Understanding Patient Focused Care in Psychiatric Care.

*Exploring mental health workers’ views and strategies on treating immigrants in Norway.*

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http://www.duo.uio.no/

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<tbody>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
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<tr>
<td>NAKMI</td>
<td>National Center for Minority Health Research</td>
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<td>NONEMI</td>
<td>Norwegian Network of Migrant Friendly Hospitals</td>
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<td>NSD</td>
<td>Norwegian Centre for Research Data</td>
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<td>MFH</td>
<td>Migrant Friendly Hospitals</td>
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<td>PFC</td>
<td>Patient Focused Care</td>
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<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
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<td>SOFT</td>
<td>Storby-og flykningeteam (Big Cities and Refugee Team)</td>
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<td>TRIM</td>
<td>Treatment and Research Integrated Model</td>
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<td>UN</td>
<td>United Nations</td>
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<td>WHO</td>
<td>World Health Organization</td>
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David Edem Asase
Oslo, October 2016.
Dedication

Dedicated to the Glory of God Almighty
Abstract
This study explored the applicability of the idea of Patient Focused Care (PFC) in psychiatric care with focus on immigrants within the healthcare system of Norway. PFC has been defined as health care that meets patients’ needs and preferences and where patients are autonomous and able to decide for themselves. The research sought to answer the question of how African immigrants receiving psychiatric care in hospitals in Norway are treated in a PFC manner from the viewpoint of health workers, bearing in mind the recent advocacy for transcultural psychiatric care. Previous studies have not looked specifically at this distinct group of immigrants, neither has the practice of PFC in transcultural psychiatry on them explored. To fill in this gap, this study sought to focus on the key aspects of PFC that can be identified among specialized psychiatric care units involved in treating refugees, asylum seekers and other immigrants. A series of in-depth interviews were conducted with health workers from two specialized psychiatric care teams involved with treating immigrants and the qualitative research method was used to analyze the data. A summary of the findings of the study indicated that the idea of PFC is unknown to the informants although they use all its key aspects in their work. The study also revealed that informants agree on the need and advocate for special psychiatric care for African patients and identified unique treatment strategies used to treat these patients. It is expected that the outcome of this study will shed light on strategies used by mental healthcare workers in treating patients whose backgrounds differ from that of the general population. The study also provides insight for policy makers for contemplation when drafting policies relating to transcultural psychiatric care.
CHAPTER ONE

INTRODUCTION AND RESEARCH OBJECTIVES

The focus of health care services has for a long time been on technology-based, disease-centered models(1). The concept of Patient Focused Care (PFC) sometimes referred to as Patient Centered Care or Person Centered Care seems to defy a single definition. However, we can set PFC aside as care that is not primarily technology centered, doctor centered, hospital centered or disease centered(1). The concept of PFC initially focused on a more narrow interpretation of patient centeredness, serving as a guide for individual practitioners interacting with individual patients. However this approach changed towards considering patient focused care as a comprehensive way of delivering health services. The Picker-Commonwealth Program for Patient-Centered Care for example identified 7 aspects of PFC as 1) respect for patients’ values, preferences and expressed needs; 2) coordination and integration of care; 3) information, communication and education; 4) physical comfort; 5) emotional support and alleviation of fear and anxiety; 6) involvement of friends and family; and 7) transition and continuity (2).

A number of empirical studies conducted over the years including those of Derose et. al (3), Abebe(4) and Adday(5) all illustrate the vulnerable position of immigrants within healthcare systems of host countries. Fewer studies have focused on African immigrants in particular possibly due to their exclusion from or too few numbers in nationally representative studies and clinical trials(6). With specific reference to the PFC model, there is little empirical studies to assess how it is practiced on immigrants in hospitals. This study will focus on the strategies health workers adopt when treating African immigrants in hospitals, specifically African patients in need of mental healthcare. African immigrants, for the purposes of this study, refer to persons of African decent living in Norway permanently or for a short period.

Despite the general acknowledgement of the importance of research-based knowledge on immigrant health problems and healthcare needs for planning interventions and informing social and policy action, there are still major gaps in this area of research. Strategies used to treat patients from the general population may not achieve same results on immigrants due to many factors including language, cultural and racial differences. It is therefore important to have a more focused study on specific sections of the population in order to develop unique strategies to be used during treatment.
This study will therefore aim at filling in some of these gaps, provide a foundation for further studies of other immigrant groups as well contribute to the limited knowledge on the issue in question.

It is important to focus on African immigrants in particular within healthcare systems since research has shown that these are people who form a part of vulnerable groups in a host population(7). However, there is also the argument that too much focus on immigrants and their health may in itself contribute to their vulnerable position since such focus might lead to immigrants standing out as anomalies in a society that is seen to be holistic and stable(4). Nevertheless, it will be inappropriate to assume that immigrants do not need or even deserve special attention in the provision of healthcare services in their host countries.

This assumption becomes even more complex for African patients in need of psychiatric care. PFC seeks among other things to promote and achieve the involvement of patients in care, but for psychiatric patients this may pose a challenge. Their condition may not make it possible or easy for them to be involved in care. This problem is compounded when patients are immigrants from countries that differ from their host countries on various levels, which calls for attention to transcultural psychiatry.

Health workers are therefore faced with peculiar challenges when treating this group of patients especially in light of the promotion of patient involvement in care through PFC. It will be interesting to find out how health workers overcome this complex challenge and identify the strategies they use to ensure that African patients in need of psychiatric care are treated in a patient focused manner. This study will therefore aim at answering the following questions;

1. Are mental health workers involved in treating African patients aware of the PFC model?
2. Do these mental health workers treat these patients with reference to the key elements of PFC?
3. What strategies do health workers adopt when treating these patients?

**Theoretical Framework**

A 2002 publication by the Institute of Medicine (IOM) titled *Unequal Treatment: Confronting Racial And Ethnic Disparities In Health Care* provided strong evidence of racial and ethnic differences in health care provision(8). This led to increased
interest in culturally competent healthcare provision. Cultural competence within the context of healthcare is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural and linguistic needs of patients(9).

This study will ride on the back of the principles identified in cultural competence in healthcare to determine whether or not health workers in the selected hospitals apply them in providing patient focused care for African patients in need of mental healthcare. Cultural competence in healthcare emphasizes awareness of and respect for different cultural traditions and perspectives. At the same time, the theory is not oblivious of the fact that it is not possible for health workers to have a detailed knowledge of all the cultural perspectives they might face in their line of work. The concept therefore suggest incorporating in hospitals a cross cultural healthcare balance between acquiring knowledge of specific cultural groups and developing attitudes and skills not specific to any particular group(9).

The theoretical perspectives from the idea of cultural competence will be used as the yardstick to identify the strategies that mental health workers in the selected hospitals adopt when treating African immigrant patients. Therefore, in an effort to answer the research questions, the study will seek to identify cultural competence strategies evident in PFC of African immigrants in psychiatric care. The analytical approach that will be used for this study will be the narrative analysis which applies when one or more speakers engage in sharing and recounting an experience or event(10).

Structure of the thesis

The rest of the thesis consists of four chapters. Chapter Two presents a review of relevant literature on PFC of immigrants and cultural competence in healthcare. Evidence, examples and debates surrounding the concept are discussed thoroughly in this chapter and the overlap between PFC and cultural competence is illustrated. Special attention is given to mental health and PFC and a case for transcultural psychiatry is made.

Chapter Three describes the research method used for this study and provides the justifications for and significance of the selected method. Ethical issues relating to the study and limitations of the study are also discussed in this chapter together with a description of the informants, the process of recruiting them and data collection procedures. Chapter Four presents the results from the methods and the various
themes that emerged. These themes are discussed in line with the literature and theories relating to PFC and cultural competence of health workers in Chapter Five. Finally, a summary and recommendations section is presented at the end of this chapter.
CHAPTER TWO

LITERATURE REVIEW

The concept of Patient-Focused Care

The concept of patient-focused care (PFC) sometimes referred to as patient-centered care may come across to many as a confusing notion especially when the general assumption is that healthcare is provided with a focus on the patient. However, if PFC is looked at simply in terms of the care we will like to receive from health providers or the care we will like our loved ones to receive, we are likely to identify shortfalls. The reasons for this shortfall includes the lack of knowledge on patients by health providers, resource constraints leading to health providers wanting to cut costs and too much focus on eliminating disease only.(11) The PFC model is quite popular in the United Kingdom, United States, parts of Europe and Asia although Davies(12) identified difficulties with the model at the implementation level.

The concept of patient centeredness, believed to have been coined in 1969 by Enid Baliant, was to put emphasis on understanding each patient as a unique human, with stress on how doctors should interact and communicate with them (2). Subsequently, Lipkin et al. described interactions between doctors and patients that are patient centered as one that approaches the patient as a unique human being with his own story to tell, promotes trust and confidence, clarifies and characterizes the patient’s symptoms and concerns, generates and tests many hypotheses that may include biological and psychosocial dimensions of illness and creates the basis for an ongoing relationship (13).

One important description of the patient-centered approach was by Levenstein et. al (14) who were of the opinion that health workers should aim at gaining an understanding of the patient and the disease (not only focus on the disease). This can be achieved through the process of addressing both the agenda of health workers and patients (not only addressing the health workers agenda).

The Picker-Commonwealth Program (2) started in 1987 for patient-focused care was also aimed primarily at promoting a patient-centered approach to hospital and health services, focusing on patients’ needs and concerns. Seven key dimensions of patient-centered care were outlined:

1) Respect for patients’ values, preferences and expressed needs;
2) Coordination and integration of care;
3) Information, communication and education;
4) Physical comfort;
5) Emotional support and alleviation of fear and anxiety;
6) Involvement of friends and family; and
7) Transition and continuity.

