

# 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  
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## 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*

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# OVERVIEW OF THE GUIDE

## Section 1: Service-level changes to improve access

The first section looks at service-level changes that can make IAPT services more accessible to Black Asian and Minority Ethnic (BAME) communities.

This section is most relevant for IAPT service managers and clinical leads, commissioners and those in other leadership roles.

What are the key messages?

- Commissioners and service managers should develop a good understanding of their local community to properly ensure that their needs are met. Right Care packs are useful resources for this; there are local packs relating both to equalities and health inequalities, and to mental health.
- Commissioners and service managers should map the demographics of the community and compare this to the profile of those who currently use services to identify any communities who are not accessing the service at the levels that would be expected.
- Services should look at specific barriers to accessing services in their locality. Examples of this work are included in this section.

[Read this section](#)

## Section 2: Adapting therapy

This section looks at how therapies may need to be adapted to improve outcomes for BAME service users.

This section is most relevant for therapists and supervisors working in IAPT services.

What are the key messages?

- The therapist should take the values and spiritual perspectives of service users into account throughout treatment.
- Therapists should take a recovery based approach that fully incorporates the spiritual needs of the service user.
- Using a genogram that includes the migration histories of family members and a discussion about the degrees of acculturation of different people in families.
- Services should develop resources or directories of organisations that can offer support and advocacy which will improve engagement in treatment.
- Therapy should be provided via an interpreter when required.
- Services should consider adapted therapies developed specifically for particular communities by members of that community where necessary.

[Read this section](#)

## Section 3: Engagement with service users and communities

This section looks at how services need to engage with their local communities.

This section is relevant for service managers, therapists and commissioners.

What are the key messages?

- Services need to ensure that access rates for BAME communities are at the level which would be expected given the demographics of the population served.
- Where access rates for BAME communities are lower than expected, IAPT services may need to undertake outreach work to develop relationships with these communities and Voluntary and Community Social Enterprise (VCSE) organisations.
- Engagement could involve community steering groups, involving more people from BAME backgrounds in service user groups and providing workshops in community settings and places of worship.

[Read this section](#)

## Section 4: Workforce and staffing

This section looks at how services need to develop their workforce to support better access and outcomes for BAME communities.

This section is most relevant for service managers and commissioners.

What are the key messages?

- Services managers should develop a strong, shared ethos of valuing diversity, which is reflected in the thinking that underpins case discussions.
- The workforce should reflect the diversity of the communities served.
- That patient outcomes are improved when services address inequalities among BAME staff members.
- Service managers should ensure that BAME staff have equal opportunities for career progression as white majority staff.

[Read this section](#)

## Section 5: Audit tool

This section provides services with a simple audit tool for teams to complete. This tool is based on recommendations which have been developed during the writing of this guide.

This section is relevant for service managers, therapists and commissioners.

[Read this section](#)

## Section 6: References and resources

This guide represents a summary of the current literature on mental health and therapies in a cross-cultural context. It is hoped that staff will be encouraged to find out more about some of the issues raised in this guide. The references and resources section will guide staff to key information that has informed the writing of this guide.

[Read this section](#)

# INTRODUCTION: THE NEED FOR CULTURALLY ADAPTED AND CULTURALLY RESPONSIVE SERVICES

The Improving Access to Psychological Therapies (IAPT) programme has made unprecedented progress towards meeting the considerable unmet need for therapies for common mental health problems and the success of this programme is internationally recognised (Bartram 2019).

People from all communities have benefited from increased availability of 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, compared to white majority service users (Mercer et al. 2018, Crawford et al. 2016). This is despite decades of awareness-raising regarding the need to achieve equality of access and treatment outcomes (Department of Health 2005). These principles are clearly embedded in the Health and Social Care Act (2012) and the NHS Constitution (2012).

Recent data from the IAPT programme (Baker 2018) suggest that, compared to people from white 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)

While this is the case for the majority of service users from BAME communities, it is not generalizable to all communities. For example, the improvement and recovery rates for Chinese service users are better than those of white 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). While initial evaluations at IAPT sites suggested a lower uptake by BAME communities once people were engaged outcomes could be as good as those for white majority service users (Clark et al. 2009).

This *Positive Practice Guide* updates the principles of the 2009 guide and provides a framework for IAPT service managers, supervisors and clinicians to work towards better access and outcomes. The guidance draws on the current body of evidence around which factors determine equitable access and therapy outcomes for BAME communities in mental health settings. Recent data from IAPT (Clark et al. 2018) indicates that clinical outcomes for service users living in socio-economically deprived areas can be as good as those in more affluent areas if services are appropriately funded and deliver therapy in line with IAPT quality standards.

