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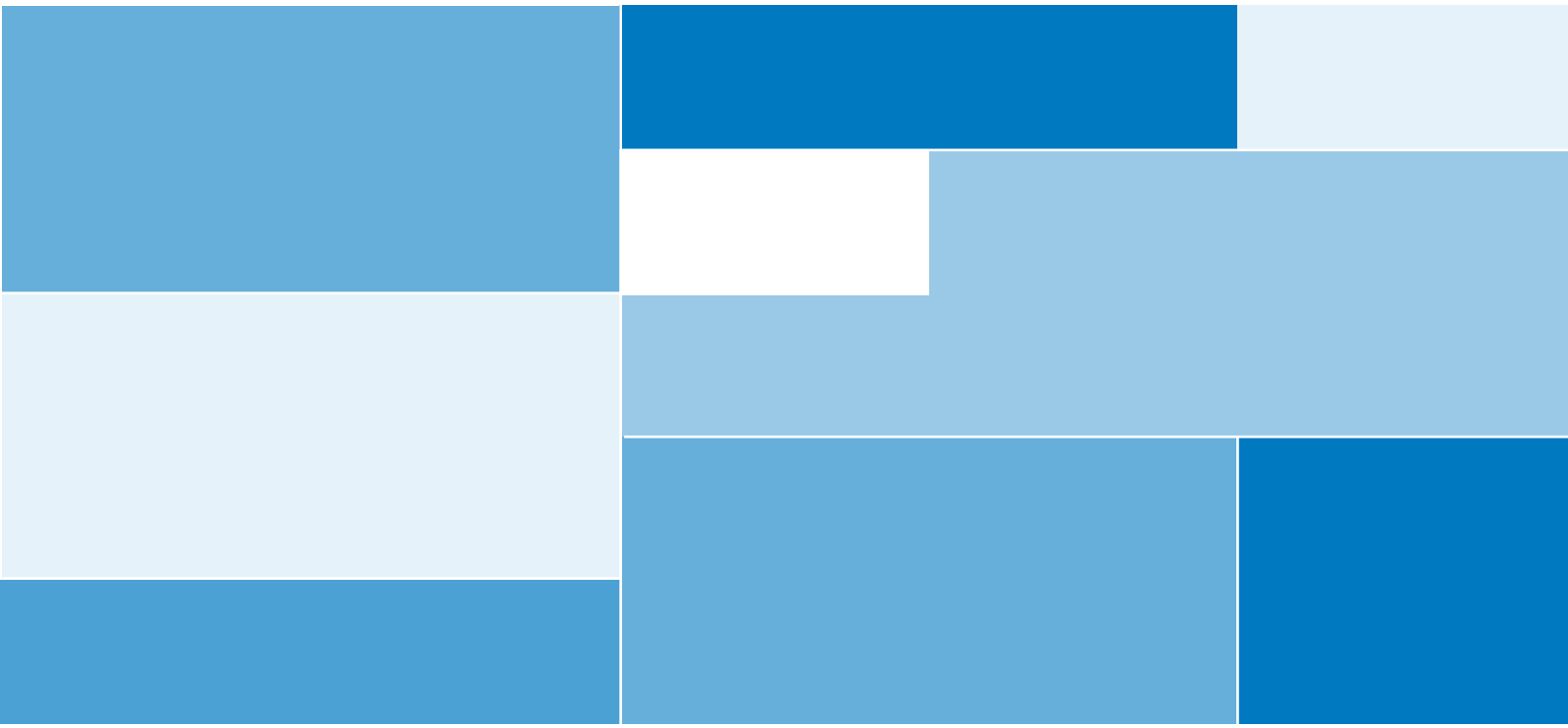
Improving Access to Psychological Therapies

NHS

Black and Minority Ethnic (BME)

Positive Practice Guide



January 2009

"Relieving distress, transforming lives"

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Contents

1. Background and policy framework

1.1 People from black and minority ethnic (BME) communities tend to have poorer health, a shorter life expectancy and have more difficulty in accessing health care than the majority of the population.[1] Mental health is an area of particular concern for the minority communities in the UK's multicultural society.

1.2 The *National Service Framework for Mental Health* states unequivocally that service users can expect services to be non-discriminatory.[2] Additionally, the Race Relations (Amendment) Act 2000 imposes a legal duty on all public authorities to actively promote race equality.