The popularity of PFC can be traced to its acknowledgement in the Institute of Medicine’s (IOM) report as one of the six important elements of high quality health care(15). For care to be regarded as high in quality, the IOM argues that it should be “patient centered” that is to say it should be “providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions”(15)\textsuperscript{p,e,6}. The IOM’s description of PFC drew on elements from the earlier Picker-Commonwealth dimensions such as coordination and integration, the provision of information and education to patients, attention to physical comfort, emotional support and involvement of family and friends(16). In addition, the World Health Organization (WHO) is mindful of the need for PFC by indicating that health services that are people-centered must adopt an approach to care that consciously adopts the perspectives of individuals, families and communities and sees patients not only as participants but also beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways\textsuperscript{*}.

According to Edvardsson and Innes (17) the past decade has seen a growing interest in PFC as well as related concepts like patient-centered care, people-centered care, patient-closer care and person-centered care. The reasons for this interest can be traced to the current situation of rising demands and limited resources in healthcare, making the element of interactive role of patients in a healthcare system important. In an attempt to achieve the triple agenda of better health, higher quality and cost containment, many healthcare systems are developing innovative ways of meeting health needs of patients. It has been suggested that at the core of the most successful of such efforts, whether structural, cultural or commercial is the concept of PFC(18).

Defining PFC has not been an easy and straightforward exercise that has received consensus. The lack of a clear definition in addition to difficulties in finding a suitable

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\textsuperscript{p} http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/

\textsuperscript{e} The Joint Commission accredits and certifies health care organizations and programs in the United States.
measurement tool for the model has been identified as hampering its implementation (19). In view of this, some scholars and institutions have attempted to find a common definition for PFC. For the UK’s Royal College of General Practitioners, defining PFC will require a mix of three interrelated elements. The first element identified is for PFC to have a holistic approach to providing care especially in the face of the increasing need for long term care of patients. This requires considering patients’ needs as a whole rather than treating medical problems in isolation. Secondly, the patients’ individual personal priorities and needs have to be taken into account in providing care. The third element points to the need for collaboration between patients and health professionals who take part in providing care. A review examined existing literature in order to carry out a concept analysis of PFC including definitions, concepts and theoretical perspectives (20). According to this review, one feature that runs through literature on PFC is the focus on individualization of patient care and the use of information and shared decision making to get patients involved in care.

For the purposes of this study, PFC will be described as “health care that meets and responds to patients’ wants, needs and preferences and where patients are autonomous and able to decide for themselves” (21). This definition puts emphasis on treating the patient as a unique individual and an acknowledgment of each patient’s own way of perceiving things related to the care been received (20). Again, this definition points to the role of health professionals, which is to offer support and practical expertise enabling the patient to follow the path they (patients) choose.

**Patient Focused Care myths**

Why is PFC so important and why should we be bothered at all? Are there any real benefits of PFC? Will implementing PFC be more costly for a hospital? These are some of the questions that have guided debate on the concept of PFC and have been the focus of a number of studies.

There are some who support basically every aspect of the PFC concept while others, especially healthcare workers, might get genuinely apprehensive or skeptical about the idea. The fears of these healthcare workers as well as policy makers who are required to sanction PFC policies are fueled by a number of myths surrounding the concept. A number of reasons have been provided to justify fears that PFC models cannot be implemented or be effective if implemented. Frampton et. al have described
these concerns as ‘myths’ in their Patient-Centered Care Improvement Guide (22). Through the publication, they sought to clarify “misconceptions and demonstrate once and for all why these persistent myths need no longer thwart the more widespread adoption of patient-centered care” (22) pg.23.

Among the most prominent of these myths is that providing care that is patient-centered is too costly. This misconception is fuelled by the assumption that PFC will require massive financial resources to be successfully implemented. Admittedly, PFC can be enhanced with some financial resources in the areas of technology, renovations and some new equipment. All these will come with staff training and education costs; however, the fundamental focus of providing PFC is human interactions, which can be done successfully without massive financial capital infusions. Providing effective PFC does not mean more healthcare workers have to be hired but it is rather about the attitude, compassion and empathy of staff. In addition, the care environment of a PFC hospital does not necessarily need massive investments to renovate or expand infrastructure to become a healing environment.

Again, there is the myth that although PFC is a ‘nice’ idea it is not really important. The basis of this myth is that aspects of PFC such as involvement of family and friends in care and communication with patients and family is only nice to do but does not achieve any significant benefits and is therefore not important. However, The Joint Commission† clarifies this by stating that:

Communication with [patients] and families about all aspects of their care, treatment or services is an important characteristic of a culture of safety. When [patients] know what to expect, they are more aware of possible errors and choices. [Patients] can be an important source of information about potential adverse events and hazardous conditions (23) pg.111.

The list of myths includes allusions to the effect that providing PFC should be the work of only nurses, PFC can only work at small hospitals and that there is no evidence to show that PFC is an effective model for healthcare delivery.

The next section will provide some evidence of the effectiveness of the implementation of the PFC model.

† The Joint Commission accredits and certifies health care organizations and programs in the United States.
**Patient-Focused Care and clinical outcomes**

Literature on the relationship between PFC and clinical outcomes can be described as mixed. The impact of PFC care can be looked at from different perspectives such as from the angle of its impacts on patients or on health workers. This section will present the impact in this two-fold description, first on patients and later on health workers.

**Patients and PFC**

What patients want is not rocket science, which is really unfortunate because if it were rocket science, we would be doing it. We are great at rocket science. We love rocket science. What we’re not good at are the things that are so simple and basic that we overlook them. – Laura Gilpin‡.

Generally, patients that are treated with PFC elements have expressed satisfaction with the practice. For instance, research has shown that when a doctor uses effective communication skills, both doctor and patient benefit (24). Again, PFC has been associated with improved patients health status and increased efficiency of care in terms of reduced diagnostic tests and referrals (25). When studied in specific areas of health care systems such as in primary care consultation, the verdict is not very different. Patients at the primary care level who were interviewed revealed strong preference for the PFC approach, especially in the area of communication (i.e. listening physician, clear explanations, exploration of concerns), partnerships and health promotion (26).

Another study that shows support for PFC by patients is an observational study of patients visiting their family physicians (27). This study was interesting in the sense that it identified physician approaches to consultation interaction with patients and went on to identify the approach that was most preferred by patients. According to the researchers, family physicians use four main approaches to consultation interaction with their patients: bio-psychosocial, biomedical, high physician control and person focused care. The bio-psychosocial approach acknowledges the fact that sickness is not influenced by only biological factors but also by social and psychological factors while biomedical approach focuses on the biological causes of illness. Out of these, person focused care interaction which involves physicians concentrating “more on the person than the disease, were personable and friendly, were open to the patients agenda and negotiated options with patients” was preferred most by patients with

‡ At the launch of Planetree. Laura Gilpin is a pioneer of Planetree (Mentioned subsequently).
nearly 50% support.(27) Other studies show support for patient centered interaction since patients are more satisfied when they “experience higher levels of psychosocial talk, encouragement, display of empathy and discussion of treatment effects”(28). Despite strong evidence of a general acceptance of PFC by patients it is important to pay attention to those who prefer other approaches different from the PFC such as the physician-centered approach. For instance, Swenson et. al in their study showed that up to 69% of patients on complimentary medicine chose a patient centered approach while 31% preferred a physician centered approach(29). What is interesting about this finding is that the researchers pointed to the fact that most of those who opted for an approach different from PFC were older and/or had less education. This discovery by extension supports the view by some authors to the effect that health care providers using a PFC model should consider adopting different approaches when dealing with different populations because PFC may not always be preferred, information may not be necessarily desired, shared decision making may not be applicable, and patients may not even want to have a choice (30).

Health workers, hospital units and PFC

It is evident that majority of patients prefer the PFC approach to how care is provided. However, since health delivery involves a provider and a receiver it will be important to look at how providers see the PFC approach. As indicated earlier, the focus of this thesis is to explore the PFC model from the perspective of health workers and how it affects their work.

Literature on the impact of PFC on health workers can also be said to be mixed. According to some studies, health workers have expressed positive feedbacks when using PFC in their line of work. They talk of increased satisfaction with work when using the PFC model(31, 32) while other studies show that health workers complained about the PFC coming with an extra workload for them and managers who implement it and decrease in work satisfaction amongst them (33, 34).

Again, an analysis of court cases relating to medical malpractice showed that the reasons for suing was often related to problems that occur during interactions between patients and health workers such as “a perceived lack of caring and/or collaboration in the delivery of health care, discounting patient and/or family concerns, poor delivery of information and lack of understanding the patient and/or family perspective”
Regarding the cost implications of implementing PFC in hospital units, an important study demonstrated the operational benefits of providing patient-centered care(35). This study was a five-year comparison of two comparable hospital units (same types of patients, skill mix and with standardized organizational pay rates, supply costs, policies, procedures, contracts and regulatory compliance programs). The difference between them was that one was implementing the Planetree model of patient-centered care and the other was not. The Planetree unit was found to consistently show shorter length of stay, lower cost per case and a shift in use from higher-cost registered nurse staff to lower-cost ancillary staff(35).

**PFC and immigrant populations**

Earlier in this section the reasons why it is important to consider adopting different approaches to delivering PFC to different sections of a population was mentioned. It has been generally acknowledged that health disparities have to be eliminated from all spheres of healthcare delivery or at least reduced. Major national agencies such as the United States National Institute for Health, Institute of Medicine and Centers for Disease Control and Prevention and the World Health Organization (WHO) admit that disparities in healthcare continue to exist across diverse populations(36). The reasons for these disparities include challenges faced by health workers in providing culturally appropriate healthcare. Closely related to this is the concern that some health disparities tend to be overlooked.

Immigrant populations tend to be faced with inequalities between them and their host populations in many health indicators, differences that are not explainable by only biological factors or by the diverse nature of healthcare models. Various studies suggest a strong linkage between barriers to effective communication (between health workers and immigrant populations) and ignorance of cultural and linguistic codes on the part of health workers(37, 38). These barriers have been reported as accounting for many of the health related inequalities mentioned earlier. In terms of specific barriers, many health workers point to language as the main problem when attending to immigrant patients(38) followed by socio-cultural barriers, beliefs and

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(34)\textsuperscript{Pg.1369}. This points to the need for health workers to take PFC more seriously in order to avoid such litigations.

