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Improving quality of mental health care for BME clients

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ABSTRACT Hackett, R. (2008) Improving quality of mental health care for BME clients. This is an extended version of the article published in Nursing Times; 104: 1, 35-36. This article shows how nursing leadership can contribute to service and practice development to improve care for clients of black and minority ethnic groups and communities through the Delivering Race Equality policy (Department of Health, 2005). It describes the Enhancing Pathways in Care (EPIC) project for clients of Pakistani origin in Sheffield, who need acute mental health services.

BACKGROUND

The available evidence suggests that people of black and minority ethnic (BME) groups have higher rates of psychiatric admissions than the general population. These admissions are often made via the criminal justice system and, usually, under the powers of the Mental Health Act. Research also suggests that these people stay in hospital for longer, and they have a higher tendency than the general population to be secluded (McKenzie and Bhui, 2007; Singh and Burns, 2006). Indeed, when in psychiatric care, their experiences of services have generally been reported to be poor (Healthcare Commission, 2007).

It is also known that stigma and mistrust are some of the barriers for clients of BME groups in seeking help from both primary and secondary care services. Furthermore, families have experienced considerable stress in these situations. Overall, all of the reported evidence - including repeated national and local surveys - has demonstrated that the pathways of care for men and women of BME groups are problematic (Audit Commission, 2003). More generally, there are ongoing debates about the pervasiveness of 'institutional racism' and inequality in mental health services as experienced by members of BME communities (McKenzie and Bhui 2007; Murray and Fearon, 2007; Patel and Heginbotham, 2007; Singh, 2007). These experiences are reported to have a negative impact on their quality of life and access to meaningful service provision and treatments (McKenzie and Bhui 2007; Patel and Heginbotham, 2007).
It is hoped that these debates will unite policy-makers, academics, clinicians and communities in seeking changes that would benefit these service users. Nurses have an interest in these discussions, particularly when considering the scrutiny of the nursing profession in the independent inquiry into the death of David Bennett (Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003), a 38-year-old African-Caribbean man who died after being forcibly restrained by nurses in a medium secure unit.

The practice of nursing patients from different ethnic and cultural backgrounds is an emerging challenge for many within the profession. Within the current global, economic and political climate, nurses have no choice but to embrace, and prepare for, the needs and aspirations of all patients. Mental health nursing should begin to accept that concepts of 'care' and 'recovery' denote different processes to different people, and this is particularly significant when such concepts are increasingly being defined by service users themselves.

The Department of Health has recognised that fundamental changes are needed to improve services for members of BME communities. It has provided NHS managers and clinicians with a framework and action plan, which is outlined in Delivering Race Equality in Mental Health Care (DH, 2005). This framework was used by the Sheffield crisis assessment and home treatment team to develop a pilot project, Enhancing Pathways in Care (EPIC). This has resulted in a partnership that has yielded much success so far.

**DELEVERING RACE EQUALITY**

Delivering Race Equality in Mental Health Care (DH, 2005) outlined a five-year action plan for achieving equality and tackling discrimination in mental health services in England for all BME people, including those of Irish or Mediterranean origin and east European migrants. It also set out the government's response to the inquiry into the death of David Bennett. Its programme of action is based on the following three building blocks:

1. More appropriate and responsive services;

2. Increased community engagement;

3. Better quality information that is more intelligently used.

**CRISIS ASSESSMENT AND HOME TREATMENT TEAM**

The crisis assessment and home treatment teams (CAHTs) offer intensive support at home for people experiencing an acute mental health crisis. The Mental Health Policy Guide (DH, 2001) directs the focus for teams to:
Be accessible 24 hours a day, seven days a week;

Operate as ‘gatekeepers’ to acute mental health services by promptly assessing all those at risk of hospital admissions and deciding about the care needed;

Remain involved until the crisis has resolved and confirm that suitable care services are in place (McGlynn, 2006).

In addition, Sheffield CAHT has included some guiding principles for our service and its development - these may vary from team to team but generally include the following:

- reduce to an absolute minimum the use of hospital admissions and institutional interventions in the provision of mental health care;
- Making the service more responsive and accountable to the local population and prioritising social inclusion;
- Making available equitable care pathways, that is, varied routes to the recovery process;
- Involving voluntary and non-statutory agencies in a coordinated system of mental health care and to work closely with meaningful local initiatives;
- Working towards the emergence of alternatives to institutional psychiatry.

THE EPIC PROJECT

The EPIC project has mainly focused on improving pathways of care for service users of Pakistani origin within the acute care sphere, using the principles of the community development model (Bhopal and White, 1993). This model involves recognising the strengths of communities and working in partnership to achieve change. We sought a partnership with a voluntary organisation to facilitate these aims. Our aims and objectives were to ensure that:

- The Pakistani community receives a timely mental health service response to reduce the need for inpatient care;
- We use community resources to facilitate early discharge into the community with the support of the CAHT if a hospital admission of a service user of Pakistani origin is unavoidable.

