (PCT) to take direct action to address the prevalence of diabetes in the South East Asian communities are:

- Bradford City tPCT has a resident population of 124 886; nearly 50% of this population is South Asian (of which 40.8% is Pakistani, 5.1% Indian, 2.8% Bangladeshi and 1.5% Other Asian)
- people of South East Asian origin are six times more likely to develop (type 2) diabetes than white communities. They develop it about 10 years earlier, are less likely to be aware that they have it and are more likely to suffer from complications associated with it
- the prevalence of type 2 diabetes in Bradford City tPCT is much higher than the national average. Furthermore, general practitioner (GP) practices

with higher percentages of South Asian patients have significantly higher prevalence.

By joining the RfHP, Bradford aims to enhance its understanding of the diverse religious, cultural and linguistic health needs of its local South Asian communities and ensure services are responsive to the needs of patients, confronting inequities and the challenge of diabetes.

Race for Health: appreciation visit

Each PCT participating in the Race for Health transformational change programme hosts an 'appreciation visit' (this model has since changed; however, the aims and objectives remain the same). The concept of the appreciation visit is to provide the host PCT with a unique opportunity to demonstrate progress in its area of interest and request partners for constructive support and advice in developing the work further. Bradford's 'appreciation visit' looked at 'diabetes and its impact on South Asian communities'. The discussions were guided by a model developed in Bradford using an 'ABC' transformational change toolkit that acts as a mnemonic for 'assessment', 'behaviour' and 'communication'. The purpose of the event was to promote a framework for learning which centred on the 'ABC' model of intervention and change.

The toolkit explained

Assessment

'A' of the toolkit focuses on the importance of 'assessment' and the value of collecting detailed data and intelligence on ethnicity to build a comprehensive profile of the local population. A detailed profile of the local BME population can allow for the effective planning and forecasting of services, according to patient need to improve the patient's journey through care. For example, collecting appropriate data and information about patient needs, such as spoken language, would pinpoint the demand of a specific language on the language support service. Presentations as part of this session highlighted the problems of working with limited data and the journey Bradford City tPCT had been on to develop methods of collecting detailed patient data in the context of ethnicity. The main problem had been that ethnicity data had not been systematically collected in primary care. Although in December 2004 6546 of the population aged 17 years and over were diagnosed with type 1 or type 2 diabetes, it was not possible to break down these data by ethnicity. Data were broken down by age, sex and postcode, but the data quality on ethnicity was poor.

To address this Bradford has a long-term vision which aims to focus on:

1 improving the quality of diabetes registers
2 using ethnicity coding within primary care
3 using this information to monitor the patient journey and quality of care.

As part of this session, structured workshops looked at the kind of profiling information that could be collected from patients, the practicalities of patient profiling, and the mechanisms that would need to be in place to ensure that patient profiling data and information are collected. The workshops explored two key questions:

1 what does an effective patient profiling template look like?
2 what systems do we need to have in place to ensure that patient profiling takes place?

Workshop discussions raised the need to create comprehensive patient profiles by collecting 'core data' to reflect the needs of the patient such as ethnic origin, language spoken and the need for an interpreter. This can be followed by 'enhanced data', such as family medical history and lifestyle, to complement the 'core data'. The general consensus of workshop discussions underlined the need for systematic and routine ethnic monitoring as an essential precursor to developing culturally appropriate and responsive services. Aside from suggestions about what information to collect for patient profiling, recommendations focused on leadership and strategic ownership to take patient profiling forward. This would provide much-needed information about the diverse communities Bradford caters for, and the information can be used to identify gaps and barriers in accessing healthcare.

Behaviour

'B' of the transformational change toolkit focuses on 'behaviour' and the importance of good knowledge and awareness about the behaviour of the different stakeholders involved in the provision of care and the effect their behaviour has on patient experiences, such as the diabetes specialist nurse, dietician, etc. There was a clear emphasis on the need to piece together the full patient journey to understand the behaviour of local communities and the different stakeholders involved in the diabetes care pathway. This would allow Bradford to build in culturally competent systems and structures that tackle the presenting and underlying inequalities in access, and provide responsiveness to the patients. Discussion focused on the barriers South Asian patients are likely to encounter in accessing services at various different parts of the diabetes care pathway, such as podiatry and dietetics,

and ways in which potential obstacles could be tackled with an emphasis on reflecting the religious, social and cultural needs of South Asian patients. Themes that emerged centred on providing culturally appropriate education and information, and the need to utilise community competencies in how services are designed and delivered.

Communication

'C' of the transformational toolkit focuses on 'communication' and the significance of culturally sensitive methods of communication to enhance awareness about diabetes with patients and the local community. This session emphasised that effective communication was not just about language. Presentations explored how neither patients nor professionals felt confident about discussing aspects of lifestyle specific to the Pakistani or Muslim culture, creating a vacuum of accurate knowledge, which can be filled with stereotypes and racism, particularly about Muslim women and fatalism. In addition, poor communication was also said to affect, amongst other things, access to services, the nature and extent of family involvement in care and whether patients felt able to use complaints procedures. Solutions to tackle inequities related to communication and the need to focus on successful partnerships between healthcare providers, patients, carers and the community. It was recommended that healthcare professionals devise health education and health promotion packages which acknowledge and accept ways in which South Asian patients acquire knowledge and information about diabetes. In addition, there was an emphasis on workforce issues related to recruiting more bilingual frontline staff, having access to formal language support and providing healthcare practitioners with training about equality and diversity issues affecting BME communities.

