**Experiences of inpatient staff meeting the religious and cultural needs of BAME informal patients and patients detained under the Mental Health Act 1983**

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**Abstract**

*Purpose*

The study aimed to explore inpatient staff experiences of seeking to meet the religious and cultural needs of Black, Asian and Minority Ethnic (BAME) inpatients on mental health wards.

*Methodology*

Nine semi-structured interviews were undertaken with inpatient staff in one NHS Trust in England to explore their views and experiences of supporting BAME inpatients to meet their religious and cultural needs. Anonymised transcripts were analysed thematically.

*Findings*

Inpatient staff reported lacking the confidence and knowledge to identify and meet BAME inpatients’ religious and cultural needs, especially inpatients from smaller ethnic groups and newly emerging communities. There was no specific assessment used to identify religious and cultural needs and not all inpatient staff received training on meeting these needs. Concerns were raised about difficulties for staff in differentiating whether unusual beliefs and practices were expressions of religiosity or delusions. Staff identified the potential role of inpatients’ family members in identifying and meeting needs, explaining religious and cultural beliefs and practices, and psychoeducation to encourage treatment or medication adherence.

*Practical implications*

Potential ways to address this gap in the knowledge and confidence of inpatient staff to meet the religious and cultural needs of BAME patients include: training for inpatient staff; the production and updating of a directory of common religious and cultural practices and needs; local resources which can help to support those needs; and religious and cultural practices and needs being documented by mental health practitioners in community teams such that this information is readily available for inpatient staff if a service user is admitted.

*Value*

This is the first study to consider inpatient staff views on meeting the religious and cultural needs of BAME informal patients and patients detained under the Mental Health Act 1983.

**Introduction**

People of a Black and Minority Ethnic (BAME) background and, therefore, adherents of different faiths and cultures, are more likely to be detained under the Mental Health Act 1983 (Department of Health and Review, 2018). Religion can be closely linked to mental health distress as a coping mechanism both positively (as a protective factor) and negatively (maladaptively) (O’Connor and Vandenberg, 2007). A lack of consideration of an inpatient’s religious needs can adversely affect their experience of being detained (Department of Health and Social Care, 2018). Despite this, the extent to which inpatients’ religious and cultural needs are met is not often explored in a medical environment (MacMin and Foskett, 2004). There is a lack of research into the experiences of inpatient staff in mental health wards meeting the religious (Heffernan et al, 2014) and cultural needs of inpatients (Clegg et al, 2016) in the UK.

 Culture and religion are two separate concepts, although both terms are often used interchangeably and there is an overlap between them (Gilbert, 2008). Fernando describes culture as “a flexible system of values and worldviews that people live by, a system by which we may define aspects of our identities and negotiate our lives” (2010: 1). Culture may include language, beliefs and customs. Heffernan et al defines religion as “organised around a specific belief in a higher power, and is associated with particular denominational, social and behaviour rituals” (2014: 222). Religious observances include access to prayer facilities and dietary requirements (Royal College of Psychiatrists, 2010). Literature also tends to use the terms religion and spirituality interchangeably despite these being two different concepts (Heffernan et al, 2014).

