IMPROVING QUALITY OF MENTAL HEALTH CARE FOR BME CLIENTS

This is a summary: the full paper can be accessed at nursingtimes.net

AUTHOR Rashna Hackett, MA, RMN, is consultant nurse, acute care, Sheffield Care Trust.


This article shows how nursing leadership can contribute to service development to improve care for black and minority ethnic clients through the Delivering Race Equality (DRE) policy (Department of Health, 2008). It describes the Enhancing Pathways in Care (EPIC) project for clients of Pakistani origin in Sheffield who need acute mental health services.

Crisis assessment and home treatment teams (CAHTs) offer intensive support at home for people experiencing an acute mental health crisis. Sheffield CAHT has included some guiding principles for our service and its development. It aims to:

- Minimise the use of institutional interventions in mental health care;
- Make the service more responsive and accountable to the local population;
- Make available equitable and varied care pathways;
- Involve voluntary and non-statutory agencies in coordinated mental health care;
- Work 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 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 hospital admission 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 proceed with treatment.

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

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. 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.

IMPLICATIONS FOR PRACTICE

- Nurses should ensure they have a comprehensive knowledge and accurate demography of the population they serve.
- Practitioners must use the resources of, and collaborate with, their organisations’ clinical audit departments 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 Steinaker and Bell (1979), to improve cultural capability in nursing practice.

APPLYING ‘DRE’ BUILDING BLOCKS

Better information, 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 from BME groups had with psychiatric services was
BACKGROUND

- 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 clients.
- The DH programme of action is based on the following three building blocks:
  - Better quality information that is more intelligently used.
  - Increased community engagement;
  - More appropriate and responsive mental health care services;
- This framework was used by the Sheffield crisis assessment and home treatment team to develop a pilot project, Enhancing Pathways in Care (EPIC).

when they had reached a crisis point. They were disproportionately represented on the wards – high numbers were detained and experienced seclusion. Their experiences, on the whole, were unsatisfactory (Healthcare Commission, 2007).

Community engagement

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

In the desire to engage the Pakistani community, the nurse consultant met with community leaders, including imams, councilors, 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 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 acute care needs. The imam would be available 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 acute inpatient wards, as well as after discharge. The CAHT would also provide mental health awareness training to all staff and attendees to the PMC. The EPIC project was established in earnest in 2005.

More 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 (www.rcpsych.ac.uk) and Brief Psychiatric Rating Scale (www.priory.com), 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. 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 yields 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 clients.

CONCLUSION

The transferability of this model has encouraged us to establish EPIC2 – a partnership project with the African Caribbean communities.

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 team.

For the full version of this paper, including background to a project and full reference list, log on to nursingtimes.net, click NT Clinical and Archive and then Clinical Extra.

This project was highly commended in the mental health category of the NT Awards 2007.