1.3 Ensuring that people's access to psychological therapies is not hindered by their ethnicity, culture or faith is one of the leading priorities outlined in *Delivering race equality in mental health care*'s action plan (DRE).[3] BME access to, and experience of, psychological therapies will be assessed in the central monitoring of both the Improving Access to Psychological Therapies (IAPT) and DRE programmes. The action plan explains the context and the need for positive action, and the work generated by the plan has helped to identify some of the good practice described in this document.

1.4 People who are born deaf and communicate mainly in sign language see themselves as part of a distinct community with a common language and cultural heritage. Many users of sign language will view English, including written English, as, at best, a second language. Estimates suggest a prevalence of mental health problems of 40% in deaf children compared to 25% in their hearing counterparts.[4] In deaf adults, a number of studies from different countries have indicated a significantly higher level of mental ill health.

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1 National Institute for Mental Health in England (2003) *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*, London, Department of Health

2 Department of Health (2000) *National Service Framework for Mental Health: Modern Standards and Service Models*, London, Department of Health

3 Department of Health (2005) *Delivering race equality in mental health care*, London, Department of Health

4 National Institute for Mental Health in England (2005) *Mental Health and Deafness: Towards Equity and Access*, London, Department of Health

2. Understanding the needs of different communities

2.1 A Joint Strategic Needs Assessment (JSNA) will help commissioners to understand the demographic profile and epidemiological data for their local community.

2.2 The 2001 Census provides some data about BME communities in the local area but these communities tend to change rapidly, so further analysis is essential to understand the range and number of BME communities within the local area. There are a number of sources that this information can be obtained from, such as:

- the regional public health observatory (see www.apho.org.uk/);
- Office of National Statistics and other relevant Government websites (see www.statistics.gov.uk/default.asp);
- the planning or economic development department in the local council;
- certain journals or magazines of local organisations or local authority departments;
- the Equaltiy and Human Rights Commission website (see www.equalityhumanrights.com/pages/eocdrccre.aspx);
- surveys conducted by BME community organisations;
- community development workers that have been commissioned to carry out mapping surveys to identify stakeholders;
- university-led community engagement projects that provide local research data; and
- the IAPT Equality and Diversity Toolkit (www.iapt.nhs.uk/2008/10/equality-and-diversity-toolkit), for more information on gathering data about the local community.

2.3 Local third-sector organisations and faith groups will often have a good level of knowledge about the range of BME communities within a local area. Such organisations are often the first point of contact for individuals from BME communities or hard-to-reach groups.

2.4 Developing IAPT services in partnership with third-sector organisations or faith groups will enable services to become more culturally appropriate to the needs of their patients. Commissioners and service providers should work with such organisations or groups to plan, deliver and evaluate services, and they should be aware of wider local social concerns such as housing, education, racism, social isolation and poverty.

Wirral Primary Care Trust (PCT)

Wirral PCT commissioned community development workers to undertake a baseline mapping exercise to identify the range of ethnic communities living within the local population. This mapping identified 26 ethnic groups that now live on the Wirral.

Links with BME communities have improved in recent months, due to the engagement with local community leaders. A positive dialogue has been established with the leader of Birkenhead Mosque and information leaflets for people from ethnic groups are on display in the mosque. This link has been developed through partnership working with Wallasey Citizens Advice Bureau (CAB) and Advocacy in Wirral, a charity.

A unique service provided by Wallasey CAB and Advocacy in Wirral (a primary care advice service) for people with mental health problems provides an outreach service at a local GP practice, and Wirral Change (an employment advice service) offers translation and signposting for people from BME communities with a common mental health problem.

2.5 Commissioners need to be aware that mental health may be understood and viewed differently by people from different cultures. It is very important that any service planning and delivery reflect this.

2.6 People from some communities or faith groups may wish to only see a therapist from the same ethnic or religious background, and some may wish to only see a therapist of the same gender as themselves. The engagement process, service planning, publicity and staffing arrangements should be enabling – not disabling.

2.7 Service providers must be aware of the ever-changing demographic of the local population. The needs of the local population will change as BME communities move out of or into the local area. In addition, different generations may develop different understandings of mental health and available services. IAPT services must be flexible in recognising and responding to these changing needs.

2.8 Social integration has positive benefits for the individual and for the wider community. Isolation is a key component of depression; it is therefore vital that IAPT services work to include BME communities and cultural groups so that people are able to access psychological therapies and are not isolated further from such services.