 Religion can be a protective factor for people, especially when in crisis, by giving meaning to their experiences (Hilton, 2002). Various studies have identified the potential for religion to play a role in helping people to cope with and recover from serious mental illness (Koenig, 2009), through providing hope, comfort, supporting a positive sense of self and potentially helping with existential crises about the meaning of life (Mohr et al., 2006). Similarly, research suggests that people experiencing serious mental illness learn to make sense of and explain their experiences through their individual and cultural reference points (Larsen, 2004). However, whilst increased religiosity can be a sign of attempts to cope with increasing mental health difficulties, it can also be an indicator of psychosis (Abdel Gawad et al., 2017). Whilst some people explain religious experiences as ‘part of spiritual development’ when unwell, others perceive such experiences as ‘both spiritual and pathological’ or as pathological only (Ouwehand et al, 2020). Further, whilst some patients believe religion should be an important topic in their treatment and report having shared their religious experiences with mental health practitioners (Ouwehand et al, 2020), others may fear discussing their cultural and religious needs with mental health practitioners due to fear of their cultural and religious practice being incorrectly interpreted as a symptom of being mentally unwell if staff lack knowledge of those cultural and religious needs (Heffernan et al., 2014). Such concerns appear founded as previous research has found it can be challenging for staff to distinguish between a delusion and a religious or cultural belief (Hilton, 2002), and research in the USA found this was more likely with the beliefs of minority religions (O’Connor and Vandenberg, 2010). Similarly, a recent Dutch study noted that ‘in clinical practice, a clear demarcation line between genuine religiosity and pathology often cannot be drawn’ (Ouwehand et al, 2020: 31). Further, the study found that mental health professionals may struggle to address or feel comfortable addressing religious experiences, may tend to interpret such experiences as related to psychiatric illness, and conflicting views on religious experiences between patients and practitioners can negatively impact on treatment. However, similar research has not been undertaken in the UK.

 In the UK, public bodies are required under The Equality Act 2010 to meet people’s cultural and religious needs. Additionally, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 refer to care being person-centred, including meeting religious and cultural needs. Person-centred care involves working in partnership with the patient, and potentially their family (NICE guidelines, 2017), to provide personalised care in a strengths-based manner (Department for Health and Social Care, 2018). How inpatient staff are to meet the religious and cultural needs of their patients, however, is not clear. There is no clear process for identifying the religious and cultural needs of mental health inpatients (Gilbert, 2008) which creates further confusion for staff striving to meet these needs (Clegg, 2016). The Royal College of Psychiatrists (2010) recommend an assessment on admission of a patient’s cultural and religious needs but this is not mandated. Such an assessment could reduce the risk of patients’ needs being stereotyped or incorrectly interpreted by inpatient staff (Swift, 2007).

 Research suggests some inpatient staff expect patients to raise religious needs with them (Foskett et al, 2004), suggesting that this is not seen as essential information. Swift et al (2007) found the majority of nurses who did not record religious needs on admission reported feeling this information was not necessary or felt it was an invasive question. However, lack of information can lead to staff recording ‘no needs’ or ‘limited needs’ without including an explanation for the lack of detail (Department of Health and Social Care, 2018).

 McSherry and Ross (2002) argue staff need knowledge of the patient’s faith during assessments to effectively identify and meet religious needs. There are assessments available that include spirituality in terms of any personal practices inpatients undertake, e.g. HOPE (Anandrajah and Hight, 2001). Whilst research has identified support amongst mental health nurses to meet religious and cultural needs (McSherry and Jamieson, 2013), assessments need practitioners to have a good understanding of needs if they are not to become a tick box exercise (Gilbert, 2008). Further, there is lack of research to validate if such tools would identify the religious and cultural needs of mental health inpatients who may lack capacity to engage in such assessments.

 In 2005, the UK Government recommended cultural competency training be delivered to staff to help address discrimination in mental health services in England (Department of Health, 2005). A systematic review into cultural competency training in UK mental health services had theoretically validated the need for such training, however, evidence of any success was limited by the lack of evaluation (Clegg et al, 2016). Bhui at al (2007) argue standalone cultural competency training cannot address meeting the cultural needs of patients. Instead, they suggest providing additional interventions such as working with religious leaders in the community. This supports the findings of research undertaken by the Department of Health and Social Care (DHSC, 2018) that training alone does not increase cultural understanding and, additionally, patient care may be influenced by the unconscious bias of staff. The Modernising the Mental Health Act report again highlighted concerns around staff understanding of different cultures and recommended introducing an Organisational Competence Framework which would include measuring staff awareness of the needs of BAME inpatients (DHSC, 2018).