We believe that adopting these principles will likewise improve access and outcomes for BAME service users while, at the same time, support better staff retention and job satisfaction and contribute to the development of an engaged and motivated workforce.

## SECTION 1: SERVICE-LEVEL CHANGES TO IMPROVE ACCESS

### Reducing barriers to accessing services

People from all social backgrounds and communities face barriers to accessing the right sort of mental health support at the right time. There is well-established research literature, including data from IAPT services, that shows people from BAME communities are less likely than those from the white majority population to access the mental health support they need.

#### Summary: Changes that can increase BAME access to IAPT

Work with referrers to increase use of services

Continue to offer self-referral

Make sure there are other routes into services besides self-referral

Consider the literacy and language proficiency of service users

Make leaflets about how the service works available in community languages

Use the Internet, social media and community media to make people aware of the help available and how to access it

Be flexible around appointments and DNAs

Use initial telephone contact to check language abilities and preferences in terms of the gender and background of therapists

Keep people engaged when they are on waiting lists through telephone or letter contact

Offer as much choice as possible in terms of the time and place of appointments

Have a transparent and accessible process for receiving and making use of feedback from BAME service users

### The importance of GPs and other referrers

There is evidence suggesting that some referrers are less likely to refer BAME patients for psychological therapy (Beck 2005). Khan et al. (2019) have suggested that GPs are less likely to refer BAME service users for psychological therapies because of difficulties in communication, cultural differences in the way that mental health symptoms are presented, different explanatory models for distress being held by GPs and service users, cultural stereotypes that might lead to misdiagnosis, or beliefs that different treatment options may be preferred.

Where IAPT services identify that some communities are under-represented, it may be useful to bring this to the attention of potential referrers and discuss any concerns they have about referring people for psychological therapies.

As concerns about confidentiality are consistently identified as a barrier to engagement with mental health services amongst BAME communities, IAPT services may need to work with GPs and other referrers to look at how best to explain confidentiality and address any apprehensions that potential service users might have. It is likely to be more helpful if GPs provide service users with a choice as to whether they would like to be referred to IAPT by their GP or whether they

would like to make the referral themselves.

## **The value of self-referral to support equality of access**

Self-referral is one of several innovations that have contributed to the success of the IAPT programme. Self-referral was incorporated into the IAPT model when pilot data found that, while BAME communities were under-represented in GP referrals, the ethnic profile of self-referrals was representative of the community being served (Clark et al. 2009). Despite this, some BAME service users have identified self-referral as a potential barrier, and it is likely to be most helpful if service users are given a choice as to how they are referred to the IAPT service.

Some service users have expressed a preference for an online system to manage self-referral, first appointments and subsequent appointments. Many report that that online contact means that it is easier to overcome language barriers using translation apps.

## **Attending the first appointment**

When the reason for referral has not been adequately explained to the service user, there is increased risk that the first appointment will result in non-attendance. This is also more likely if there is a poor fit between the way that someone is conceptualizing the cause of their distress and the way that their referrer is describing the help that may be available.

Some people from BAME communities may see services as not understanding or reflecting their values and, where this is the case, people are also less likely to engage. There may be other concerns that translate into barriers to attending services, such as worries about confidentiality, concerns about accessing services when the immigration status is not clear, concerns that services will not understand the culturally specific concerns of the service user, and worries about the implications of being identified as having mental health problems.

In this context, it is critical that the service has a clear understanding of information-sharing principles and practices with regard to referrers and other relevant local stakeholders. In particular, local policy will need to be explicit about arrangements to secure consent to share information with GPs and other bodies, such as solicitors, the Department of Work and Pensions, housing agencies and the local authority. This will need to be consistently applied and explained to all IAPT service users.

Although there is limited research on gender issues and engagement with mental health services amongst BAME communities, anecdotally, there is a suggestion that men in some communities are less likely to access mental health support than women (Project Focus Group 2019), particularly if they are working long hours in low-paid jobs. This is likely to be further exacerbated if people are working in sectors where there is no provision for time off work to attend appointments.

Where gender-specific BAME projects have been developed, these have tended to focus on meeting the needs of women. Thus, it might be important for specific consideration to be given to the mental health needs of men in these communities too. However, services should continue to take account of needs relating specifically to sexual violence, abuse and exploitation where these particularly affect women, including some from BAME communities such as refugees and asylum seekers.