The previous chief nurse of Sheffield Care Trust, who was also the trust's diversity lead, took the decision to fund a post for a community development worker to facilitate this partnership in a robust way. The community development worker's job plan was divided between the
CAHT, inpatient wards and the Pakistani Muslim Centre (PMC - a voluntary, charitable organisation that aims to improve the welfare of the Pakistani community through social activities, support, advice and Information). Her role has been dedicated to improving pathways of care through early discharge from hospital, providing psycho-education to families, encouraging engagement with the PMC for social activities, and acting as an advocate for service users and carers. She has also been available to accompany the CAHT on home treatment visits and attends our weekly multidisciplinary meetings.

Her task was central to this collaboration and she has helped improve understanding of the explanatory models of health and illness in Pakistani communities - that is, how patients and their families have a different way of understanding illness and its consequences, and how best to treat it.

The CAHT acknowledged that we could contribute to improving pathways of care for patients of BME groups. This could be achieved via our gatekeeping role and early discharge from hospital function, thereby avoiding hospital admissions and, if admission was inescapable, reducing the length of stay.

Clients of Pakistani origin referred to the team receive an ‘enhanced’ care package, that is, assessments that ensure we have a better understanding of the presentation of the distress expressed or observed. For example, it is quite common for clients to express symptoms that are closely related to their world views, particularly when some of their beliefs are grounded within the religious or spiritual context. From the Western scientific perspective, the belief in concepts such as the 'evil eye', black magic and Satan as antecedents to illness is deemed irrational and does not warrant credence. However, to clients, their families and often the community, this is an acceptable cause of illness. In such cases, the team would seek to work alongside the imam (spiritual leader) to assist in assessment and care management.

The team has had to take account of the 'language of distress' (Belliapa, 1991), as expressed by our clients of Pakistani origin and their families. For many of these service users, distress can be expressed in a variety of ways, often having leanings towards the Eastern philosophies (Fernando, 1996). In this context, ‘emotional pain’ can be described in a very physical way, for example, using expressions such as 'pain in my heart', 'my heart is not in the right place' and 'sinking heart' (Krause, 1991). For Pakistanis who do not subscribe to the mind-body dichotomy - that is, the separation of the mind and the body (Descartes, 1954) - these expressions can be misunderstood in the context of care-giving or, worse still, clients may encounter dismissal of their lived experience (Fernando, 1996).
In situations where clients or carers need respite from each other, the team ensures that the 'enhanced' care package includes the facilities of the PMC. The PMC has been acceptable to our clients and their families because it has a culturally acceptable day-to-day regime, that is, gender consideration for group activities, dietary factors and so on. The variety of culturally appropriate activities (including learning English as a second language, sewing classes, swimming classes and gym) appeals to many of our clients and their carers. Their facilities have also been of great value in encouraging early discharge from hospital.

Once a Pakistani patient has been admitted to the ward, an EPIC worker will ensure that she or he has made contact with the patient and their family to discuss community support on discharge. Patients and their families are welcome to visit the PMC and discuss further support in addition to the statutory services. Carers have found this particularly useful as the burden of care can be overwhelming and finding appropriate support structures can be bewildering.

Alternatives to mainstream psychiatric treatments such as Indian head massage and reiki are equally valued and used by our clients - these are available at the PMC.

Intelligent information-gathering assists in understanding some of the barriers members of our BME communities face in accessing mental health services. Information we gathered in Sheffield enabled the development of EPIC - Fig 1 and Fig 2 highlight the rationale and aims of the project.

**APPLYING THE ‘DELIVERING RACE EQUALITY’ BUILDING BLOCKS**

**Better quality information, more intelligently used**

Data and information was sought from Sheffield City Council and the audit department within Sheffield Care Trust. The findings were typical of the national picture in that the first contact that patients of BME groups had with psychiatric services was when they had reached a crisis point. They were disproportionately represented on the wards: high numbers were detained and experienced seclusion and their experiences, on the whole, were unsatisfactory (Healthcare Commission, 2007).

Sheffield’s BME population accounts for fewer than 10% of its total population of 480,000 - the largest minority group has a Pakistani background (Fig 3). While Sheffield’s policy of ethnic integration is included in the wider strategy of social inclusion, there is a risk that the specific aspects of social exclusion as experienced by members of BME groups may be overlooked. Fig 4, Fig 5 and Fig 6 demonstrate the challenges these communities face in all areas of social inclusion.
**Community engagement**

The community development model (Bhopal and White, 1993) recognises the leading role of communities. However, the responsibility for policy development and practice cannot be the responsibility of individual communities alone but necessitates a multi-agency approach with effective partnership arrangements.