 In 2018, the year in which the current research was undertaken, the UK Department of Health and Social Care noted mental health services were facing demanding pressures in meeting patients’ needs on a systemic level due to insufficient staffing, a reliance on agency staff and high staff turnover. Further, wards were increasingly viewed as non-therapeutic due to lack of staff time to provide person-centred care (DHSC, 2018). These factors risk patient care being affected.

 The study reported in this paper aimed to explore inpatient staff experiences of seeking to meet the religious and cultural needs of BAME inpatients on mental health wards, both informal inpatients (admitted to hospital voluntarily) and patients detained under the Mental Health Act 1983. The study was undertaken in one NHS Trust in the West Midlands in England.

**Methodology**

*Design*

 The study utilised a qualitative research design to explore inpatient staff views and experiences on identifying and meeting the religious and cultural needs of BAME inpatients on mental health wards. Semi-structured interviews supported participants to share their subjective views as this method ensured core questions were asked of all participants whilst still allowing participants to raise points not covered by the topic guide but which were felt to be relevant to the area of study (Green and Thorogood, 2018).

*Approvals and ethical considerations*

 Approval for this research was granted by an ethics committee at the University of York (Reference: SPSW/MTA/2018/9) and the Research and Development Office of the NHS Trust in which the research was conducted.

 At the time of the research the researcher was employed within the Trust as a community-based Adult Mental Health Social Worker. Risks were identified that participants may provide responses they thought the researcher would expect in line with Trust policies, or would be cautious in taking part or giving honest answers due to concerns around confidentiality and anonymity. To mitigate these risks, it was emphasised in the recruitment email, information sheet and at the start of the interview that the research was being undertaken as part of the researcher’s academic studies and not for or on behalf of the Trust, that nobody within the Trust would be informed who had taken part or what any individual had said, and that all responses would be kept confidential unless there was a disclosure of harm.

 The researcher is of a BAME background. The authors reflected upon whether participants may have been influenced by this but felt it unlikely as the interviewees themselves were a diverse ethnic mix. The researcher reflected whether their own bias was resulting in assumptions being made according to their world view. However, frequent discussions with the second author kept a check on potential researcher bias in the interview questions, data collection and data analysis. The researcher attempted to maintain neutral facial expressions and body language in order not to influence responses.

*Recruitment*

 Two recruitment strategies were adopted. First, with the consent of senior management, a recruitment email detailing the study, with information sheet attached, was circulated via email or in person to 15 of the Trust’s Ward Managers for mental health inpatients across the three sites. Over half of the Ward Managers (n=8) contacted gave permission to advertise the research to their staff. Feedback was not obtained from those Ward Managers (n=7) who declined to advertise the research. Secondly, the research was advertised in the Trust weekly e-bulletin. Eligibility criteria were that participants worked on an adult inpatient psychiatric ward and were over 18 years of age. There were no restrictions on professional role as the researcher was interested in the views and experiences of all staff who came into contact with inpatients. Interested staff were advised to email the researcher at their University email address.

*Participants*

 Purposive sampling was used to target inpatient staff on mental health wards. Nine inpatient staff, from a target of ten, volunteered and took part in the study; a sampling frame was thus not required. Recruitment was contained to one West Midlands Trust to ensure as far as possible that any differences in the data were not attributable to any differences in policy, training or culture between Trusts. The Trust covers an urban area with a relatively large population from BAME backgrounds.

 Of the nine participants, five were Female and four Male. Six described their ethnic origin as White British, one as African and two as Indian. Four participants were younger and five participants older than 40 years of age. The number of years participants had worked in mental health services ranged from under a year to over 40 years, with an average of 15 years. Participants spanned a variety of roles: Consultant Psychiatrist, Psychiatric Nurse, Healthcare Assistant, Occupational Therapist (OT), Deputy Ward Manager and Ward Manager.

*Data collection*

 Once potential participants emailed the researcher and volunteered to take part, a time, date and location for the face-to-face interview was arranged. Interviews were undertaken with participants in July 2018. Interviews took place in a pre-booked private room at the site of each participant’s place of work for their convenience. At the start of each interview the researcher went through the information sheet and consent form with the interviewee and invited any questions. Interviews only began once the consent form was completed and signed. Interviews were audio-recorded, with consent, on a password-protected digital recorder, apart from one interview where consent to record was declined and the researcher instead took hand-written notes.