Some people from BAME backgrounds may be more likely to attend their first appointment if services are based in local and accessible community facilities, such as places of worship, neighbourhood community centres and the premises of targeted projects.

## Initial telephone contact, language proficiency and literacy

The English-language proficiency of service users will need to be assessed when initial contact is made. Referral forms should request information about language proficiency and literacy so that services understand the needs of BAME service users as early as possible in the engagement process. Members of staff who are proficient in the first language of the person to be contacted can be asked to contact them in the first instance. At this stage, service users can be asked if they have a preference for the gender or ethnic background of their therapist, with assurance given that these preferences will be met if possible. This can also be established during the first session.

It is important that services do not automatically refer BAME service users to BAME therapists. This locates the responsibility for work with BAME communities to BAME therapists when it is the responsibility of all staff to develop skills and competencies in this area. It also assumes that all BAME staff have the skills to work with all BAME service users irrespective of their mutual backgrounds.

Service users may not answer telephone calls where the number is withheld. Services need to ensure that an identifiable number is apparent on the telephone of the call recipient. Service users should be given a choice in terms of when they would like the telephone call to take place. This may be important when there are concerns about family members finding out about the referral to IAPT services. This may be of particular concern in some BAME communities.

## Waiting list management

After initial assessments, people may be placed on further waiting lists for higher-intensity interventions. Where there is a lack of clarity about how long the wait for services might be, or where the wait is longer than people were led to expect, there is an increased likelihood of people dropping out of services. BAME service users have asked for clearer information about waiting times and regular updates from IAPT services in terms of how long their wait is likely to be. These updates and contacts can be used to check for deterioration in mental health, which will increase a sense of engagement with the service and clearly communicate that services are concerned about the well-being of the person being contacted.

The *Improving Access to Psychological Therapies Manual* (2018) – hereafter referred to as the IAPT Manual – includes useful information about waiting list management, and these principles will be helpful for BAME communities accessing IAPT services.

Services should develop a network of BAME community projects they can work with, or connect with existing networks, so they can support social prescribing while people are on waiting lists or as part of therapy. It is important to ensure that these projects are a good fit for the goals, values and preferences of BAME service users. IAPT services may wish to consider funding specific social prescribing projects that are a good fit for the cultural background of service users where an unmet need is identified.

## Managing DNAs

Many services operate a policy of allowing one or two DNAs before someone is discharged back to the referrer. As some BAME service users may be less likely to attend a first appointment (Beck 2005), this policy could be seen as indirect discrimination.

Where possible, initial contact letters should be sent in English and the first language spoken or read by the service user. Where a service user is identified as belonging to a BAME community and not having engaged initially, services may need to make additional telephone contacts to ensure that there is a shared understanding about the referral and to address any concerns the service user may have.

There is some evidence of patient preference for a more flexible system for managing appointment times, duration and endings, which in turn seem to enhance engagement and user satisfaction; further, the online management of service use is likely to enhance this (Carey et al. 2010).

## Effectively communicating what IAPT can offer

*'I didn't know anything about mental health services. I was afraid of the services so I didn't seek help.'* – IAPT service user

Given the lower uptake of IAPT services by BAME communities, it is important that services work closely with referrers to ensure that rates of uptake are improved. This can be supported by community-language leaflets, online materials and social media, building partnerships with community organisations that already have trusted relationships with BAME people and by having therapists co-located with referring agencies in order to be able to meet with people who have been referred informally.

Many service users in our focus group identified a lack of understanding in BAME communities about how services might help them, even after they had been referred and assessed (Project Focus Groups 2019). There is clearly a need for greater clarity about these processes to be available in English and in community languages. There may be a need to explain mental health services to asylum seekers and refugees who may have a limited understanding of how health services in general and mental health services in particular work in England.

Given the increasing importance of self-referral and the likely increase in this regard following community engagement events, it will also be helpful if people who self-refer are given accurate information about what will be likely to happen next in terms of timelines, the frequency and duration of therapy, and expectations in terms of attendance and collaboration. This information could include an overview of what therapies are available, how confidentiality works in the service, whether there is a choice in terms of the gender and ethnicity of their therapist (and in which service locations this choice will be available), and whether interpreters are available.