Recommendations

Assessment

Clear leadership determining clear systems and structures to allow primary care staff to collate detailed data and information about patient needs based on ethnicity and requirements with clear protocols and guidelines for implementation and review.

Behaviour

Piece together the complete patient journey to develop a better understanding of the underlying barriers and obstacles patients may experience and use information to create services which are more sensitive to the language, cultural and religious needs of BME communities.

Communication

The workforce needs to be reflective of local communities and demonstrate that they have the necessary skills and competencies to deliver care which dovetails with patient need.

For further details please contact Ghazala Kazmi: Ghazala.kazmi@bradford.nhs.uk.

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Resources

Diabetes UK: www.diabetes.org.uk
Resources for people with diabetes from diverse communities

Diabetes UK, the charity for people with diabetes, is committed to equality for all in achieving our mission of 'improving the lives of people living with diabetes'. We will promote equality and strive towards ensuring that our work meets the needs of diverse communities living in the UK. We believe we have much to learn and profit from diverse cultures and perspectives, and acknowledge that diversity will make our organisation more effective in meeting the needs of all. The latest official figures (the first time there have been actual figures based on general practitioner (GP) registers) show there to be 2.1 million people diagnosed with diabetes in the UK (approximately 1.8 million in England, 170 000 in Scotland, 120 000 in Wales and 55 000 in Northern Ireland). Of that total figure, over 1.8 million have type 2 diabetes and around 250 000 have type 1 diabetes. The prevalence of diabetes is rising in black and minority ethnic communities. Rates of diagnosed diabetes are six times higher in the South Asian community and three to five times higher in the black African-Caribbean community than in the white population, and may have earlier onset.

Information available for people with diabetes and healthcare professionals includes the following:

Fact sheets

What is diabetes?
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

How Diabetes UK can help you
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

Hypoglycaemia
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

Managing diabetes
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

Healthy lifestyle, fasting and diabetes
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

Diabetic complications
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

Cardiovascular disease and kidney disease
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

Your eyes and diabetes
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

Ramadan and diabetes
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

Nerve damage and diabetes
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

Pregnancy and diabetes
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

Treating your diabetes: insulin and tablets
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

A guide to African-Caribbean people – your key to better health
English: new version out soon

Understanding diabetes
English, Welsh

Audiotapes

What diabetes care to expect
English, Gujarati, Hindi, Bengali, Urdu, Punjabi, Chinese

So you think you know about diabetes
English, Bengali, Urdu

DVD/video

Understanding and managing diabetes within the South Asian community
English, Gujarati, Hindi, Bengali, Urdu, Punjabi

All of the above are free (although you may have to pay some postage and packing) and can be ordered from our catalogue or via our website www.diabetes.org.uk)

Newsletter

Diabetes lifestyle – engaging with communities (2 issues a year)
English

All of the above are free and can be ordered by sending an email to diabeteslifestyle@diabetes.org.uk or call +44 (0)20 7424 1108.

Diabetes awareness toolkit

This is aimed at healthcare professionals and community leaders. It includes speaker's notes and slides, and is designed to assist key workers in holding diabetes awareness days and helping people to understand diabetes and complications involved.

How to raise awareness of diabetes and Diabetes UK in your community
www.diabetes.org.uk/good_practice/innovative/examples/innovate6.htm

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Equality and Diversity Advisor

Juliet Enever: juliet.enever@diabetes.org.uk
Project Co-ordinator
Diabetes UK

SignHealth: www.signcharity.org.uk/

A programme, called SignHealth, has been launched by the national charity Sign, to enable doctors and nurses to communicate with the deaf community and people whose first language is not English. It is the first programme of its kind available to GP surgeries, recommended by the Department of Health and National Institute for Mental Health in England. Health professionals often have a number of difficulties communicating with patients who have a hearing impairment, particularly those who use sign language or have difficulty understanding English. There are often misunderstandings, sometimes even misdiagnoses. Recent research carried out by the Department

of Health demonstrates a disturbing picture where deaf and hard-of-hearing people face difficult and often distressing obstacles in order to access the NHS. Consequently, the programme has been developed to give doctors and patients a simple way to communicate easily and quickly. SignHealth allows a GP, nurse or receptionist to choose what they want to ask a patient from a list of questions on the computer screen. The computer then shows a video clip of someone signing the question, and the deaf patient can answer, mostly by yes or no, but sometimes by selecting from a list of on-screen answers.