2.9 Robust data collection from each therapy session will show whether the needs of individuals from specific BME or cultural groups are being met effectively by the IAPT service. Culturally sensitive outcome measures can indicate whether the IAPT services are successful for the whole community group.

Ealing IAPT Pathfinder site

Ealing PCT, in partnership with West London Mental Health Trust, delivers an IAPT service in Southall, which has a BME population of over 70%. The majority of the population is Asian, with Punjabi the most commonly spoken language.

Through extensive consultation with users and community groups, Ealing's Pathfinder IAPT project re-designed services in Southall to make them culturally appropriate and accessible to the BME community. This was done by integrating all mental health services into one primary care 'Wellbeing Team' with:

- Punjabi-speaking high- and low-intensity psychological therapy workers (recruited from the same culture, community and class as the population that they serve);
- local voluntary sector services providing culturally specific therapies (e.g. the Asian family counselling service);
- community development workers to improve access for specific cultural and ethnic groups;
- the option of self-referral through a multi-lingual telephone helpline, which is advertised in multiple languages across community sites in flyers and information booklets; and
- an *Overcoming Depression* self-help audio-book in Punjabi, with support provided by low-intensity psychological therapy workers.

Careful monitoring of Southall referral rates in relation to ethnicity has enabled Ealing's Pathfinder site to demonstrate an increase in the number of Asian, Punjabi-speaking clients accessing and using the service effectively.

3. Removing barriers to access

3.1 All individuals accessing mental health services will have potential barriers to overcome. However, people from BME communities may face additional barriers involving ethnicity, culture, language or faith.

3.2 Along with other social factors, these barriers may affect the perception, availability, use and potentially the outcome or effectiveness of an IAPT service. Therefore, commissioners should ensure that IAPT services are established, developed and maintained in a way that is suitable for all BME communities, with high-quality, culturally responsive and language-appropriate services delivered in accessible locations.

West London Mental Health Trust

West London Mental Health Trust (WLMHT) has a whole-systems approach to improving BME groups' experience of psychological therapies services. The project is located in the Primary Care Psychological Therapies Service of Hammersmith and Fulham, where 42% of the local population is from an ethnic group other than White British.

Dovetailing with the IAPT agenda, this project aims to implement service-level changes to improve access and engagement with BME clients in need of evidence-based psychological interventions.

This is being done by:

- building good relationships and liaising closely with local community organisations;
- establishing focus groups with service users from BME groups;
- developing internal audit projects; and
- the collection of baseline data to monitor effectiveness.

WLMHT's main aim is to reduce admission rates of individuals from BME communities to psychiatric wards by improving access to effective services in a primary care setting.

3.3 Non-English-speaking people may not be able to communicate their needs effectively if an IAPT service lacks appropriate language capacity. This could mean that proper and correct assessments may not be made.

3.4 Cultural and social differences may be a barrier for some BME communities in accessing psychological therapies. The stigma or lack of understanding of mental health problems may be a prohibiting factor for some individuals. For example, there is not a specific word that means 'depression' in certain languages, including Punjabi, Urdu and Hindi.

3.5 Community isolation may be a barrier for individuals from the 'newer' influx of ethnic minorities, i.e. new European Union member states or emergent African communities. These individuals may have little or no understanding of the availability of services provided in this country, and may become isolated from many statutory services, including the wider health services. Issues relating to migration status can exacerbate such problems. In such circumstances, a person's mental health may not be their priority.

3.6 A lack of understanding of psychological therapies may also be a barrier to accessing these services. Some cultures or community groups will have little or no understanding of what psychological therapies are and what is involved. Some individuals may be fearful of engaging with a service they do not fully understand.

Birmingham and Solihull Mental Health Trust

Birmingham and Solihull Mental Health Trust has been working in partnership with Rethink, a voluntary sector organisation, and local mosques to develop a mental health training programme for imams. Its aim is to help the Muslim community have a better understanding of the benefits of psychological therapies, and to increase awareness of services in the local area.

4. Engaging with BME communities

4.1 Proper and effective engagement with individuals from BME groups is essential if IAPT services are to meet the needs of the whole community.

4.2 Voluntary and community sector organisations and faith groups have an important role in engaging with hard-to-reach communities. Such groups may act effectively as intermediaries by:

- providing commissioners with information that helps to engage the target group;
- raising awareness and signposting individuals to the IAPT service (by being included in the referral pathway to IAPT services); and
- providing commissioners with useful feedback to help IAPT services improve the way that they encourage engagement.