General leaflets for the service should also include photographs of people from a range of ethnicities, genders, ages and backgrounds to ensure that there is genuine equality in communication about whom the service is there to help. Where this is the case it might be helpful to have these checked by a group with expertise in the culture and language group the leaflet is designed for. Ideally these people would also have some expertise in mental health.

Where regular face-to-face contact or co-location between referrers and IAPT services is not possible, good working relationships should be facilitated by telephone contact and discussions about referrals.

NHS England has developed useful standards regarding making information accessible to service users, including the consideration of disabilities as well as literacy and language needs (NHSE 2017) (NHSE Accessible Information Standards 2017).

## SECTION 2: ADAPTING THERAPY

### Engagement in therapy

Engagement in the assessment and treatment process needs to include clear communication that the service and the therapist understand and respect the need for cultural diversity. This may start with a waiting area that reflects the breadth of cultures in a particular locality, including information sheets and posters in community languages.

Therapists can enhance engagement by asking about the ethnic and cultural background of the service user with confidence (Beck 2016, Chapter 2). Therapists will need to be skilled in the application of culturally responsive principles in delivering therapy.

Engagement and improvement will also depend on factors such as having stable housing, sufficient income and access to meaningful study, training or employment. Services should develop resources or directories to signpost service users to the right organizations that can offer support and advocacy.

It is important that therapists work in a way that communicates a good level of competence in working across cultures as there is evidence that service user perceptions of therapist skills in this area has a positive impact on therapy outcomes (Soto et al 2018).

Where engagement has occurred, careful consideration should be given to decisions about referring service users onto stepped-up or stepped-down services. It can be difficult to re-establish trust in a new therapist. Where possible, services should ensure that the level of intervention is correct early on, based on the referral information from the GP (Project Focus Groups 2019).

### Culturally Adapted and Culturally Responsive therapies

Improving outcomes in therapy for BAME service users can be supported by developing culturally adapted or culturally responsive therapies. The difference between these two approaches is outlined below.

*Culturally adapted therapy* takes an existing therapy as a starting point and then specifically adapts the language, values, metaphors and techniques of that approach for a particular community. The adaptation and provision of this therapy is typically carried out by therapists who are members of that community. This ensures that the work is done by staff who have an inside knowledge of the language, values and beliefs of that community.

A good example of culturally adapted therapy is the work of Mir et al. (2015) who look at how to adapt Behavioural Activation for Muslim service users. This approach includes a thoughtful overview of how metaphors, language, spiritual practices and religious parables can be adapted to support values led behaviour change. It also offers thoughtful perspectives on how community expectations can shape the kind of choices services users might make in terms of valued activities to undertake to support recovery from depression.

Recently Hinton and Bui (2019) have summarised decades of work adapting CBT for service users from Cambodian backgrounds living in the United States. This work shows that considerable adaptation can be made to core CBT models provided the staff group includes members with extensive knowledge of that community and the resources to research the core cognitive and

behavioural mechanisms associated with anxiety and depression in that community. Their model of treatment is clearly build on CBT as all practitioners would understand it but includes considerable specific adaptation that takes into account beliefs, customs and practices that are grounded in culturally specific phenomena (such as health beliefs that are different to the Western model) and historical processes experienced by members of that community.

The work of Acarturk et al (2019) is another good example of work where CBT is adapted for a specific cultural group, in this case Turkish adolescents, by members of the Turkish community. This work incorporates adaptation based on an understanding of somatisation, metaphors and religious beliefs in this community increased the acceptability of this treatment model and allowed for a culturally specific adaptation of mindfulness based approaches to be developed.

*Culturally responsive therapies* may be more helpful for teams which do not reflect the ethnic composition of the communities served. The team values that are necessary to underpin culturally responsive work are found in **Section 3**, in the summary box entitled **Key values to support effective work across cultures**. This approach means that therapists are able to recognize and value diversity and draw on the support of team members and supervisors to make adaptations to evidence-based therapies, so that they will fit with the particular culture and context of the service user. A good example of a team embodying these values in the way that cases are discussed and therapy is provided can be found in d’Ardenne et al. (2005).

Hinton & Patel (2018) outline the key dimensions of what they call culturally sensitive work with refugee populations. This model provides a summary of the points to be considered when working across a variety of cultures and emphasises the need to consider the context of the service user, their particular circumstances and migration history and the degree to which they engage with culturally specific spiritual beliefs and practices around physical and mental health. Again, this model is a general one that can be adapted to work with any BAME community. This approach has the advantage of helping therapists adapt a particular therapy to the unique combination of values, beliefs and customs of each service user. Culturally responsive work does not assume a service user holds a particular set of values and practices based on their ethnicity. It enables the therapist to be flexible in terms of their understanding of BAME service users in a way that avoids assumptions and stereotypes, while recognizing differences at the same time. This approach is useful in areas with rapidly changing demographics, as it is responsive to new communities accessing services.