 The semi-structured topic guide consisted of a small number of demographic questions plus 11 open-ended questions. Questions focused on participants’ understanding, and their confidence in their understanding, of religious and cultural needs; how, if at all, the religious and cultural needs of inpatients were assessed; the extent to which staff felt able to meet those needs; the extent to which staff included patients’ families in identifying and meeting religious and cultural needs; the extent of any staff training on meeting the religious and cultural needs of inpatients; challenges and facilitators to meeting inpatients’ needs; and suggestions for improving staff ability to meet inpatients’ religious and cultural needs. Interviews spanned 25-45 minutes.

 Audio files, notes and transcripts were saved using unique participant identification numbers to ensure anonymity; the data key was stored separately and securely destroyed at the end of the research. Interviews were transcribed by a professional transcription service for a fee and transcripts checked for accuracy.

*Analysis*

 Transcripts were analysed using a framework approach to thematic analysis (Gale et al, 2013). Framework analysis was used as this offered flexibility and, in this study, provided insight into participants’ experiences of practice (Braun and Clarke, 2006; Green and Thorogood, 2018). Analysis involved immersion in the data through reading and re-reading of the transcripts, the development of a coding frame initially based upon the interview questions, and then the identification, categorisation and exploration of *a priori* and emergent themes in the data via an iterative process of coding and re-coding as the coding frame was refined. Data was summarised under each thematic category and similarities and differences within and between summaries were analysed (Gale et al, 2013). A sample of the transcripts were coded by the second author with codes subsequently refined through discussion and agreement of categories.

**Results**

Seven themes emerged from the data: understanding of religious and cultural needs; identification of needs; barriers and facilitators to meeting the religious and cultural needs of BAME inpatients; mental health symptomology; the role of family; staff training, support and guidance; and suggestions around how to better meet the religious and cultural needs of BAME inpatients.

*Understanding of religious and cultural needs*

All participants felt it was important to meet the religious and cultural needs of BAME inpatients in order to support the patient’s mental health recovery and build a therapeutic relationship:

“It’s being made to feel included in everything and that’s being inclusive…It’s making them feel welcome in their own party.” (Participant 3)

When asked if they could identify any religious and cultural needs of BAME inpatients, all nine participants gave broad examples of religious needs: prayer, dietary requirements, and access to faith representatives and holy books. However, none gave examples of potential cultural needs, suggesting a lack of knowledge of cultural differences.

*Identification of needs*

 There was no consistent method of how participants attempted to identify the religious and cultural needs of BAME inpatients despite the fact the initial assessment included a question on religion and religious needs.

The explanation for why questions on religious and cultural needs were sometimes missed varied. Some participants reported some staff felt uncomfortable or not confident having a conversation about a patient’s religious and cultural needs thus relying on the patients themselves highlighting such needs:

"…sometimes people find asking the question quite unsettling…it's like a taboo subject… the patient has to tell us what their religion is. We won’t necessarily be the ones that ask that so maybe it can be missed sometimes.” (Participant 8)

Staff reported that any notes about religious and cultural needs on the patients’ files were not necessarily accurate and they assumed a lack of information meant the question had not been asked. It was argued that White British inpatients were more likely to spontaneously tell staff about their religious and cultural needs which may suggest that this group felt more comfortable in making such requests.

 Many participants argued that staff did not always have time to explore with an inpatient their religious and cultural needs and/or saw this as additional work:

“It’s that we don’t have time to sit down and deal with paperwork and any extra…” (Participant 7)

This suggests that staff did not necessarily accept or understand the potential importance of patients’ religious and cultural needs in supporting their recovery.

