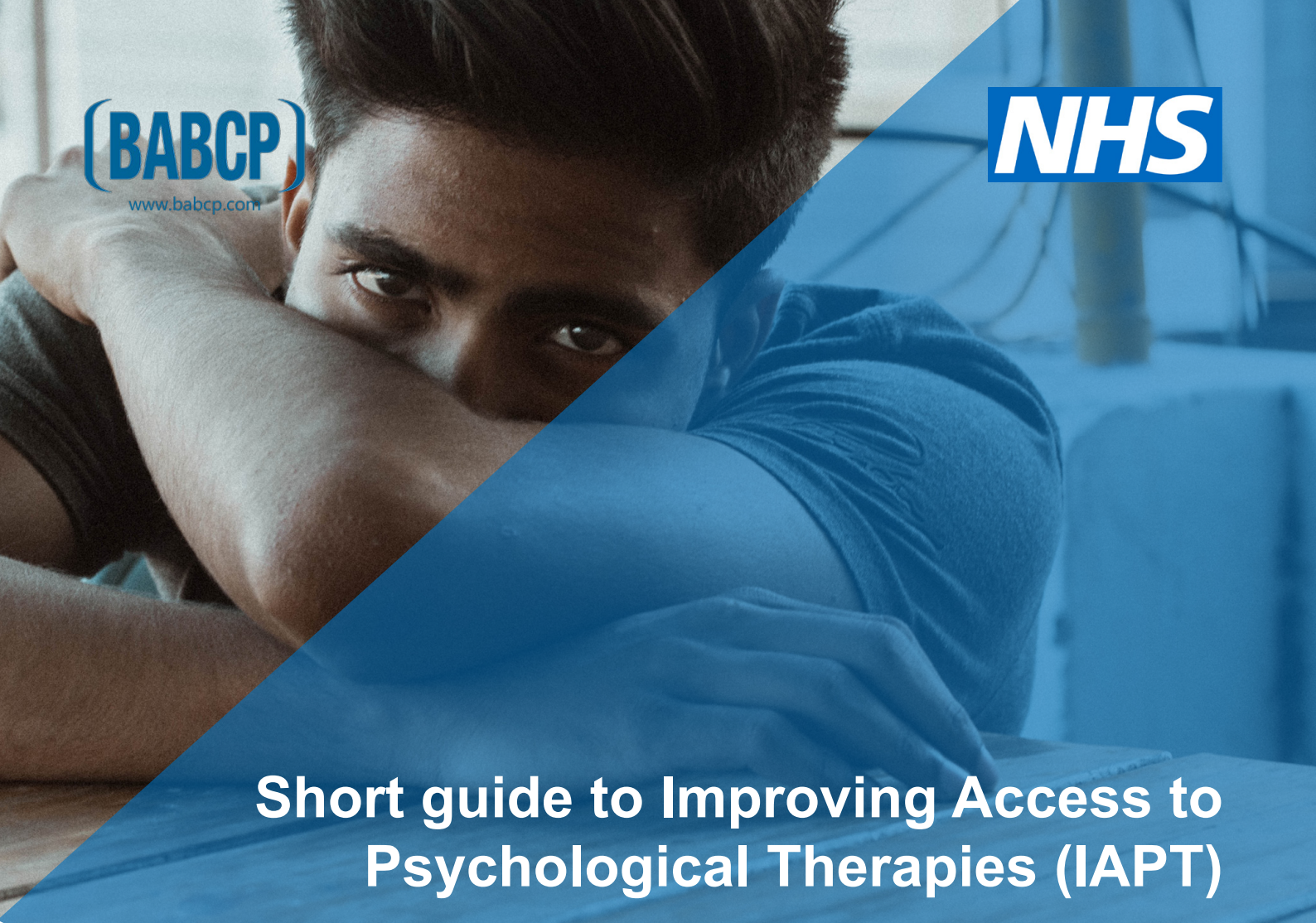

Short guide to Improving Access to Psychological Therapies (IAPT)

BLACK, ASIAN AND MINORITY ETHNIC SERVICE USER POSITIVE PRACTICE GUIDE

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Preface

by Professor David M Clark

In recent years there have been substantial advances in research on the treatment of common mental health problems. New psychological therapies have been developed and have shown their worth in randomised controlled trials. Some older therapies have also been rigorously tested and now have a strong evidence base. The National Institute of Health and Care Excellence (NICE) recognises these advances and recommends evidence-based psychotherapies as first line interventions for depression and anxiety-related disorders.