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\textsuperscript{8} Planetree Inc. is a mission based not-for-profit organization that partners with healthcare organizations around the world and across the care continuum to transform how care is delivered.
misconstrued concepts(39). In addition to these and contrary to the perception that immigrants use more healthcare services, there is evidence that immigrants access and/or use less healthcare services than host populations (40). For example, Spain, a country with large number of immigrant in-flows over the past 20 years, has seen various studies identifying inequalities between immigrants and the host population with regards to access to healthcare services and other health indicators (40-42). This situation is not ideal especially when placed within the requirements of the right to health, which places an obligation on governments to make sure that “health facilities, goods and services are accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds”(43) Pg.4.

In Europe, it is difficult to study migrant health for a variety of reasons. There is a lack of data and problems with defining the subject as a consequence of uncertainty regarding when migrants from the various sub-categories (students, economic migrants, asylum seekers, irregular migrants and displaced persons) can constitute a socially and culturally distinct group of residents(44). Reviews of relevant literature on migration and health points to the conclusion that “it is not useful to make generalizations about the health of migrants, since mortality and morbidity patterns vary across space, time, age, gender, disease, across different countries of origin and type of migration” (44) Pg.2. There have been some attempts to solve the problems faced by immigrants in particular within the health care systems of their host countries. Cultural competence of health workers has been advocated to help meet inequalities and challenges faced by immigrants in the healthcare system of their host countries(9).

With regards to PFC, there have been a number of studies and policies in this direction. For instance, it has been noticed that American Muslim women although fast growing in terms of numbers are under-studied and formed part of an under-served American population(36). This led to the Agency for Healthcare Research and Quality funding a project titled “Patient-Centered Health Care for Muslim Women in the United States” to identify ways of ensuring that the health care issues of Muslim women in particular are understood and addressed. Again, a study has been conducted on caring for Asian immigrants in the USA to identify the tips on their culture that can enhance patient care(45). Others include studies on patient and family education
services for Albanian, Korean, Latino and Vietnamese immigrants** and health and healthcare for Chinese-American elders††.

There is little literature on the practice of PFC on immigrants in general and virtually none existing on African immigrants in particular. This is an alarming observation especially in the light of earlier evidence pointing to the need to study specific sections of a population in order to develop strategies to serve them better(37). PFC of African immigrants might face unique challenges for a number of reasons. In many African countries nurses and doctors are seen as ‘superior’ or ‘authoritative’ and this mind-set might hinder the ability and willingness of immigrants to actively take part in their own care(46). Again provider-patient relationships might be weakened when African immigrants do not trust Western medicine and medical procedures.

On the side of health workers, ignorance of cultural and social practices of African immigrants might lead to eliminating such practices from strategies for providing care. At the same time some cultural practices of African immigrants might actually have positive impacts on treatment and it is important for healthcare workers to be aware of such practices. For example, a study by Silow-Carroll et. al(47) described the close family bonds exhibited in certain cultures predominant to certain patient populations and how these bonds make it “more realistic to place important responsibility for care in the hands of the patient and family”(47)Pg.9. In addition to these the authors indicated that knowledge regarding healthier lifestyles and habits such as use of herbs and spices among immigrants remains unknown or untapped among health providers.

**Patient Focused Care and mental care of immigrants**

A study by Leplege et. al indicated that health workers in psychiatric care tend to avoid the term patient focused care. The authors suggested that this is the case because PFC ‘pretends’ to put the patient in charge of care when in fact it is health workers that are in charge(48). This situation is worsened by health workers in mental health assuming that mental patients cannot speak for themselves, therefore, take decision-making powers away from them(49).

Another study recommended that community mental health workers should use the ideas of PFC in their work since it stresses many concepts that are important to mental

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** Available at http://depts.washington.edu/pfes/CultureClues.htm
†† Available at http://www.stanford.edu/group/ethnoger/chinese.html
healthcare(50). It also stressed on how these concepts embody the values and practices they claim to embrace but hardly use in practice. The IOM also made mention of the fact that PFC is as relevant to mental health as it is to physical care(49).

Recently, the Human Rights Council of the United Nations (UN) in their draft resolution at the General Assembly shared some concerns regarding mental health and human rights. Prominent among their concerns was that they were,

Deeply concerned that persons with mental health conditions or psychosocial disabilities, in particular persons using mental health services, may be subject to, inter alia, widespread discrimination, stigma, prejudice, violence, social exclusion and segregation, unlawful or arbitrary institutionalization, over medicalization and treatment practices that fail to respect their autonomy, will and preferences ‡‡ Pg.2.

It is clear that the UN is concerned that people with mental health problems may face discrimination and stigma among other things. We also know that immigrants are at higher risk of facing these problems, which is why it is important to respect their preferences, will and autonomy.

To better understand the applicability of PFC to mental health, it is necessary to look at the 7 key elements of PFC together with mental health practices.

- Respect for individual needs, preferences and values: In psychiatric care, providers aim to develop individualized plans of treatment based on the patients’ preferences and values. Treatment planning in mental health has been described as becoming more and more of a partnership where health professionals “respect the needs of the service user, but also create conditions for the service user to assume and express his or her own power”(50) Pg.137. In addition to this, partnerships between patients and health workers and active participation of patients in the provision of care has been described as the cornerstone of psychiatric rehabilitation(51).

- Information, communication and education: Mental health workers are expected to make use of open lines of communication and to adopt the role of educators since education enhances treatment. It is expected that the patient is provided with information on available treatment options and expected outcomes. The role and importance of good communication and information in mental health is emphasized in some studies(52).

• Emotional support and alleviation of fear and anxiety: In mental health, the patients’ entire sense of reality can be affected by his condition. It is therefore important for health workers to provide emotional support or ensure that it is provided. Emotional support is important due to the stigma that continues to exist towards people with mental illness(53). It is essential for these patients to feel accepted and welcome at places where they receive treatment and for providers to exhibit an attitude of hope and empathy, which enhances emotional support for patients.

• Involvement of family and friends: Organizations such as the National Alliance on Mental Illness and Depression and the Bipolar Support Alliance insists on community mental health workers involving support persons in treatment planning and care processes (50). Mental health professional are required to include friends and family in treatment planning, goals setting and rehabilitation processes.

• Physical comfort: At a glance this element of PFC may seem irrelevant to mental healthcare but the creation of an atmosphere of comfort and relaxation for rehabilitation encounters is important. Aside creating comfortable conditions for consultations, mental health workers are often involved in assisting patients with their daily lives.

• Continuity and transition: The movement of psychiatric patients among different levels and types of health workers happens sometimes and although this might be necessary it ought to be done properly. One author mentions the need to ensure continuity between providers and clear directions on transferring care from one setting to another because this can make the difference between stability and chaos for patients coming out of acute care(50).

• Coordination and integration of care: At management levels, mental health practitioners provide linkages between mental health services, income, employment, housing, vocational training and other support services for mental health patients. This coordination is important otherwise immigrant mental patients especially will ‘get lost’ in the often complex systems of host countries.
It is obvious that there are practical linkages between the key elements of PFC and mental healthcare service delivery. Despite this linkage, it is unclear if (and how) mental health workers employ these elements when caring for immigrants.

As stated earlier, immigrants tend to be faced with peculiar challenges in the healthcare system of their host countries. With regard to mental health in particular, an assessment of experiences of mental health workers with treating immigrants further sheds light on the linkages between PFC and mental health of immigrants. Across the 16 countries studied, it emerged that there are complications with diagnosis, difficulty in developing trust and increased risk of marginalization in providing mental health services to immigrants(54). This study points to the need to have special focus on immigrants seeking mental health services and to incorporate the elements of PFC in treatment procedures.

The next section will explore the idea of cultural competence and proceed to relate it to PFC within the context of strategies used by mental healthcare workers when treating immigrants.

**Cultural Competence and Patient Focused Care**

Within the context of healthcare, cultural competence is defined as the ability of providers and organizations to understand and integrate individual values, beliefs and behaviors about health and well-being into both the structure and delivery of health care(55). In other words, it is the ability to understand cultural factors (e.g. health beliefs and practices) and be aware of them. This is important because they have a major influence on the way patients behave and think about illness and the treatments they are offered. In this regard, cultural competent health care service aims at providing the highest quality of care to every patient irrespective of race, ethnicity, cultural background and dominant language proficiency or literacy levels. Brach and Fraser (55) provided an extensive list of strategies that are common in culturally competent health care systems. These include providing interpreter services, recruiting and retaining minority staff and providing training to increase cultural awareness, knowledge and skills. Other strategies are incorporating culture-specific attitudes and values into health promotion tools, including family and community members in health care decision making, locating clinics in geographic areas that are easily accessible for certain populations and providing linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical
billing and other written material(55). This again illustrates the links between the elements of cultural competence and the idea of PFC. Indeed, both approaches to improving the quality of healthcare have seen extensive promotion in recent years although there are disagreements as to whether PFC is only an aspect of cultural competence or vice versa. It has been explained that

early conceptual models of cultural competence and patient centeredness focused on how healthcare providers and patients might interact at the interpersonal level and later conceptual models were expanded to consider how patients might be treated by the healthcare system as a whole (56)\textsuperscript{ Pg.4}. Early conceptions of cultural competence stemmed out of the awareness that cultural and language differences between patients and healthcare providers impact the effective delivery of health services. This awareness subsequently led to the introduction of many programs majority of which were targeted at sections of the population, mostly immigrants with limited exposure to western cultures and “whose health beliefs may be at variance with biomedical models” (57)\textsuperscript{Pg.934}. The immediate challenge that the models of cultural competence presented was the acknowledgement of the fact that it was practically impossible for healthcare workers to be familiar with all cultural perspectives that will surface in their line of work(57).