4.3 Collaborative working with local community organisations and groups is crucial. The voluntary sector has a history of leading the development of culturally appropriate services for BME groups. IAPT services need to be appropriately diverse, and provided through both statutory and voluntary agencies. Community and faith groups can also offer knowledge about what is effective for specific individuals from BME communities.

4.4 It is often much easier to consult individuals, voluntary or community groups and organisations that are already known. Investing time and effort in engaging with specific communities with which there had previously been limited contact may be more challenging. However, there are ways of reaching most groups in the community, although some may require additional support in order to engage. Commissioners may need to talk to the target group about the best way to consult and involve them.

Derby IAPT Pathfinder site

The mental health commissioners leading the IAPT Pathfinder project have commissioned the Black Wellness Initiative (BWI), in order to forge links with the BME community.

Members of the BWI have linked with African-Caribbean community groups and faith leaders, and plan to also link in with Asian community groups and faith leaders. Their role has been to obtain views on mental health and wellbeing from members of the groups and faith leaders, and to work with the PCT by using this information in order to improve access to services.

Derby PCT facilitated a workshop event with representation from community leaders, community development workers, Rethink (a voluntary sector organisation), mental health commissioners and the PCT's public health manager. The focus of the event was to discuss the following issues, with the aim of finding solutions for service development:

- The definition of 'wellbeing' among African-Caribbean people.
- What stops people from these communities from talking to GPs, medical professionals and therapists about difficult emotions and thoughts?
- What stops African-Caribbean people from asking for help when they need it?
- What information should be collected from clients? How is it obtained, utilised and retained?

4.5 Commissioners should develop links with specialist culturally and linguistically specific service providers, or, where none exist, ensure that the service has access to translators and interpreter services that can be used for individuals who speak little or no English.

4.6 Ensuring that language-appropriate services are available enables the correct assessment of individuals to be made within a supportive environment. Translated reading material about IAPT services will also raise awareness and promote the use of interpreters and translators within the service. Ways that the language barrier can be removed include:

- producing leaflets, pamphlets and flyers in languages representing the local community;
- providing therapists able to speak other languages; and
- ensuring that interpretation and translation services are available.

4.7 Commissioners will want to ensure that the location of the IAPT service encourages engagement. A location that offers some form of anonymity would help to engage people who fear the perceived stigma of having mental health problems, or who feel isolated from – or anxious about using – statutory services.