Unfortunately, when NICE started issuing its mental health guidance, psychological treatments were rarely available, even though surveys indicated that the public has a 3:1 preference for psychological therapies compared to medication.

The Improving Access to Psychological Therapies (IAPT) programme, which started in 2008, aims to give the public what it wants by greatly increasing the availability of NICE recommended psychological therapies in the NHS. Substantial progress has been made in the first decade of the programme. Over 1 million people a year are now seen in IAPT services, outcomes are recorded and reported for 99% of those who have a course of treatment. Overall outcomes are in line with the expectation from research studies. In particular, around 7 in every 10 treated individuals show substantial improvements, with 5 in every 10 being categorised as recovered.

From the start, the IAPT programme aimed for fairness. In particular, people from all sections of the community should have a chance to benefit from psychological therapy. An early finding in the Newham Demonstration Site was that people from the BAME community were under-represented in referrals using conventional primary care routes. To help overcome this problem, IAPT was opened up to self-referral. While this is likely to have helped to improve BAME access, it is clear that more needs to be done. In some areas of the country, people from the BAME community are still under-represented in IAPT services, and their clinical outcomes can also be less good (Baker 2018).

This excellent BAME Positive Practice Guide brims with helpful suggestions for how to achieve access and outcome equity for the BAME community. The Guide has been co-developed by IAPT clinicians and BAME service users. Separate sections cover increasing access, reducing DNA rates, developing an appropriately skilled workforce, and ensuring that the core principles of effective psychological therapies are delivered in a culturally sensitive manner. The Guide concludes with a helpful audit tool for IAPT teams to complete.

Understanding the perspectives of others is a helpful process in all psychotherapies and also for organisations. The positive approach to listening and responding to the experiences of people in different communities that is elegantly advocated in this guide is therefore likely to enrich us all.

Professor David M Clark CBE
National Clinical and Informatics Advisor for IAPT

Foreword

by Professor Paul Salkovskis

It pretty much goes without saying that in order to *really* improve access to psychological therapies, IAPT has to be inclusive. Easy to say, harder to do. Through the ten years since it was initiated, it is clear that inclusion has been high on the IAPT agenda, as it has been for the rest of the NHS. However, there are challenges at all levels: service provision, staffing and the actual psychological interventions which are deployed through IAPT. The transparency which is built into IAPT means that there are generally available data which inform us about the success and shortcomings of efforts to promote and build in inclusivity and equality in service provision. We can read what emerges from these data like a school report: excellent effort but could do better.

So, here we have the IAPT Black, Asian and Minority Ethnic Service User Positive Practice Guide, which sets out the problems (poorer access, less clinical improvement) and begins to tease out some solutions. In doing so the guide has sought to draw upon the evidence base and pull it together with best practice, experience of delivering IAPT and the values which underpin the NHS as set out in the NHS constitution. The guide is not the last word; those who have put it together have made it clear that it's a work in progress, and it has evolved through co-working with stakeholders and people with personal experience (service users and carers). Positive practice will continue to evolve around the benchmarks set by the dedicated authors of this guide and those they have so extensively consulted. As current President of the British Association for Behavioural and Cognitive Psychotherapies (BABCP), I welcome this guide as pointing to the way forward in terms of how to shape IAPT services, the therapy they deliver, the workforce it recruits and nurtures and the communities which it seeks to involve and serve. The BABCP is proud to endorse this fantastic piece of work, and will actively seek to promote its objectives.

Professor Paul Salkovskis
President of the British Association for Behavioural and Cognitive Psychotherapies

THE NEED FOR CULTURALLY ADAPTED AND CULTURALLY RESPONSIVE SERVICES

As a result of IAPT people from all communities have benefited from evidence-based therapies; however, in England, members of Black, Asian and Minority Ethnic (BAME) communities with mental health problems are currently less likely to access therapy, less likely to have good outcomes and more likely to report negative experiences in therapy and are more likely to see mental health services as hard to access compared to white majority service users (Mercer et al. 2018, Crawford et al. 2016). This is despite many years of awareness-raising regarding the need to achieve equality of access and treatment outcomes (Department of Health 2005).

Recent data from the IAPT programme (Baker 2018) suggest that, compared to people from White British backgrounds, people from most BAME communities are:

- less likely to use IAPT services (13% of IAPT referrals are from BAME groups whilst 20% of England's population are from BAME groups)
- less likely to complete treatment (46% of White service users complete treatment compared to 40% of Asian service users)
- less likely to reliably improve (66% of White service users reliably improve compared to 61% of Asian service users)
- less likely to achieve full recovery (50% of White service users achieve full recovery compared to 44% of Asian service users).