In the desire to engage the Pakistani community, the nurse consultant met with community leaders, including imams, councillors, voluntary-sector organisation managers, attendees of social groups in the community, school governors of Pakistani origin and a female Islamic scholar. These meetings facilitated the foundations of partnership working, aimed at improving pathways of care for clients of Pakistani origins who need acute mental health services.

A reliance on prescribed social activities and alternative treatments as an addition to psychiatric treatment plans (medication and psychological services) was favoured. The community would have access to the CAHT for any acute care needs. The imam would be available, when required, to assist with assessments and the delivery of home treatment, as would other members of staff. Issues of confidentiality were discussed and agreed on as a standard requirement by both organisations. The PMC would offer daytime respite and social activities to service users and their carers during their period of care under the CAHT or on the acute inpatient wards, as well as post discharge. Additionally, the CAHT would provide mental health awareness training to all staff and attendees to the PMC. A launch event to celebrate this partnership was held, attracting over 100 people from the community. The EPIC project was established in earnest in 2005.

**More appropriate and responsive service**

The clinical governance structure within the team enables us to ensure that the CAHT is accountable for continuously improving the quality of our services and safeguarding high standards of care for all our clients. Its utility value to this project cannot be underestimated and without the clinical governance framework, the team would have struggled to stay focused on the work of the EPIC project. Through the audit mechanism we were able to understand the care pathways of our BME clients and where improvements needed to be made. The mechanism provided us with statistical evidence of any changes or trends that had occurred. In introducing the clinical outcome measurements of the Health of the Nation Outcome Scales (HONOS, [www.rcpsych.ac.uk/crtu/healthofthenation.aspx](http://www.rcpsych.ac.uk/crtu/healthofthenation.aspx)) and Brief Psychiatric Rating Scales (BPRS, [www.priory.com/psych/bprs.htm](http://www.priory.com/psych/bprs.htm)), we were able to understand the favourable outcomes experienced by BME clients who underwent home treatment.
Training in cultural capability for acute inpatient wards and the psychiatric intensive care unit was delivered by the consultant nurse. Independent evaluation of this training suggests it was received positively and also raised awareness of nursing care in the context of this group of patients. Further training is planned, with scope for service users to be involved in the evaluation.

The use of imams to extend alternatives in the recovery process has been a great success. This has improved the resilience of our BME clients and their families. This way of working has had a great impact on improving relationships between clinicians, clients and their families. Early discharge of Pakistani patients from hospital has been achieved and there are increased episodes of home treatment, resulting in less disruption to patients’ and clients’ lives and their families. Home treatment also has better results for these patients. The tools used to measure outcomes suggest an overall improvement in symptoms and social functioning for them compared with our white British patients (Fig 7). Fig 8 shows other outcomes from EPIC.

**Implications for practice**

- Nurses should ensure they have a comprehensive knowledge and accurate demography of the population they serve;
- Practitioners need to use the resources of, and collaborate with, the clinical audit departments within their organisations to ensure they work towards evidence-based practice;
- Knowledge of community resources and key stakeholders assists in building capacity and can be useful sources of support for local BME communities;
- Nurses can use learning theories, such as the experiential taxonomy (Steinaker and Bell, 1979), in order to improve cultural capability in nursing practice;
- Nursing care for clients from BME communities should take account of their specific needs in all healthcare environments - this should not be seen as ‘out of the ordinary’.

**CONCLUSION**

The success of this project was recognised and won a DH DRE award of excellence for more appropriate and responsive services in March 2007. The transferability of this model has encouraged us to establish EPIC2 - a partnership project with the African Caribbean communities. Our new partners are a voluntary service organisation. We have been
successful in attracting support and some funding from the Health Foundation to facilitate leadership skills in projects for BME communities.

Such an undertaking is virtually impossible without the support of at least one executive board member of the trust. The involvement of senior managers also ensures that successful pilot projects become mainstream. The challenges have been enormous but not insurmountable. The project is ongoing and has been owned to some degree by the community and the CAHT. Inpatient wards have developed a good working relationship with the PMC and we can rely on the continued support of the PMC to assist us in improving pathways of care.

Understanding the cultural differences between the partner organisations, both statutory and voluntary, was one of our biggest challenges. Accountability for workers in the voluntary sector takes on a different dimension. The workers succeeded in including a number of women who had limited political visibility, voice and power. In addition, accountability to commissioners was taken seriously and their constant negotiations with the funding agencies required much energy and zest.

I would recommend that nurses seek these partnerships as there is much we can learn, then bring these insights back into their own organisations. Through this project, it became evident that the preoccupation with funding by those who wish to develop projects such as EPIC can hinder creativity and innovation. We often fail to see how best we can make use of what we have and to accept that, on many occasions, we will be unable to attract much funding - working smarter, as opposed to working harder, may be applicable to this project.

If partnerships seek a shared dimension that unites their aims and objectives, they will realise they do have common goals. For EPIC, the agendas for social inclusion united the Pakistani community and the crisis assessment and home treatment teams.

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References