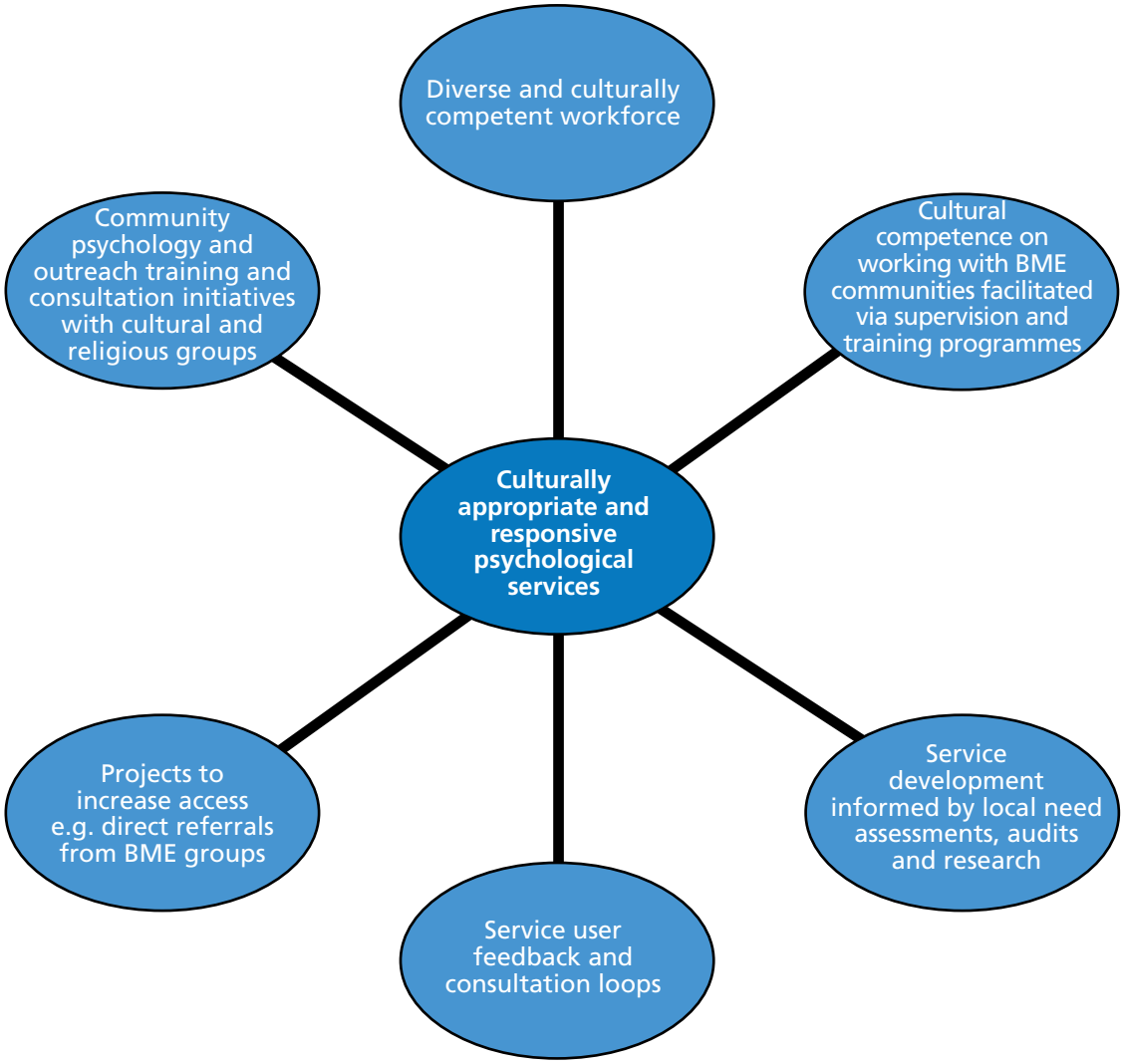
Newham IAPT demonstration site

Newham has a 63% BME population. This presents specific challenges to clinical service delivery, including cultural, ethnic and language barriers.

Existing services have worked hard to meet this challenge by appointing multi-lingual therapists from diverse backgrounds. There is greater emphasis on services being responsive to local need and on delivering culturally appropriate services. The principles of effective links and partnership working have, over the years, enabled a good rate of access for all ethnic groups.

The approach is multi-focused to ensure that psychological service provision is effective and responsive to meet the needs of local people. (see Figure 1, below).

Figure 1: Newham IAPT demonstration site approach



5. Training and developing the workforce

5.1 It is an important principle that the IAPT workforce should reflect and be representative of the local community. The capacity and capability of therapists must be appropriate for the people that they will be seeing. IAPT services need to recruit, develop and retain a workforce that is able to deliver high-quality services that are fair, accessible, appropriate and responsive to the needs of different groups and individuals.

5.2 Commissioners should understand their local population in order to commission an IAPT service with the appropriate number, skill mix and make-up of the therapist(s). The workforce should reflect the communities in which they work. The training of individuals from BME communities or faith groups to become part of the IAPT service workforce will be beneficial to both the IAPT service and the patients themselves, in the context of assessments and interventions.

5.3 The training of staff is an important aspect of addressing inequalities within an IAPT service. It is essential to improve the cultural competencies and capacity of the IAPT service workforce in order to overcome any possible professional bias and/or personal prejudices. Commissioners should be satisfied that service providers are taking steps to ensure that the therapy workforce is culturally aware and sensitive to the specific needs of individuals from different cultures and backgrounds, and to the needs of those with different religions or beliefs.

5.4 Recruiting low-intensity and high-intensity workers from represented BME communities or religious groups should be encouraged. The level of engagement between the therapist and the service-user may be enhanced if there is a shared ethnic or cultural background. Individuals may feel more confident in talking to 'strangers' in their own language, or from the same culture or religious group.

5.5 Commissioners should ensure that IAPT services are delivered in a person-centred and culturally sensitive manner. Services and therapists should be aware of the broad range of diverse but specific barriers and needs relating to psychological treatments for people from BME communities, and ways of addressing them. All therapists should have received appropriate values-based and DRE training; in addition, IAPT training courses should specifically cover cultural sensitivity and the delivery of psychological therapies. Additional resources may be required to translate therapeutic materials into different languages and to ensure that self-help materials are available in a wide range of formats, including computerised resources, books and leaflets, and audiotapes, CDs and DVDs for those with literacy problems.

Acknowledgements

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