There is a clear legislative duty on the part of mental health services to provide equality of access for all communities within their catchment area (Equality Act 2010).

This short guide and the IAPT BAME Positive Practice Guide published by the BAPCP provide a framework for IAPT commissioners, service managers, supervisors and clinicians to work towards better access and outcomes. The guidance draws on the current body of evidence around improving BAME access and therapy outcomes and these recommendations have been extensively reviewed by Service User and specialist service provider organisations. We would like to thank everyone who has been involved for their time and invaluable insights.

Recent data from IAPT (Clark et al. 2018) indicate that outcomes for service users living in socio-economically deprived areas can be increased to close to those of more affluent areas, provided that local IAPT services are appropriately funded and deliver therapy in line with IAPT quality standards.

By adopting the principles in this guide commissioners, service leads and clinicians will be able to accelerate their improvement in access and outcomes overall, while, at the same time, supporting better staff retention and job satisfaction and enabling the development of an engaged and motivated workforce.

1: Service-level changes to improve access

Effectively implemented by IAPT service managers and clinical leads, commissioners and those in other leadership roles, service-level changes that can make IAPT services more accessible to Black, Asian and Minority Ethnic (BAME) communities include:

- Understanding the full range of needs across local communities including history, culture and political factors. Local community engagement is essential and both quantitative and qualitative intelligence and insight gathering is required. Right Care packs can be a useful resource; there are packs covering equalities and health inequalities, and mental health. The Advancing Mental Health Equality Toolkit can also be used as a basis for service development.
- Routinely mapping the demographics of the community served and comparing this to the profile of those using services, to identify unwarranted variation in access by specific ethnic groups.
- Where inequalities in access and / or outcomes are identified proactively consider and plan to secure improvements through e.g. community engagement via faith communities or other networks, developing community specific staff roles or other bespoke initiatives.
- Locally agree metrics for improvements and routinely review.

Further examples of service level quality improvement projects are included in the IAPT BAME Positive Practice Guide.

2: Adapting therapy

Therapists and supervisors working in IAPT services may need to adapt therapy delivery models to improve access, retention rates and outcomes for BAME service users. Care needs to be taken to maintain fidelity with the evidence base whilst increasing effectiveness.

Therapists should:

- Take the beliefs, values and cultural and spiritual perspectives of service users into account throughout treatment.
- Use a recovery-based approach that incorporates the social, community and spiritual needs of the service user.
- Ensure therapy provision is available on the basis of service user need irrespective of their ethnicity, religion or refugee status.
- Consider the use of a genogram that includes the migration histories of family members and a discussion about the degrees of acculturation of different people in families, to help understand the perspectives of BAME service users.
- Use an appropriately trained and supported interpreter when required, checking that this is acceptable to the service user and making additional time available.

Services should:

- Develop resources or directories of organisations that can offer support and advocacy which will improve engagement in treatment.

- Consider culturally appropriate and sensitive adapted therapies developed in partnership specifically for particular communities by members of that community where necessary. Case examples of these adaptations are found in the IAPT BAME Positive Practice Guide.
- Use the audit tool to assure themselves they are providing equality of access and outcomes.
- Give additional consideration to the complex nature of presentation and treatment needs for asylum seeker and refugee service users. Further information on working with asylum seekers and an example of good practice are available in the BABCP's IAPT BAME Positive Practice Guide.

3: Engagement with service users and communities

Services can engage with their BAME communities through:

- Outreach work to develop relationships including developing links with places of worship, faith based organisations, Voluntary and Community Social Enterprise (VCSE) organisations and third sector organisations already working with these communities.
- Developing community specific steering groups, involving more people from BAME backgrounds in service user groups and providing workshops in community settings and places of worship.
- Accessing community specific media such as newspapers and radio stations, which have well established coverage in local communities.

The Royal College of Psychiatrists has published Working Well Together which includes helpful information and tools to support co-production in mental health commissioning.