For people who neither speak nor read English, SignHealth offers healthcare professionals and patients an option to choose from 12 different languages. A question asked by the doctor is translated into the chosen language and appears on the screen, while being played over a loudspeaker. In addition, the programme prints out information sheets for the patient about their medical condition, or simple advice on how to take their medication. SignHealth also enables GPs and receptionists to send appointment reminders to deaf patients via SMS text messaging, helping to avoid the difficulty deaf people experience when contacting the surgery to book an appointment. According to Steve Powell, Chief Executive at Sign, over 60% of GP appointments do not provide communication support to people with hearing difficulties or to those who have limited English. SignHealth has been developed to ensure healthcare professionals can communicate effectively with patients to make sure an accurate diagnosis is made. All primary care trusts in England will be offered the programme free of charge from the beginning of February 2006 for a limited period.

A demonstration version of SignHealth can be viewed by logging onto: www.signhealth.com user: media; password: media.

The charity Sign provides living, advocacy, outreach and training activities for any deaf person in need of emotional support. They also actively campaign to reduce the likelihood of deaf people developing preventable mental health problems in the UK, through working with health and deaf organisations, generic mental health charities, statutory bodies and service providers.

Curriculum innovation for internationally educated nurses

Internationally educated nurses (IENs) make an important contribution to the Canadian healthcare system and to the health of Canadians. In 2002, 6.9% of the 230 957 registered nurses (RNs) employed in Canada, or 15 847 nurses, had graduated from foreign nursing programmes (CIHI, 2002). In Ontario, that

figure was almost 10%, while 31% of the applicants for registration as RNs in the Province of Ontario in 2003 were IENs. This number has been as high as 46.7% in 2002 and is expected to be as high again. While IENs have always faced a number of serious barriers to securing a licence to practise their profession in Ontario, as of January 2005, these barriers have become even greater. New College of Nurses of Ontario (CNO) entry to practice guidelines require applicants to have completed a baccalaureate degree in nursing in order to be eligible to write the Canadian Registered Nurse Exam (CRNE), the national licensing exam, whereas previously the minimum requirement was a college diploma or the equivalent. Additionally, because IENs, whose educational preparation in their home jurisdiction is evaluated by the CNO as being equivalent to a diploma rather than to a degree, are not eligible to write the CRNE and thus obtain licensure in Ontario, they are also not eligible to enter traditional Post-RN Bachelor of Science in Nursing programmes that would enable them to earn a baccalaureate degree while building on previous learning. The result is a closed circle of inaccessibility for many IENs in Ontario, with the only option being the completion of a four-year BScN degree.

Curriculum innovation

In response to this situation, York University School of Nursing has developed an innovative programme designed specifically to build on the knowledge and skills that IENs bring. While not engaging in or supporting practices that may deplete other countries of essential, educated workers, this programme aims to provide access to employment in their chosen profession for IENs who are resident in Ontario. The programme, which is built on a strong collaborative model between academia, nursing regulatory and professional bodies, and practice partners, consists of a four-month qualifying pre-session that leads to admission into a modified post-RN BScN programme. Students who successfully complete the qualifying pre-session enter the BScN degree with not only the nine academic credits earned through that term, but also an additional 60 programme-bound block transfer credits, equivalent to the amount of transfer credit granted to a post-RN student possessing RN licensure in Ontario. The programme consists of essential courses that support transition to nursing in Ontario, including a focus on role enactment, full scope of practice, and safe and competent nursing practice. Theory courses include leadership, nursing theory, ethics, health promotion, an overview of the Canadian healthcare system, research, and quantitative data analysis. Clinical courses include health assessment, providing client-centred care in the Canadian context,

community as partner, and a final advanced nursing science practicum. Students take two electives, which are used to fill in any remaining gaps such as mental health nursing. The programme, which is completed over 20 months of full-time study, is designed to address the following known barriers to licensure and employment for IENs:

1 access to baccalaureate-level nursing education, necessary for licensure in Ontario, which builds on previous learning while ensuring that students are safe and competent practitioners
2 access to licensure through eligibility to write the CRNE
3 access to high-level English language support and instruction, including professionally relevant English language support and instruction
4 access to a range of formal and informal mentors who will provide social support, practice with English language skills, clinical guidance, and opportunities to experience and discuss the Canadian context of nursing

5 nursing workplace experience in the Canadian healthcare system that includes a focus on supporting transition to employment as an RN in Ontario.

Programme evaluation is under way, and will continue over the next several years as we evaluate student success throughout the programme, pass rates and actual scores on the CRNE, success in securing and maintaining employment as RNs in Ontario, and experiences of transition into nursing in Ontario. Additionally, research examining student perceptions of self, barriers and facilitators to nursing practice in Ontario, self-efficacy, caring attributes, professional self-concept, and technological influences over time is under way.

For further information about this programme, please contact Dr Sue Coffey (scoffey@yorku.ca) or see the York University School of Nursing website at: www.atkinson.yorku.ca/NURS/IEN

Knowledgeshare welcomes the following contributions:

- short accounts/evaluations of specific initiatives to improve practice or education in health and social care
- reviews of books, websites, games or other resources that can inform practice or education
- information about assessment tools and their applications
- conference reports
- other information that may inform the development of health and social care practice.

All contributions for this section should be sent to Lorraine Culley, email: lac@dmu.ac.uk