*Barriers and facilitators to meeting the religious and cultural needs of BAME inpatients*

 The majority of participants felt there was a lack of understanding of BAME inpatients’ religious and cultural needs, especially for emerging communities. Whilst resources to meet religious and cultural needs had been put into place over time for long-term settled ethnic communities this had not yet happened for new and emerging BAME communities. Whether this would happen to the same extent was perceived to be partially dependent on funding:

“…It takes time. I think that is a very interesting issue, right now, will come from if they can afford to support their needs” (Participant 1)

For example, in relation to language barriers, participants reported that the availability of leaflets in different languages and access to interpreters was generally good. However, there were problems with interpreters not being readily available for inpatients of emerging and smaller ethnic groups such as Eastern Europeans and some African dialects. For staff, the language barrier resulted in difficulty building a rapport with non-English speaking inpatients and to explaining medical terminology. In such situations, pictures were used to attempt to communicate with inpatients who did not speak English. However, concerns were raised that BAME inpatients were stereotyped with assumptions based upon staff members’ limited knowledge of the inpatient’s ethnic origin rather than exploring their needs with them.

Participants believed access to faith representatives, via chaplaincy, was well facilitated in regards to Christian inpatients. However, for other faiths it took more time and a referral to access a faith representative. Prayer needs were facilitated by providing time and space including a quiet space; whilst this was designed for Christians it could also be used by inpatients of other faiths.

 Generally, participants thought dietary needs were well met. However, a participant experienced initial difficulty meeting the needs of a BAME inpatient fasting for the Islamic festival of Ramadan due to fixed ward mealtimes:

“…somebody was fasting for Ramadan. It was bit of a difficult situation… the set structure of the clinical environment [means] meals at this time, meds at this time… [However, it was arranged for] food [to be] frozen for them to have later.” (Participant 5)

Staff expressed concerns about the potential lack of communication between staff, in particular agency staff, and kitchen staff leading to dietary needs not being consistently met.

 Staff tried to meet religious and cultural needs within limited resources. For example, leave to attend a place of worship was possible but only where this was planned and staff resource available:

“We had a Muslim gentleman here…he could not go unescorted outside the grounds. He wanted to attend the Mosque for Friday prayers…That’s just manageable…if he said “I need to go to the Mosque five times a week” I couldn’t have done that because that would have meant…staff gone for several hours…a week.” (Participant 3)

 Risk was an additional factor for inpatients on the mental health wards and this, coupled with resourcing, meant that managing risk took precedence over meeting religious and cultural needs.

*Mental health symptomology*

 Some participants reported that a lack of knowledge made it more challenging to differentiate a BAME inpatient’s religious and cultural needs from a potential psychotic episode. For example, one participant described an occasion when an inpatient of a Ghanaian background believed somebody was practising voodoo on him, a cultural belief prevalent in Ghanaian culture, but this was deemed by staff to be a delusion. The participant felt the professional in charge would not listen to their concerns of the inpatient’s cultural beliefs being wrongly interpreted as a delusion:

“They were quick to label what he was talking about as a mental disorder without exploring and not giving enough time in a clinical area to assess and put into perspective… In my opinion, it was a cultural difference. He said things that they believe in spiritually, which I have experience with… it’s frustrating…that you’re a nurse, you can’t say what we have to say to a medical team.” (Participant 5)

Once again, time was cited as a barrier to staff exploring such views with patients and trying to make sense of their experiences in the context of their religion and culture.

 Challenges also arose when supporting inpatients who were acutely unwell and lacked capacity to make informed decisions about their religious and cultural needs:

“…I had a chap who was Muslim…he was eating sausages on the weekend…they were pork but he didn’t care. On any other day, he would have eaten vegetarian sausages when he’s well…the challenge is…you see them in a frame of mind where they are not well…you can’t engage what their needs [are].” (Participant 5)

*The role of family*

 Participants reported that they were sometimes informed about a BAME inpatient’s religious and cultural needs by family members and this helped staff to understand more of what the inpatient had been saying or doing:

“…things…they were saying…they were quite psychotic, but nobody was actually picking up…that this was actually in relation to their religion… [it] made sense when [it was]…explained…by the family.” (Participant 7)

Staff also explained the benefits of helping family members to understand an inpatient’s condition or treatment from a medical perspective as family could be instrumental in, for example, supporting the patient during their hospital stay, ensuring medication compliance and more broadly working with the staff or at least having a better understanding of the patient’s treatment:

“If mental health isn’t understood, especially [by people] from different backgrounds, their families may not understand…They may think that taking the person home, and without medication, and doing this ritual and practicing in this way, that will help them… [For staff] having an understanding of the background and why people think the way that they think and have the families think the way the way that they do, you can connect with them more…building trust and rapport, their views might not change but they become more accepting of what you’re offering.” (Participant 7)

 Family members of BAME inpatients were also sometimes able to help meet the patient’s religious and cultural needs. For example, by taking them out on leave for religious practice or bringing in culturally appropriate foods. The role of family as advocates was highlighted, especially in ward rounds. However, it was not always appropriate to involve family due to the patient not giving consent or due to safeguarding issues. For those without family involvement professional advocates were helpful in providing signposting to staff in meeting the religious and cultural needs of BAME inpatients.

*Staff training, support and guidance*

 Six of the nine participants said they had received ‘equality and diversity training’ within the Trust during their induction, covering the Trust’s policy, forums for staff and the chaplaincy service. The other three participants had not received such training but stated they would like to do so. Participants also reported developing their understanding of BAME inpatients’ religious needs by speaking to BAME colleagues and even asking colleagues to interpret if the need arose. This in itself could be problematic as it suggests potential stereotyping and presumptions around the ethnic origin, language/dialect, religion, and religious and cultural needs or experiences of inpatients and colleagues.

 Some participants argued that further and/or repeat training would reduce the likelihood of a BAME inpatient’s religious or cultural practice being incorrectly interpreted as a risk. For example, one participant explained how they had only recently become aware that baptised Sikhs wear a ceremonial dagger and noted how this could have been perceived as a threat to the patient or staff rather than explored in a religious context and alternatives considered. However, another participant spoke of the limits as to what could be taught in training and argued instead that staff being open-minded and accepting of different religions and cultures was more important:

“…the training is there but it can only take you so far. You as a person need to want to do things, need to want to think a certain way…” (Participant 5)

 Participants reported other ways in which they had accessed information about the religious and cultural needs – and/or beliefs – of BAME inpatients. Some had looked online for such information or had used the internet to find translated leaflets or to try to translate from English to the inpatient’s first language. Some participants mentioned their awareness of the Trust’s equality and diversity department, a resource folder including some information about religious and cultural practice and beliefs and relevant organisations, and local and national policies. However, in practice, none knew how to access this support.

*Suggestions around how to better meet the religious and cultural needs of BAME inpatients*

 In light of the difficulties and diversity of practice reported in the interviews, participants suggested potential ways of better meeting the religious and cultural needs of BAME inpatients. Some requested a directory of the diverse religious and cultural needs of BAME inpatients which could be available on the intranet. Another participant suggested a link person from the Trust equality and diversity department go to the ward to speak to staff about support they required to meet the religious and cultural needs of BAME inpatients on a weekly basis. This was based on staff feeling that the chaplaincy’s approach of going to the ward to support inpatients and staff, rather than the ward going to them, was more accessible. It was also suggested by some that staff receive training on the involvement of family in an individual’s life, learning how the role of family differs between individualistic and collective cultures, and thus the importance of working with families in some cultures.

**Discussion**

 The findings suggest that while inpatient staff state they understand the importance of meeting the religious and cultural needs of BAME inpatients on mental health wards, the practice of identifying and then seeking to meet those needs is limited. Inpatient staff reported not feeling comfortable or confident in using existing assessment tools and asking inpatients about their religious or cultural needs, felt they lacked the time to take on what some perceived to be additional work despite acknowledging the potential benefits of meeting such needs, and felt that they lacked training on identifying and meeting such needs. Concerns were raised regarding the extent to which particular beliefs or practices were part of religious or cultural practice (and thus potentially protective factors) or were delusions, and thus how to respond. However, there were also examples of positive practice, for example of involving family members to help identify and sometimes help to address religious and cultural needs, looking online for information about particular religious and cultural beliefs, needs and practices, and asking BAME colleagues for information, advice or help with translation.