This aside, looking at patients as members of ethnic, racial or cultural groups rather than unique individuals might lead to health workers stereotyping them and making wrong assumptions based on their beliefs and behaviors. It was therefore necessary to develop approaches to cross-cultural healthcare that will successfully balance “acquiring some background knowledge of the specific cultural groups encountered in clinical practice and developing attitudes and skills that were not specific to any particular culture but were universally relevant”(56)\textsuperscript{Pg.278}. The result is the development of ‘generic’ attitudes and skills, which were earlier on in this section described as strategies in culturally competent healthcare provision. In recent years PFC and cultural competence have evolved from focusing on interpersonal interactions to including entire health systems. However, this thesis will limit itself to PFC and cultural competence on the interpersonal interactions level in mental healthcare.

Interpersonal interactions between healthcare providers and patients is said to depend on the providers knowledge, attitudes, skill and behaviors(56). Away from arguments as to whether it is PFC that forms part of cultural competence or vice versa, this study
sides with the suggestion that at the interpersonal level there exists overlaps between the two as illustrated by the figure below.

Figure 1. Overlap between PFC and Cultural Competence

![Overlap between PFC and Cultural Competence](image)

Source: Saha et. al(56)

The figure shows PFC and cultural competence have elements that are similar as well as those that are unique to each aspect. For both concepts, respect for patient beliefs, values, preferences and needs, building rapport and trust, involving family and friends if desired and providing information and education based on the level of understanding of the patient are identified as common elements. On the other hand, whereas PFC alone is focused on techniques that are applicable to a general population, cultural competence points to those strategies that are applicable to certain sections of the general population whose characteristics and background are different from that of the host or general population.

In psychiatric care, research has shown diagnosis changed from a psychotic to a non-psychotic disorder after a cultural consultation(58). In this study, clinicians used the Outline for Cultural Formulation from a Diagnostic and Statistical Manual of Mental Disorders model and discovered differences in diagnosis before and after the use of the manual. This points to the need for methods and tools that are culturally sensitive to be used in psychiatric evaluations.
The case for Transcultural Psychiatry

The World Psychiatric Association-Transcultural Psychiatry Section (WPA-TPS) defines transcultural psychiatry as the study of the relations between disorders and the psychological characteristics which differentiate nations, peoples or cultures and aimed at identifying, verifying and explaining the links between mental disorders and these broad psychosocial characteristics §§.

According to the WPA-TPS, transcultural psychiatry aims at achieving 5 main objectives;

1. Exploration of the similarities and differences in the manifestations of mental illness in different cultures;
2. Identification of cultural factors that are predisposed to mental illness and mental health;
3. Assessment of the effect of identified cultural factors on the frequency and nature of mental illness;
4. Study of the form of treatment practiced or preferred in different cultural settings;
5. Comparison of different attitudes toward the mentally ill in different cultures ***

Due to increasing migration there have been shifts in the world’s cultural balance, which has a direct impact on world mental health. Also, there are studies that show that immigrants stand a higher chance of getting mental illnesses when compared to host populations(59-61). Various researches on the causes and symptoms of Post-Traumatic Stress Disorder (PTSD) and other mental problems is available but little is known about what treatment is best for helping immigrants with this often debilitating disorder. The reasons for this lack of knowledge in this area of mental health can be attributed in part to the extensive and resource-intensive nature of data collection. This situation is worsened by a misunderstanding of these patients’ frail condition, which results in not being asked to participate in research projects. Some researchers avoid some patients because they are of the opinion they (refugees, asylum seekers and immigrants) have suffered enough; thus there is no need to add to their burden.

§§ World Psychiatric Association - Transcultural Psychiatry Section (http://www.wpa-tps.org/about-wpa-tps/transcultural-psychiatry/)

*** http://www.wpa-tps.org/about-wpa-tps/transcultural-psychiatry/
Nevertheless, allowing these patients to continue to undergo long treatment courses that have not been proven to work nor adapted to the individuals’ case is not ideal. The need for transcultural psychiatry is gradually getting the attention of health policy makers. For instance, in Denmark, it is noted that about 35,000-50,000 refugees suffer from severe PTSD.††† Bearing in mind the challenges faced in treating this group of patients, there is an initiative aimed at providing better care for them. Denmark’s Competence Centre for Transcultural Psychiatry developed what is known as the Treatment and Research Integrated Model (TRIM). TRIM operates a system where clinicians collect all the data that’s normally entered into medical records and organizes the information into checklists instead. It is then easier to enter this data directly into any research database. The hope is that this will aid in better matching patients with treatments and avoid situations where they go through long and expensive care that has no positive effect on their health or quality of life. The model will therefore ensure that refugees, asylum seeking and immigrant patients consistently receive best practice treatment based on the latest research findings‡‡‡.

The model has led to changes to psychologists’ treatment manual for the cross-cultural target group. A questionnaire has also been developed to help with understanding how physiological, psychological and social factors affect the outcome of mental treatment for individual patients. Presently, three randomized trials are been carried out with the TRIM model to determine whether combined medical and psychological treatment has a greater effect than the two treatment forms separately. It is also aimed at testing various types of psychological treatment and medical treatments. It is expected that the results will provide new and unique information about which elements of the treatment actually work for this group of patients and which one does not. This data will then be used to create a culturally adapted and effective treatment for traumatized refugees.

Norway also has special clinical teams with focus on transcultural psychiatry. The teams; ‘Storby-og flykningeteam’ (SOFT) team at the Lovisenberg Deaconess Hospital and the Transcultural Centre at the University of Stavanger hospital are selected for this project.

††† http://sciencenordic.com/new-centre-will-improve-treatment-traumatised-refugees
‡‡‡ https://www.psykiatri-regionh.dk/undersoegelse-og-behandling/Behandling/Behandling-i-psykiatrien/Sider/default.aspx
Summary

This chapter reviewed the literature on PFC and cultural competence in health care with a focus on mental health of African immigrants. The relationship between PFC and cultural competence was established and a case for transcultural psychiatry was presented.
CHAPTER THREE

METHODS

Introduction

This section provides information on the data collection process for this study. It describes the characteristics of the informants, the interview process and justifications for the methodological approach adopted. The section ends with a discussion on the limitations of the study, ethical issues and the role of the researcher.

The informants

Due to the focused nature of the study, informants that were directly involved in providing mental health services for immigrants were sought. This led to the purposive selection of two clinical teams that specialize in providing mental health services mainly to refugees and asylum seekers. In addition to this, one academician working on projects involving PFC was included as a key informant.

The first team is located at the Lovisenberg Diakonale Hospital in Oslo. This team is known as ‘Storby-og flykningeteam’ (Big Cities and Refugee Team) or the SOFT Team. It is made up of 5 members; two psychologists, one nurse, one social educator (vernepleier) and a social worker (sosiolarbeider). They provide mental health services for refugees and other immigrants especially from East Africa and other parts of Africa. SOFT provides outpatient services for refugees in general but specifically for adult refugees with traumatic backgrounds due to violence and/or serious mental disorder. Treatment of these patients according to the team consists of the study, assessment, diagnosis and integrated healthcare focusing on basic needs, culture, trauma history and social networks. Their services cover vulnerable patients who do not utilize the mainstream mental treatment due to limitations in their cognitive abilities. The team focuses on cultural backgrounds of patients that have influences on mental healthcare. They also allow for patients to be met outside of the hospital at locations convenient for both parties for consultations and other sessions. All members of this team were interviewed for this study.

Lovisenberg Diakonale Hospital is a member of the Norwegian Network of Migrant Friendly Hospitals (NONEMI). NONEMI is Norway’s version of the European Project ‘Migrant Friendly Hospitals’ (MFH). It begun with 6 hospitals in 2010 and later 6 more hospitals joined the network. Currently, all regions of Norway are
The first team was purposively selected for this study based on the fact that it is a specialized team directly involved with providing mental health services for refugees and asylum seekers, many of who are Africans. The leader of team two came in to provide supplementary information on the activities of a similar group of professionals working in a different city in Norway. The academician who also works
with hospitals as a consultant on patient involvement in care was included to respond to certain themes that emerged from the study. The characteristics of the informants are presented in Appendix A.

**Data collection procedure**

A series of semi-structured face-to-face interviews were conducted to obtain data with the aid of an interview guide (Appendix D) laced with themes of open-ended questions which allowed the participants more freedom to control the pace and subject matter of the interview. A total of seven interviews were conducted and all the interviews were recorded with an audio recorder for analysis after consent was sought from and granted by the participants. The interviews lasted between 30 minutes to 1 hour. Interviews were conducted in English only due to the researchers non-proficiency in Norwegian. One informant understood and could speak some English but was more comfortable with using Norwegian. In view of this that particular interview had responses mixed with some Norwegian expressions, which were later translated.

**Data analysis**

Qualitative research methods authors such as Marshall and Rossman argue that in qualitative studies data collection and analysis must be a simultaneous process entailing the classification of things, persons and events as well as the properties that characterize them(62). In describing the important elements of a phenomenon during analysis, many qualitative researchers make use of the Colaizzi analysis method(63). This seven step method as illustrated in scholarly works of Sanders(64), Speziale and Carpenter (65) was used in the analysis of data for this study after the transcription of interviews. First each transcript was read thoroughly to get a general idea of the content. Secondly, significant statements vis-a-vis the phenomenon being studied were identified from each transcript with the help of academic supervisors for this study. In the third step, meanings were formulated from these significant statements with the fourth step comprising of formulated meanings, which were sorted into categories, cluster themes and main themes. The fifth step involved writing a rich and exhaustive description of the phenomenon under study. Step six involved the formulation of the essential fundamental structure of the phenomenon under study. Finally, the
researcher sought participants’ validation of the findings for confirmation and additional information.

**Rigor of procedure**

To insure rigor the researcher sought the opinion of his assigned academic supervisor in identifying themes. Member checking which involves cross checking findings with participants by presenting them with a final report of the findings was also used to check for accuracy of responses. The results of this study were shared with informants for their comments prior to submission of the finished work. None of the informants disagreed with any part of the findings nor raised concerns over the interpretation of the results. In addition to these, colleagues and supervisors continually scrutinized the entire study and provided valuable inputs.