4: Workforce and staffing

Increasing access and improving outcomes for BAME communities has a number of key implications for IAPT workforce development including:

- Fostering a strong, shared ethos of valuing diversity, reflected in the thinking that underpins all aspects of case discussions and supervision.
- Investing in training staff in culturally adapted and culturally responsive therapies. An example of using culturally adapted therapies effectively is provided in the BABCP's IAPT BAME Positive Practice Guide.
- Ensuring through proactive review, recruitment, training and succession planning, that the workforce reflects the diversity of the communities served at all levels.
- Ensuring that BAME staff have equal opportunities for career progression as all other staff. Services may need to take a proactive approach to developing BAME staff using the Workforce Race Equality Standard (WRES, NHSE 2019)

5: Audit tool

Developing an overall strategy to increase access and improve outcomes for BAME communities can be supported and structured through adoption of the audit tool developed for this purpose. The tool can be used to establish the degree to which services are culturally responsive and develop action plans to improve the work they do with BAME communities. NHS England and NHS Improvement has committed to developing a Patient and Carers Race Equality Framework (PCREF) to support organisations to identify and build core competencies in delivering culturally responsive care for BAME patients and carers. Development will start in 2019/20 and the PCREF is expected to complement this positive practice guide.

This tool will be most effective if it is discussed with staff, BAME service user representatives and community organisations prior to use. All these groups are likely to have useful suggestions regarding how the standards can be improved and how areas for development can be best addressed. New standards can be added, based on these discussions.

Using the tool will enable services to understand the demographics of the populations served and begin to describe them. The audit tool will enable services to take a baseline measure of data quality, who is using the service, the different rates of access to the service amongst communities served, and therapy outcomes.

This information can be used as a discussion point for teams and service user or community groups to develop action plans in order to address any problems identified. Further, this audit should be repeated once these plans have been implemented in order to measure whether they have been effective.

Standard	Is the standard met? How has this been evidenced?
1. Improving access	
The service records the ethnicity of 100% of service users	
The service has mapped the ethnicity of the population served using appropriate convergent sources	
The ethnicity of service users reflects the population served	
Where the above is not the case, an action plan has been agreed to remedy this	
The action plan has sufficient input from senior staff to be effective	
BAME service users fare as well as White British service users in their clinical outcomes and level of satisfaction of using the service	
Where this is not the case, an action plan has been agreed to remedy this	
The action plan has sufficient input from senior staff to be effective	
Information leaflets are available in community languages	
Information leaflets have been approved by service user representatives from the appropriate community	
Staff have access to materials to support adapted therapy	

2. Adapting therapy	
100% of the clinical staff group have accessed CPD which included working with cultural diversity	
100% of the supervisors have accessed CPD which included working with cultural diversity (either therapeutically or in terms of providing supervision)	
The service has looked at whether there is a need to develop provision in specific culturally adapted therapies	
The service has shared values and practices to support the provision of culturally responsive therapies	
Therapists have accessed specific training on working with asylum seekers and refugees where these populations are identified as having an unmet need	
The service has a coherent policy for working with interpreters	
There is training in basic principles of mental health and self-care available to interpreters	
Family members are not used as interpreters	
Clinicians are allowed additional time for sessions where an interpreter is used	
Clinical contact expectations are reduced where work involves interpreters	
Interpreters are adequately prepared for the session before the appointment starts and have the opportunity for debriefing	
3. Improving engagement with service users and communities	
Workshops on mental health and accessing help are held with local BAME communities	
Participation groups involve stakeholders who reflect the ethnic composition of the population served	
Stakeholder groups include organisations that reflect the ethnic composition of communities served	
4. Workforce and staffing	
The clinical staff group broadly reflects that of the population served	
Where this is not the case, an action plan has been agreed to remedy this	
The action plan has sufficient input from senior staff to be effective	
The senior staff group includes a range of ethnic diversity that reflects the community served	
Where this is not the case, an action plan has been agreed	
BAME staff have the same access to CPD and career development as white staff	
BAME staff development is guided by the WRES	

6: References and resources

The references and resources section of the BABCP's IAPT BAME Positive Practice Guide will support further reading and the development of expertise across a range of domains.

Baker, C. (2018). Mental health statistics for England: Prevalence, services and funding. Briefing paper 6988. House of Commons Library.

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R. & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy*, 47(11), 910-920.

Clark, D. M. (2018). Realizing the mass public benefit of evidence-based psychological therapies: The IAPT program. *Annual Review of Clinical Psychology*, 14, 159-183.

Crawford, M. J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., ... & Parry, G. D. (2016). Patient experience of negative effects of psychological treatment: results of a national survey. *The British Journal of Psychiatry*, 208(3), 260-265.

Department of Health (2005). *Delivering Race Equality in Mental Health Care*. London: Department of Health

Equality Act (2010). London: HMSO

Mercer, L., Evans, L. J., Turton, R. & Beck, A. (2018). Psychological therapy in secondary mental health care: Access and outcomes by ethnic group. *Journal of Racial and Ethnic Health Disparities*, 1-8.

NHSE (2019). https://www.england.nhs.uk/2019/01/race-equality/

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