 Inpatient staff demonstrated some understanding of BAME inpatients’ religious needs but this was predominantly limited to prayer, dietary requirements and access to holy books or faith representatives. This limited knowledge of religious needs and ignorance of cultural needs may have been linked to there being no specific assessment to identify a BAME inpatient’s religious and cultural needs. This echoes findings by McSherry and Ross (2002) who also noted that religious and cultural needs should be identified and discussed as part of the assessment. Staff reported feeling uncomfortable speaking to inpatients about such needs, reminiscent of Swift et al’s findings (2007), and perhaps expected religious and cultural needs to be raised by the inpatients themselves, as found in an earlier study by Foskett et al (2004). This indicates a gap in confidence, knowledge and procedures.

 The study thus found that identification of religious and cultural needs was dependent upon staff knowledge in recognising the needs or the inpatient spontaneously stating their needs without prompting. There was limited reference to advocacy and none in relation to supporting BAME inpatients to express their needs despite culturally appropriate advocacy being recommended by the DHSC (2018) to support staff to identify BAME inpatients’ cultural and religious needs.

 Not all the inpatient staff who took part in this study had received training on meeting religious and cultural needs and some of those who had felt the benefit was limited. Some staff informally consulted BAME colleagues about BAME patients’ religious and cultural needs, echoing findings by Bhui et al (2007). However, BAME staff in this Trust were not representative of the ethnicities of inpatients, a reality that is reflected nationally (DHSC, 2018). Thus, the needs of small ethnic groups and newly emerging communities were less likely to be known due to lack of knowledge and lack of staff of the same religions and cultural backgrounds.

 Staff felt they did not have the confidence or skills to explore inpatients’ narratives of their experience of their mental health and struggled to identify whether unusual practices or beliefs displayed by BAME inpatients represented religious and cultural practices or beliefs and/or were due to becoming increasingly mentally unwell. This reflects the work of Hilton (2002), and suggests a need to use a person-centred approach to identify the meaning of the behaviour, as highlighted by Macmin and Foskett (2004). Staff gave examples of where a lack of knowledge of religious and cultural needs, beliefs and practices had risked an inpatient’s presentation incorrectly being attributed to mental illness rather than as an expression of, or potentially a coping mechanism derived from, their religion or culture, building upon evidence from the USA (O’Connor and Vandenberg, 2010).

 Staff were supportive of involving the family of an inpatient especially where the family members could inform staff of the BAME inpatient’s religious and cultural needs. Conversely, family involvement could be detrimental if family lacked understanding of the inpatient’s condition and treatment and/or discouraged the inpatient from adherence to the treatment plan. As noted by Larsen (2004), people may seek to understand mental health experiences according to different narratives including religion and culture. Mental illness is understood differently within different cultures and can be viewed particularly negatively due to stigma or lack of psychoeducation (Fernando, 2010). Staff felt that being knowledgeable about families’ religious and cultural backgrounds would enable them to build a rapport and to provide psychoeducation which could ultimately lead to the family supporting the inpatient to be open to treatment or medication. Staff understanding of religious and cultural beliefs and practices could also help them to identify when an inpatient was displaying greater religiosity versus experiencing delusions and thus respond to them accordingly.

 Staff reported that chaplaincy was often viewed as the first point of contact when seeking advice on community services, places of worship and referrals to representatives of other faiths. Chaplaincy was thus viewed as the link to accessing community based religious and cultural services, reaffirming the findings of Brimblecombe et al (2007) that nurses supported patients’ cultural and religious needs through community resources. Staff noted that chaplaincy attending the ward proactively helped staff to engage with them as they would not otherwise have had the time to seek out support. Staff in this study also identified the internet as a resource in helping staff to identify religious and cultural practices and beliefs and also in supporting staff to meet some of the religious and cultural needs of BAME mental health inpatients. This has not been identified in previous research.