**Ethical issues**

Ethical clearance was sought from the Norwegian Centre for Research Data (NSD) (Appendix C) and participants were provided with a written consent form to agree to take part in the research voluntarily (Appendix B). Consent agreements were written and signed by both the informants and researcher prior to conducting interviews. Participants were given the opportunity to withdraw from the study at any point or decline to answer certain questions. Again, the objectives of the study were made known to the participants in writing and they were given the option to see transcriptions and interpretations of data for crosschecking.

To ensure anonymity, all information was captured without the inclusion of real names, national ID number or other direct identifying information of participants. The only way participants could be identified was through their voices on the tape-recording. However, the recordings were securely stored when not in use and deleted after transcriptions. Finally, details of the African patients who were cited as examples during interviews was not sought by the researcher nor disclosed by informants.

**The role of the researcher**

Using the qualitative method for a research requires the researcher to indicate his/her personal values, assumptions and biases that are related to the study. At the time of preparing the proposal for this study, the researcher was on an internship program at
the National Center for Minority Health Research (NAKMI, Norway). During the internship the researchers interest in equity in health care for minority groups was further awakened through introduction to the work of NAKMI. As an African immigrant, the researcher is particularly interested in special processes within healthcare systems for immigrants based on the conviction that strategies for delivering equitable healthcare to the general population, might not achieve same for immigrants. Again the researcher’s personal experience as a patient within the Norwegian healthcare system has played a role in deciding to conduct this study. However, the outcome or conduct of this study is not affected by the personal feelings of the researcher but rather based on evidence from academic literature and facts gotten from this study.

**Reflexivity and validity**

Closely related to the role of the researcher is the need to continually have a reflection on the research process. This process known as reflexivity involves the researcher examining himself as well as the research relationship (66). The assumptions of the researcher and how this affects the words used in asking questions as well as the way of asking forms part of the self reflection. Again, the researcher ought to take note of his relationship with informants and if/how this affects the responses. The interviews for this study came out as a learning process for both the researcher and the informants. The informants were eager to know more about the concept under discussion while the researcher was interested in learning from the informants the role of the concept in their work. It was acceptable during the interviews for both parties to interrupt a submission in order to get clarity or further explanation. In effect, both the interviewer and informant interacted in an effective way to produce knowledge that is presented in this thesis.

Validity in research has an internal and external component. Internal validity answers the question of whether the instruments we use actually investigate what it was intended to study. Based on the nature of the topic for this thesis, the methods chosen were appropriate and ended up delivering the needed answers to the research questions. Face to face interviews with the informants allowed for follow-ups on interesting themes that emerged. Tape recording of the interviews also provided the additional advantage of having an accurate report of the interview through transcriptions. There were diverse as well as similar opinions that were shared by
informants and by the time all members of the team were interviewed, saturation point was neared. Saturation is when the researcher is of the view that interviewing new informants will not introduce any new angles to the issue under discussion aside what has been previously gotten(67).

External validity is used in reference to how transferable the findings of a study can be in another setting. This is often not an aim in qualitative studies. Nevertheless, the findings of this study conducted in Norway can be transferred to countries similar to Norway in terms of immigrant population. Elements of transcultural psychiatry and PFC can be transferred to countries that receive immigrants whose cultural and social backgrounds differ from that of their host countries. Also, whereas some findings of this study are in line with general theoretical assumptions others were not.

**Limitations of the study**

Patient-nurse interaction observation as well as views of African patients that are receiving or received mental care from these teams would have been valuable in complementing health workers interview data. However, due to the extensive mandatory requirements that ought to be met before permission is granted for such an observation or interview it did not form part of this master thesis. In addition to this, evaluation of the activities of the teams has not yet been done, making it impossible to know the real impact of their strategies. Although these limitations did not affect the outcome and quality of this study, it nevertheless opens up rich opportunities for other researchers to conduct studies to fill in the gaps.
CHAPTER FOUR

RESULTS

Introduction

This section presents results from interviews conducted with members of a clinical team that is directly involved in treating African immigrants in need of mental healthcare. In addition, results from interviews with the leader of another similar team and an academician are also included. The following key themes emerged from the interviews;

1. The Patient Focused Care concept is unknown to informants.
2. Informants use all 7 key aspects of PFC.
3. The need for special care for African patients.
5. Patient Focused Care does not cover power relations between patients and health workers.

These themes, which were identified through a thematic analysis of the data, are presented below. The informant’s code names appear at the end of quotes (e.g. R2 for Informant 2).

The Patient Focused Care concept is unknown to informants

This theme encapsulates each of the informants’ unawareness of the concept of PFC. During initial correspondence with informants to schedule interviews, they expressed a lack of knowledge on the idea. This was further demonstrated unanimously throughout the interview. The researcher was under the impression that this was the case because PFC is an English concept and might not exist in Norwegian. However, the informants could not pinpoint a Norwegian equivalence of the concept. Also, informants who studied in English said the concept was unknown to them. A specialist nurse told me: “No, I have never heard of that term before…no…not that concept”(R2).

An experienced psychologist who has been working with African patients for a long time also responded by saying; “It’s not a concept that we use on the ground (in clinical work)”(R1). She admitted that she had to Google the idea prior to the interviews to have an understanding of the concept. When I asked a social worker about the concept, his response was similar to the other informants; “No…no…. I am
not familiar with that concept” (R1). The responses from all the other informants from both teams were in line with the examples stated above. Apart from not being aware of the concept, informants thought of PFC as more of a healthcare management concept than a model for clinical work. A psychologist said: “I get the impression that it (PFC) is more like a healthcare management concept...probably like a health management leader kind of thing” (R1).

To this informant, the idea of PFC is one that should concern top managers who will be expected to put structures in place for its success. This thought was expressed after the researcher provided a theoretical definition of PFC to the informants.

Since the informants were not aware of the idea of PFC, the author provided a brief definition and explanation of the idea to them. The informants were then asked to mention concepts or ideas they think are similar to the idea of PFC. The informants consistently made use of the Norwegian word brukermedvirkning (user involvement) as the closest concept to PFC in Norway and in their line of work. A psychologist explained that:

We have a huge focus on brukermedvirkning which is the idea that each patient or each client should join in his or her or individual treatment and also in giving feedback to the people who organize healthcare so that the patient or clients perspective can be heard and that you build services based on that (R1).

A specialist nurse and another psychologist said this respectively about brukermedvirkning in response to the question on similar concepts:

We use a lot of brukermedvirkning...maybe it’s the same (as PFC). It is a goal for treatment and it’s also backed by law (R2).

We have this model called brukermedvirkning, which is something we learn about in our study, and it is also backed by law (R5).

The informants did not feel that this lack of awareness of the concept of PFC among clinicians such as themselves was alarming because they believe that it will gradually become known in Norway with time. A psychologist opined that: “I think it’s a trend... you have a concept that I haven’t heard about but I think that the ideas and values are absolutely sipping down” (R1).

The researcher for this thesis was a student of healthcare management at the time of conducting the study. The idea of PFC formed part of lessons that were thought to the researcher as important for health care managers to be aware of. However, there seems to be a general knowledge within academic circles of the concept whereas this is not
the case among clinicians. This observation was put to a professor of healthcare management who is involved in teaching and research on PFC for his thoughts. When asked why the idea was common in academic circles but unknown among clinicians based on the findings of this study, he indicated that “I have followed reforms in the Norwegian health care system and all of those reforms do not use the term PFC but they are all related to that line of thinking” (R7).

He explained further that the last reform was called “pakerfollep”, which says patients should be given diagnosis and treatment in a certain span of time. It used to be known as “waiting time guarantee”. He indicated that this reform “is spot on when it comes to PFC and it is a revolution that is sweeping through hospitals” (R7). Presently, it is being implemented in cancer care but is yet to be introduced in psychiatric care. In his opinion, it will be difficult to implement this in psychiatric care since it is challenging to give a package of treatment in psychiatric care as is done in say, cancer care. That according to him is why it is necessary for care in psychiatry to be organized differently and in a special way such as having a team made up of a psychologist, medical doctor, social worker and others to treat patients instead of passing patients to different professionals.

This key informant admitted that Norway is lagging behind other countries in terms of implementing the ideas of PFC due to the way hospitals are organized. Unlike hospitals in Sweden and Denmark, those here are organized in a unity of command way according to him. However, he stated that Norway is making reforms too like organizing from beneath (as evident in pakerfollep), which according to him is forcing hospitals to work in teams. He also believes PFC is “something that is coming with increasing force” but the current implementation of PFC through pakerfollep is making the hospital chaotic in a way. He explained that forcing new structures of organizing on the old structures could lead to problems with coordination and cost control.

**Informants use all 7 key aspects of Patient Focused Care**

It emerged from the interviews that although the concept of PFC is unknown to the informants they use all the 7 key elements of the concept when they treat African immigrants. This theme points to the fact that informants are fully aware of the key elements of PFC. Informants were presented with a list of all the 7 key aspects of PFC during interviews to identify the ones they use when treating African patients. The
responses unanimously pointed towards the awareness and use of all the elements in treatment. A specialist nurse said: “I think we use all of them...almost all the time. It’s not possible to treat them without these” (R2).

A social worker explains that the use of these elements came from experience over the years with treating patients and not because PFC is an established goal for treatment:

These elements are (used in my work) because of the continuous experience we have with patients. Personally, I have been working with these elements for so many years so it is integrated in me and has become a part of me…this is what I have in my head when I start treatment (R3).

This theme in effect further illustrates some link between attitudes of health workers, their clinical work experience and usage of the key elements of PFC in treatment. The informants indicated that the ability to use these PFC elements depends on the inward attitude of the individual health professional. The view of a psychologist sums up this point; “They are things that I learn from experience and they are things that I have with me as a person and also from education” (R5).

There was however no consensus among the informants as to whether or not they think it will be necessary to establish PFC as a goal of treatment for their patients in general and African patients in particular. Some of the informants were unsure if that would be necessary. A psychologist said: “I don’t know if I really need to have those 7 aspects on my desk to do a good job or have them as a goal of treatment” (R5).