 However, staff also reported challenges to meeting identified religious needs. For example, the rigidity of certain procedures such as set mealtimes meant that it could be difficult to support inpatients who were fasting and eating outside of set mealtimes. Furthermore, the use of agency staff sometimes resulted in information not being shared, for example dietary requirements being communicated to the kitchen staff daily. Such examples highlight the importance of continuity of care (Care Quality Commission, 2018).

 Due to their self-reported lack of knowledge, inpatient staff were keen for further training. Such training could cover religious and cultural beliefs and practices, dietary considerations, festivals and associated observances. This would help to build staff knowledge and confidence and thus encourage them to explore inpatients’ religious and cultural needs and respond appropriately.

*Implications for policy and practice*

 Firstly, the research implies there is a knowledge gap and training need amongst inpatient staff around how to identify and meet the religious and cultural needs of BAME inpatients. Whilst it would be impractical to cover the religious and cultural beliefs and practices of all religions and cultures, training could potentially cover a number of the most common religions and cultures locally. Training could also include having sensitive conversations with inpatients about their religious and cultural needs, and the role of unconscious bias among staff. The beliefs and practices of a larger number of religions and cultures could be detailed in an intranet directory, with staff signposted to relevant community services. However, there would be resource implications of keeping this updated.

 Secondly, the research suggests that the religious and cultural needs of BAME inpatients are not being systematically identified. Options to rectify this could include use of an assessment tool on admission to the ward or as soon as the inpatient is able to engage with this, or family involvement in the assessment process. Accurate and consistent recording of this information should reduce miscommunication of an inpatient’s needs. Alternatively, if the patient is under community services, community staff could discuss religious and cultural needs with the patient during a stable phase and record this information in a care plan which could then be accessed by inpatient staff on admission. This information could also aid inpatient staff in identifying mental health symptomology by comparing needs and practices pre- and post- admission.

*Limitations*

 The research was conducted with nine inpatient staff in one NHS Trust in England and thus the findings may not be transferable. Further, it is possible that those who volunteered to take part in the study had a personal interest in the topic which may have biased their responses; although this was not apparent in the data. Future research could triangulate the views of BAME inpatients and their family members with the views of inpatient staff to highlight the views and experiences of each and identify suggestions by all of how the religious and cultural needs of BAME inpatients on mental health wards could be better met.

**Conclusion**

This research sought the views of inpatient staff on meeting the religious and cultural needs of BAME patients on mental health wards. Interviews with nine inpatient staff identified that while staff believe in the importance of meeting the religious and cultural needs of BAME inpatients, they admit a lack of knowledge and confidence in asking about these needs and a lack of resources in meeting those needs. To compensate, staff reported utilising guidance from chaplaincy services, the knowledge of BAME colleagues and practicing a person-centred approach. Staff expressed particular concerns that newly emerging and smaller ethnic groups were at a higher risk of their religious and cultural needs not being met due to a lack of knowledge of their specific needs and the resources available. Concerns were also raised about the religious and cultural needs of BAME inpatients being misinterpreted as delusions or psychosis. Further, the dominance of the medical model on the wards minimised consideration of the social needs, linked to the religious and cultural needs, of BAME inpatients. The research implies that staff need support to meet the religious and cultural needs of BAME inpatients in a person-centred manner. This could be achieved by introducing training on the religious and cultural needs of BAME inpatients which could increase staff skills and confidence to explore needs with inpatients and increase awareness of unconscious bias; the development of a resource directory on religious and cultural needs and practices; and use of an assessment tool during or shortly following admission, potentially including the patient’s family, or undertaken in the community during a stable phase for those who access community services to identify religious and cultural needs.

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