A specialist nurse shared similar thoughts and is of the opinion that having PFC as an established goal of treatment would not be necessary because PFC forms part of an already existing goal of treatment;

Brukermedvirkning is similar to PFC and it is a goal for us unlike PFC. To change this to PFC may not be necessary or important. Also, I think PFC already forms part of brukermedvirkning (R2).

However, a social worker had a different opinion to the effect that:

It can always be useful to have these elements (of PFC) in a framework or standardized to show which direction we are heading… when you start to work here I think it will be good to have it as a framework to guide you (R3).

This informant was of the opinion that newly trained mental health professionals can be educated on PFC and encouraged to use the elements in treatment.

Again, a medical doctor (and psychiatrist) was of the opinion that PFC is a broader concept than brukermedvirkning and that brukermedvirkning says nothing about doctors’ responsibility to be open to patients’ preferences and values. Therefore, brukermedvirkning forms a part of a broader PFC. She pointed out that
*brukermedvirkning* in mental health can pose some challenges when health workers do not take into consideration whether the patients are able to express their views and how sick they are. To her *brukermedvirkning* in mental healthcare is probably only a politically correct term.

**The need for special care for African patients**

The interviews show that the informants agree that African patients in psychiatric care in Norway need special attention. Indeed, this was the reason why one of the teams interviewed was created (previously named the East Africa Project). A psychologist who has been working in the team since its formation said:

> These refugees have different needs from the Norwegians. We need to give them practical help to understand how the system works. Go to NAV with them and help them understand what kind of rights they have here and help them go to the doctor. They have a lot of mistrust in the system from their country so to them a doctor may not be safe to talk to here. Their health seeking behavior is different from Norwegians (R5).

The informant went on to explain that because of differences in awareness of psychological problems between African refugees and Norwegians for example, it is necessary to provide information to these patients differently:

> They need more time for us to explain their conditions to them because they have not heard of PTSD or depression or anxiety unlike Norwegians who maybe at 15 years old know what depression and anxiety is but not in Somalia for example (R5).

According to the informants, other differences that are social and cultural in nature exist between African patients and the general population. This further supports their case for special care for the former. This statement made by a psychologist captures an example of these social and cultural differences:

> The belief that you can get better by talking is not something most of the African patients are used to and often they have learnt not to talk and there are cultural differences regarding how much are you allowed to speak about personal problems (R1).

Also prominent among the issues mentioned is the importance of transcultural psychiatry for foreigners in general. An informant indicated that the Norwegian understanding and explanation of mental issues is not always universally applicable. The western view of psychiatry in her view should not be considered as the best or only way of understanding and explaining mental issues. She indicated that her team
considered cultural differences between them as health workers and their patients and how these can be incorporated into general practice.

**Use of unique treatment strategies for African patients**

Despite the general acknowledgement that they use the key elements of PFC, the mental health professionals interviewed singled out some key strategies they use when treating African patients in particular.

- **Building Trust**

  For all the informants, building trust with African patients was fundamental to having a successful consultation and treatment. This statement by a specialist nurse sums up their opinion: "Some of them (African patients) do not trust the system in general but when we first have a good relation with them they tend to trust us a lot" (R2).

  This lack of trust can be attributed to experiences from their home countries and during the migration journey. Another informant laid emphasis on building trust between her and her African patients. For this social worker, building trust was fundamental: "You have to work by building trust before you can get to the values and trying to help them on the basis of their values together with my knowledge" (R3).

  The importance of trust building in providing care for these patients came from experience for some of the informants. The social worker went on to explain how the importance of building trust was learnt through experience:

  I need to develop a trustful relationship with them and my experience is that if I am able to do that, then often, we can have a common understanding about their psychological problem. When I am open to their understanding they can also take in mine understanding and we can become like two experts on the same case (R3).

  A psychologist also agreed that building trust is vital in the treatment of African patients:

  I am careful not to push my professional education on them but to have a trusting relationship so that they can trust that I want to help them… I achieve trust through giving them that support, to make them feel safe (R5).

  The psychologist went on to explain that they are able to build trust successfully to the extent that patients sometimes call them back many years after they part ways:

  We have some patients who leave to their home country or another country then we have to close the case…then 1 year later they are back and they are
calling you because they know you and they trust you...either they call you or they come here and say ‘hey…. I am back. Can you help me again?’ We do that... we help them to make them feel better (R5).

Due to successful trust building, the health workers say they sometimes have to answer to calls and other requests from their patients even outside of working hours. When their patients need someone to talk to they call on them.

• **Considering Values and Beliefs**

This is another theme that appeared prominently in the interviews. A psychologist stated: “I can’t get anywhere with the patient if I don’t do that (i.e. take their values and belief into consideration) (R1).

The psychologist explained that based on her experience with treating African patients, ignoring their values and beliefs will make treatment very difficult. This informant also preferred working with the team because:

Elsewhere, you don’t have time to respect patient values…you don’t have the money for it…and one of the biggest reasons I work in SOFT is that maybe it is the most flexible team in this whole hospital…so if the patients want to see me one more time this week I have the time for that but the others don’t (R1). According to the informant, elsewhere there is little or no flexibility to be able to take values and beliefs of patients into consideration. The flexible nature of the work of the SOFT team allows for meeting patients outside of the hospital, at their homes or in a public place.

A specialist nurse shared similar opinions regarding values and beliefs of their patients.

The thing is if you don’t get the patient to show you their values then you have nothing to work with…you have to work by building trust before you can get to the values and trying to help them on the basis of their values together with my knowledge (R2).

When asked if it was important to take the preferences, values and expressed needs of African patients into consideration a psychologist responded by saying:

Yes, that’s is very important. Often in Norway we are thought in school one way of understanding a disease but when you meet other people you have to acknowledge that they may have another understanding of health and what is good health and what is good life. A patient may say to me that I need to have an Imam to read the Koran to me to get rid of the things I see and I am thinking its psychosis and they are like no its demons. And if I insist that no that is not true and that he needs to take medication then the patient never comes back. So I have two thoughts in my mind…their understanding of what is happening and
their use of the knowledge they have and what is available to them and my understanding. I have to use both to help the patient (R5).

This response shows that despite cultural and belief differences between the health workers and their African patients, the former do not disregard the beliefs of the latter. The responses from the interviews indicated that taking values and beliefs of these patients into consideration helps in the treatment process. A psychologist said: “I see that if I am willing to open up and understand their values, that will help me instead of being a challenge” (R5).

This informant gave an example that because the religious values of some of the patients frown on suicide, it tends to prevent them from considering taking their own life when faced with psychological problems. The informant therefore reminds such patients of that aspect of their belief when it becomes necessary in treatment.

Although the informants say they take values of African patients into consideration, a social worker expressed worry that some of these values might impede treatment: “Some of the values impede treatment...they stand in the way of treatment” (R3).

An example was provided regarding patients whose entrenched beliefs in the supernatural makes it very difficult to make them open to other possible interpretations of mental problems.

• Involving Family and Friends

The role of friends and family in the treatment of African patients came up severally during the interviews. A psychologist spoke on this:

I often treat loners...if they (African patients) have a lot of friends and family they often don’t come to us because when you don’t have enough friends and family you get sicker (R1).

When asked if the team makes efforts to create families for loners, this was the response from this informant: “We try to get them to like organizations like Norsk Folkehjelp (Norwegian Peoples Aid) and also we try to connect them to social networks” (R1). This is a place where people go to make new friends, socialize and relax. The center provides food and drinks for visitors who are mainly refugees.

Regarding the benefits of family and friends’ involvement, informants unanimously agreed that it delivered positive results for African patients. A social worker said:

I think it brings benefits into treatment than problems. Involving families can be a very good reminder to the patient of what is going on and how to handle the situation. It is also a very important part of treatment to try to involve them in social networks and social systems (R3).
A psychologist shared similar views:

I think it helps me...Africans have a more collectivistic thinking...that the family is often the one who takes care of you so they are more dependent on the family than Norwegians (R5).

**Patient Focused Care does not cover power relations**

An informant who is a medical doctor was of the opinion that PFC does not mention power relations between patients (such as refugees and asylum seekers) and the health workers. She stated:

I see that power relations are not mentioned in this PFC idea…it is important for the patient to feel as equal as possible to us… we have the money, the resources, the know-how but we should be able to reach out to these patient and make them feel that they are important as well and that we are on the same line with them. (R7)

She is of the opinion that many of these patients previously faced situations where they had less power than others. During treatment, these patients feel afraid to speak up about their problems because of unbalanced power relations. Some of them see doctors and other health workers as ‘know-it-alls’ who are not to be questioned nor disagreed with.

**Summary**

This section presented some of the significant themes that emerged from interviews conducted with informants from the two teams.
CHAPTER FIVE

DISCUSSION

Introduction

This study focused on PFC and the provision of mental healthcare services for African patients in hospitals in Norway. As mentioned earlier, research has identified African immigrants to be in vulnerable positions within the healthcare system of their host countries. At the same time, not many studies in general have been conducted on this section of the population due to their exclusion from or too few numbers in nationally representative studies and clinical trials. The challenge with PFC specifically is the lack of studies on its awareness and use in the treatment of these patients especially in mental healthcare. This requires conducting more focused studies such as this, which is targeted at filling in the gaps in knowledge regarding the issue.

This study therefore aimed at finding out from mental health professionals how aware they were of the PFC concept and whether they used its elements when treating African patients. This research was also interested in exploring PFC from a cultural competence angle of mental health workers in relation to treating African patients. In order to address the research problem illustrated above, 3 key research questions were posed and answered by the study as follows:

1. *Are mental health workers involved in treating African patients aware of the PFC model?*

   The study found out that mental health workers interviewed were unaware of the PFC concept.

2. *Do these mental health workers treat these patients with reference to the key elements of PFC?*

   Although interviewed health workers were unaware of PFC they used all the 7 key elements of the model when treating African patients.

3. *What strategies do health workers adopt when treating these patients?*

   Mental health workers in this study develop and use unique strategies in treating African patients. These strategies point to the conclusion that they are culturally competent in treating these patients.

The next section will interpret and describe the significance of the findings in light of what is already known about the research problem under investigation. It will present
explanations of any new understanding or fresh insights about the problem after taking the findings into consideration.

**The PFC concept is unknown to informants**

Despite the claim that PFC or patient centeredness is “becoming increasingly familiar within health and social care at a global level”(68), informants were not familiar with the idea. On the other hand, this finding sides with literature on the use of PFC among mental health professionals. It has been documented that mental health professionals avoid the term PFC because it ‘pretends’ to put the patient in charge of care when in fact it is health workers that are in charge(48). For mental health workers interviewed in this study, findings that disclosed their unawareness of the PFC idea was unexpected because in neighboring Sweden the idea of PFC is quite known. Recently, the Swedish Agency for Health and Care Service Analysis commissioned an external evaluation of patient centeredness in their health care system(69). However in Norway the idea appears not to be known among clinicians although it is widely discussed among academicians and politicians. For instance, in 2014, the Minister of Health and Care Services of Norway stated in the National Statement of Norway at the World Health Assembly “as a Minister of Health, I must work to ensure that our health services are patient-centred and empower the individual”§§§. These facts in addition to the focus on policies to drive improvement in the quality of care in the country’s 2012 Coordination Reform are in contrast to the findings of this study.

Furthermore, it can be deduced from the responses in this study that the unpopularity of the PFC concept in Norway is linked to the more widespread knowledge of brukermedvirkning (user involvement in care) among mental health workers. Brukermedvirkning is a statutory right of the patient and no health worker can choose not to do this. Among other things, health workers are required by law to take patients seriously, treat them with respect and build trust and confidence under brukermedvirkning. It can therefore be suggested that PFC is not well known among mental health workers in Norway because brukermedvirkning has similar elements of PFC.

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Key aspects of PFC used in mental care of African patients

Despite mental health workers in this study being unaware of the PFC model, they use all 7 key aspects of the model in providing mental health services for African patients. This finding was not surprising given that the key elements of PFC are supposed to form an integral part of treatment in mental healthcare. Many authors (51-53) focused on these key elements in mental healthcare provision and are of the opinion that they must form a prominent part of treatment plans especially for immigrant patients. The argument is that mental health workers experience complications with diagnosis, difficulty in developing trust and have an increased risk of marginalizing immigrant patients when providing mental health services to them (54). In view of these complications and challenges, mental health workers are encouraged to use the ideas of PFC since it stresses on many concepts that are important to their work (50).

On the part of informants for this study, it will be practically impossible to attempt to treat African patients without falling on these elements. As expected of mental health workers, the informants acquired these elements through experience from treating these patients over time. As to why only the key aspects of PFC are known and not PFC as a whole can be traced to the discussion in the earlier section. The use of these key aspects of PFC is an indication that the informants are aware of the need to be culturally competent in treating African patients. The informants showed their ability to understand and integrate individual values, beliefs and behaviors about health and well-being into both the structure and delivery of health care as is expected of culturally competent health workers (55).

Use of unique strategies for treating African patients

The results indicated a general agreement among interviewed mental health professionals that African patients deserve special attention and special treatment for a number of reasons. In fact, this according to the informants was the reason behind the setting up of the two specialized mental health teams used in this study. Both of the teams were set up specifically to provide special care for refugees and other immigrants.

The justifications provided by the informants for the need to have such specialized units are in line with existing literature on the subject. For instance, it is known that immigrants face unique challenges in mental health due to the immigration process, acculturation, intergenerational conflicts (between immigrant parents and their
children), employment problems, racism and discrimination and traumatic experiences (70). The informants alluded to these factors in offering justification for setting up specialized teams for immigrant patients. An example is these quotes from two psychologists interviewed:

They are strangers in this country...they have lost peer and family and there are strangers to themselves...they get intrusive picture...memories and sounds and they do not trust and understand the crazy Norwegian system (R1).

The refugees have different needs from the Norwegians. We need to give them practical help to understand how the system works. They have a lot of mistrust in the system from their country so to them a doctor may not be safe to talk to here…. and their health seeking behaviour is different from Norwegians (R5).

In addition to this, immigrants are faced with socio cultural barriers such as differences in symptom expression and attribution and conflicting views about the causes of and ways of coping with mental health problems (70). The findings revealed that African immigrants and some other immigrants explained symptoms of their conditions differently from Norwegian patients usually from the angle of spirituality. Closely related to this, immigrants are said to be faced with contextual-structural barriers to mental health services. These are barriers that include

- lack of access to appropriate and culturally sensitive mental health services in immigrant languages, lack of access to interpreters and shortage of racial/ethnic minority mental health workers and/or persons trained to work with racial/ethnic minority persons and culturally diverse elders (70)\textsuperscript{9}.

The informants made mention of the lack of interpreters and undesirable quality of interpretations as some of the challenges.

For one of the teams used in this study, I noticed a blend of health workers from different racial backgrounds, which I was told, helps in some cases during consultations with African immigrants. The other team was however made up of only Norwegians but they indicated that it does not affect their interactions with African patients.

The other barrier, known as clinical-procedural barrier, is a “lack of culturally sensitive and relevant services, clinician bias and communication problems related to language differences and cultural nuances”(70)\textsuperscript{9}. The authors cited examples of clinical-procedural barriers to include the possibility of clinicians downplaying the role of religion and spirituality in the patients’ story and life, putting too much
emphasis on autonomy and independence as therapeutic goals and failing to take into consideration the patients cultural values. This study did not make use of methods that will allow for observation and analysis of interactions between mental health workers and African patients to check for clinical biases and communication problems. However, the mental health workers interviewed indicated strongly that they acknowledge cultural and religious values of African patients and factor them into treatment strategies.

Based on the outcome of the interactions with the mental health workers interviewed for this study, it can be said that they are aware of these key barriers to mental health for immigrants and have developed strategies to break such barriers.

**Overlap between PFC and cultural competence of mental health workers**

The link between PFC and cultural competence of health workers as emphasized in literature (Figure 1) was evident in the findings. Health workers in general are expected to understand and be interested in the patient as a unique human being. Throughout the interviews, the informants emphasized looking at each African patient as a unique human being. The health workers also regarded exploring and respecting the beliefs, values and meanings of mental illness, preferences and needs of the African patient as important.

Other key elements of the overlap between PFC and cultural competence that were identified in this study related to the health workers striving to build rapport and trust with their immigrant patients. They indicated that they try to find a common ground with African patients in order to treat them successfully and they involve friends and family when desired. Finally, since the African patients they treat come from different backgrounds with different characteristics such as age, gender and literacy levels, the health workers provide information and education tailored to the patients’ level of understanding. One of the teams studied in this thesis (The SOFT team) explained that they make use of picture and video illustrations to educate their patients and families.

In the other group (The Transcultural Centre), one of the strategies used is known as ‘Tales of a refugee’ which is a narrative group intervention aimed at the prevention of psychosocial problems among unaccompanied refugee minors arriving in Norway.

In effect, the overlap between PFC and cultural competence of health workers in general as illustrated in literature(56) is very much applicable and observable among mental health workers involved in treating African patients and other immigrants.
based on the findings of this study. This is further evident in the setting up of a transcultural center for psychiatric care mainly for refugees and asylum seekers. The idea of transcultural psychiatry seems to be spreading within Scandinavian countries alongside the acknowledgement of the need to have special systems in place to cater for psychological needs of refugees, asylum seekers and other immigrants.

**Recommendations**

This study aimed at understanding how the idea of PFC works in the mental healthcare of African immigrants in Norway. Studying literature on PFC and mental health of immigrants internationally and in Norway in particular formed the background of the study. The study sought to find out if mental health workers involved in treating these patients in Norway are aware of the idea and if/how they use the seven key aspects of PFC. To be able to answer these questions, two specialized clinical teams involved in treating African patients and other immigrants were selected for interviews. The outcome of the interviews revealed a number of issues that are summarized below;

- The PFC concept is unknown to the informants.
- The informants use all key aspects of PFC although the idea is unknown to them.
- The informants agree that African patients need special mental care.
- Health-workers have devised unique treatment strategies for African patients.
- PFC does not cover power relations.

Based on the outcome of the study, it is recommended that more specialized teams that have transcultural psychiatry at their core be established in hospitals in Norway. The setting up of the teams used in this study is a step in the right direction. However, the size of the teams in relation to the workload and the nature of treatment they offer will make it difficult for them to cover as many patients as possible. It is therefore recommended that the teams be expanded or many smaller teams be created in order to cover as many patients as possible. It is also recommended that health workers from minority groups be recruited and included in such teams to create a cultural balance and provide guidance on important cultural factors to take note of in treatment. For clinical teams that are already treating immigrants in psychiatric units, it is recommended that they incorporate the key aspects of PFC in their work.
It is also recommended that an evaluation of the work of these teams be done in order to measure their real outcomes on patients. As at the time this study was conducted, an evaluation of this nature was yet be done. In addition to this, it will be important to speak to African patients themselves for their opinion on the strategies that are used to treat them. This together with evaluations on the impact of the teams’ activities on patients can form the basis of future research.

**Conclusion**

The findings of this study open up debate on the whether or not it is necessary for PFC to be set as a goal for treatment particularly in mental healthcare in Norway. In the face of evidence of other goals of treatment such as *brukermedvirkning*, which are backed by law and already in practice, it is unclear if models such as PFC should be fashioned out as goals of treatment in Norway. Although the elements of PFC are similar to the ideas of *brukermedvirkning*, certain key elements of PFC can be incorporated into it to further strengthen it. On the other hand, the PFC model can be adopted and used in training mental health workers involved in the treatment of Africans patients and other immigrants.

A striking finding in this study is the acknowledgment by the health workers that these immigrants in general and African immigrants in particular need special care. This is contrary to the suggestion that too much focus on immigrants and their health may in itself contribute to their vulnerable position since such focus might lead to immigrants standing out as anomalies in a society that is seen to be holistic and stabile(4). This finding opens up avenues for research to be conducted which will focus on other minority groups in the Norwegian society. Most importantly, it will be necessary to conduct studies to assess the strategies used to treat Africans and other immigrants from the viewpoint of the patients themselves. This will afford researchers the opportunity to crosscheck what health workers say with the views of the patients involved. The findings of this study does not side with the view that PFC is fast spreading and is been used by healthcare professionals especially in Scandinavian countries. In the case of Norway it seems the concept of PFC is better known among academic circles than among clinicians.
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## Appendix A

### List of informants and their characteristics

<table>
<thead>
<tr>
<th>Informant ID</th>
<th>Gender</th>
<th>Role</th>
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<tbody>
<tr>
<td>R1</td>
<td>Female</td>
<td>Psychologist</td>
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<tr>
<td>R2</td>
<td>Female</td>
<td>Specialist Nurse</td>
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<td>R3</td>
<td>Male</td>
<td>Social Educator (Vernepleier)</td>
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<td>R4</td>
<td>Male</td>
<td>Social Worker (Sosialarbeider)</td>
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<tr>
<td>R5</td>
<td>Male</td>
<td>Psychologist</td>
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<tr>
<td>R6</td>
<td>Female</td>
<td>Medical Doctor/Psychiatrist</td>
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<tr>
<td>R7</td>
<td>Male</td>
<td>University Professor</td>
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Appendix B

Consent Form

Invitation to participate in a research project
(For Norwegian version please refer to page 2)

Understanding Patient Focused Care in Psychiatric Care. Exploring mental health workers' views and strategies on treating immigrants in Norway

**Background and objectives**

This is a personal invitation to you to participate in research study on patient-focused care strategies used by health workers when interacting with patients with African background. Asase David Edem, a final year student at the University of Oslo, is conducting this study. I will like you to take part in this study because you interact with African patients in your line of work. The main objective of this study is to explore the strategies that you use when treating these patients and to determine how different and effective they are from your viewpoint.

**About the study**

Asase David Edem will conduct one-on-one interviews with health workers who treat patients with African backgrounds. The questions you will be asked will be related to your experiences in interacting with African patients including the challenges and strategies you adopt to overcome them. All interviews will be recorded with your permission for transcription and analysis.

Kindly note that this interview will take some time (about 1 hour). Again, I will be grateful if you will permit me to record the interview in order to make it easier for me to do transcription and analysis.

**What happens to the tape recording and information about you?**

Real names, national ID numbers or other information that is directly linked to you will not be captured. Audio recording and other information will only be used for the purposes of the objectives described in the study. You can only be identified through your voice on the tape recording however the recordings will be securely stored when it is not in use by the researcher. Latest by June 2016 when transcription of recordings are done they will be deleted. It will not be possible to link any part of the published study to you. If you consent to participate in the study, you have the right to insight into information registered about you. If you withdraw from the study, you have the right to demand that the recording is deleted.

**Voluntary Participation**

Participation in the study is voluntary. You can withdraw from the study at any time without stating the reason. If you would like to participate, please complete the form of consent below. If you agree to participate you can withdraw your consent at any time. If you wish to withdraw at a later date, or if you have any questions regarding the study, please contact David Edem Asase on 96718053. Thank you.

<table>
<thead>
<tr>
<th>Declaration of consent: I hereby agree to participate in the study</th>
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I hereby confirm that I have supplied the participant with information about the study:

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57
Forespørsel om deltagelse i et forskningsprosjekt

Pasientfokusert behandling innen mental helse. En undersøkelse av mentale helsearbeideres syn på og strategier knyttet til behandling av immigranter i Norge.

Bakgrunn og mål
Dette er en personlig forespørsel til deg om å delta i et forskningsstudie om pasientfokusert behandlingsstrategier som brukes av helsearbeidere når de samhandler med pasienter med afrikansk bakgrunn. Asase David Edem, en avgangsstudent ved Universitetet i Oslo, driver med denne undersøkelsen. Jeg vil gjerne at du deltar i denne undersøkelsen fordi du samhandler med afrikanske pasienter i ditt arbeid. Hovedformålet med dette studiet er å undersøke hvilke strategier du bruker ved behandling av disse pasientene, og for å finne ut av hvorvidt de varierer og hvor effektive de er fra ditt synspunkt.

Om undersøkelsen

Vær oppmerksom på at dette intervjuet vil ta litt tid (minst en time eller mer). Jeg har forståelse for at opphør av intervjuegene kan være ubehagelig for deg. Jeg ber likevel om å få lov til å ta opp det som blir sagt ettersom jeg ikke kan huske alt av den verdifulle informasjonen du vil gi meg på intervjutidspunktet. Av hensyn til prosjektet er det svært viktig for meg å få med alt som blir sagt.

Hva skjer med båndopptaket og informasjon om deg?

Hvis du samtykker til å delta i undersøkelsen, har du rett til innsyn i opplysninger som er registrert om deg. Hvis du trekker deg fra undersøkelsen, har du rett til å kreve at opptaket slettes.

Frivillig deltakelse

Samtykkeerklæring: Jeg samtykker herved til å delta i undersøkelsen:

(Signatur, dato)

Jeg bekrefter herved at jeg har gitt denne deltakeren informasjon om undersøkelsen:

(Signatur, dato)
Appendix C

Ethical Approval

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Ivan Spehar
Institutt for helse og samfunn Universitetet i Oslo
Postboks 1130 Blindern
0319 OSLO

Vår dato: 21.03.2016

Vi vilte til melding om behandling av personopplysninger, mottatt 05.02.2016. Meldingen gjelder prosjektet:

47216 Patient-focused care of African immigrants: What are the strategies used at hospitals in the Oslo area?

Behandlingsansvarlig: Universitetet i Oslo, ved institusjonens øverste leder

Daglig ansvarlig: Ivan Spehar

Student: David Edem Assa

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meddelelignet i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering fortsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseorganisatorloven med forskrifter. Behandlingen av personopplysninger kan sette i gang.


Personvernombudet vil ved prosjektets avslutning, 30.04.2016, sette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaker Segadal

Kontaktperson: Anne-Mette Sørby tlf. 55 08 24 10

Innskrevet av: Hildur Thorarinsen

Dokumentet er elektronisk produsert og godkjent ved NSDAs rutiner for elektronisk godkjenning.

Anmeldelseskontor / Access Office

DOK: NSD: Universitetet i Oslo, Postboks 1130 Blindern, 0316 Oslo. Tel: +47 22 85 52 11, mail@nds.no

THORDIS ØR: NRD: Bergen teknisk universitetskommune, 5017 Bergen. Tel: +47 55 30 19 07, thordis@or.no

Dokumentet er elektronisk produsert og godkjent av NSDAs rutiner for elektronisk godkjenning.

Dokumentet er elektronisk produsert og godkjent ved NSDAs rutiner for elektronisk godkjenning.
The sample will receive written information about the project, and give their consent to participate. The letter of information is well formulated.

The Data Protection Official presumes that the researcher follows routines of Universitet i Oslo regarding data security.

Estimated end date of the project is 30.04.2016. According to the notification form all collected data will be made anonymous by this date. Making the data anonymous entails processing it in such a way that no individuals can be recognised. This is done by:

- deleting all direct personal data (such as names/lists of reference numbers)
- deleting/rewriting indirectly identifiable data (i.e. an identifying combination of background variables, such as residence/workplace, age and gender)
- deleting digital audio files
Appendix D

Interview Guide

Preliminary introduction
Exchange of greetings and introduction of myself and brief summary of the interview process.

Warm up Questions

- Can you tell me what your role here is and how long you have been working here?
- What kind of patients do you usually receive here? Their backgrounds?
- Can you tell me more about your team?

On Patient Focused Care (PFC)

- Are you familiar with the concept of Patient Focused Care?
  - Definition of PFC "Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions."
  - If No, why in your view is the idea not popular in Norway?

(Skip next questions if No to earlier question)

- Are you aware if this is being practiced at your hospital? Are there any specific clinical practice guidelines about patient focused care in place at this hospital that you are aware of?
- What in your opinion are the most important elements of PFC?
- Do you feel that the idea of PFC is unnecessary work for health workers? If yes why so? If no how does it contribute to making your work any easier?
- Are you aware of the Network of Migrant-Friendly Hospitals initiative? What does this mean to you as a health worker here?

On African Patients, Cultural Competence and PFC in psychiatric care

- How often do you receive African patients here (Provide conceptual definition of African patients…by African patients I mean…)

- Do you notice any differences in your interactions between African patients and other patients (such as Norwegians?) What are some of these differences?
- The idea of PFC puts emphasis on 7 aspects of care- (Present cards)
  1) Respect for patients’ values, preferences and expressed needs;
  2) Coordination and integration of care;
  3) Information, communication and education;
  4) Physical comfort;
  5) Emotional support and alleviation of fear and anxiety;
  6) Involvement of friends and family; and
  7) Transition and continuity.

With regards African patients, which of these aspects do you fall on often in
your line of work? (Follow up with how this is done).

• What are the commonest needs expressed by African patients you treat?

• How will you describe the experience of interacting with African patients who cannot for example speak Norwegian?

• Over the years that you have been working with African patients which of their cultural traditions and perspectives have you identified as most important?

• Will you say you are faced with some challenges in your interaction with African patients?

• What are some of these challenges?

• What to you has been the most difficult interaction with an African patient at this hospital?

• What strategies do you use in interacting with African patients who are faced with cultural and communication challenges for example?

• Can you describe the attitudes or reaction of African patients on whom you apply such strategies?

Closing Questions
• Are there any other issues regarding the topic that I have not mentioned that you will like to share with me?
• Are there any issues concerning African patients in this hospital that you will suggest to researchers like me to look into?

(Express thanks for the time and assure informant of feedback on the interview)
The CARDS
The 7 Key Aspects of Patient Focused Care

<table>
<thead>
<tr>
<th>Coordination and integration of care</th>
<th>Respect for patients’ values, preferences and expressed needs</th>
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