## Main differences between culturally adapted and culturally responsive CBT

	Culturally adapted CBT	Culturally responsive CBT
Developed for a specific population	Yes	No, generalizable
Delivered in community languages	Yes, generally	No, usually in English unless via an interpreter or bilingual therapist
Therapists of the same ethnic background as service users	Yes, generally	No, although they could be
Developed from existing evidence-based therapies	Yes	Yes
Takes values, beliefs and situation of service user into account	Yes	Yes
Flexible around different degrees of cultural identification, religious affiliation and identity	Yes, to some extent	Yes

These approaches are not mutually exclusive and services may well wish to develop a strand of culturally adapted therapies for particular communities, whilst also supporting therapists to develop a generally culturally responsive therapeutic style.

When social prescribing is used in culturally adapted and culturally responsive CBT, it is important that staff are confident that the projects that service users are signposted to are a good fit for their values and customs.

Further reading on the role of culture in therapy can be found in Burnham (2013) and Divac and Heaphy (2005). Both of these papers are written for systemic therapists, but contain frameworks and insights that are likely to be helpful to therapists from all backgrounds.

### **ROSHNI-2 Project for British South Asian Women with Postnatal Depression**

In the UK, postnatal depression (PND) is more common in British South Asian women than in majority white women, suggesting that ethnic and cultural differences are risk factors for developing PND. British South Asian women have higher birth rates compared to the majority white population. Previous research indicated that British South Asian women with depression may have difficulties with marital and other close relationships, housing and finance, lack social support and the resources to obtain assistance, are isolated and lack fluency in English. Isolation and lack of social support are therefore important elements to be addressed in interventions for depression in this population.

The ROSHNI-2 (meaning light in Urdu and Hindi) study is a multi-centre randomized controlled trial with four- and 12-month follow-up. The trial has been funded by the NIHR-HTA programme.

The culturally adapted group intervention is based on the principles of CBT and was developed following qualitative interviews with British South Asian mothers about the type of help they might want to access. The central adaptations made to the intervention were: language-specific translations of CBT terms, culturally appropriate assignments and homework, folk stories and examples with consideration given to religious beliefs, and understanding the ABC model using culturally appropriate stories.

The ROSHNI-2 study focuses on improving engagement with the family, self-esteem, social support and independent coping strategies. The emphasis is on keeping the programme culturally appropriate. This includes a family-centred recruitment pathway, ensuring that all study assessments and the delivery of the programme is available in the key South Asian languages (Urdu, Bengali, Gujarati, Punjabi, Hindi and Tamil), while also using stories to help service users understand situations and apply the principles of CBT, incorporate religious/spiritual activities; further, the provision of childcare and transport is also important.

Given the concerns about blame, labelling and stigma, the women expressed a preference for the programme to be called the Positive Health Programme (PHP). A major adaptation is an engagement protocol for mothers, fathers and extended family. To address stigma concerns, it is framed as an educational programme for building problem-solving and additional life skills, and people who attend are given certificates at the end of the intervention. The PHP involves 12 weekly sessions facilitated by a trained research therapist who leads the group. Regular supervision is provided by a senior CBT therapist and a senior psychiatrist. The sessions last approximately 60-90 minutes and involve group discussions, case scenarios, individual goal-setting and skills-based activities. The programme has been designed to be simple and pragmatic and can be delivered by an individual trained in basic mental health and CBT principles.

## Asking service users about their ethnic and religious background

The ethnicity of service users should be recorded in 100% of cases for administrative and service evaluation purposes. It is the responsibility of the clinical commissioning group (CCG) to ensure that this information is collected, recorded and submitted as part of the national reporting process in line with the Equalities Act (2010).

Asking about the background of service users also plays an important role in developing the therapeutic alliance and supporting better therapy outcomes.

There is some evidence that therapists are reluctant to ask about the ethnic background of service users in case such questioning impacts negatively on the therapeutic relationship by, for example, suggesting that the therapist is racist or culturally insensitive (Dogra et al. 2007). Therapeutic effectiveness can, in fact, be enhanced when this question is asked for several reasons, as doing so:

- is likely to have a positive effect on the therapeutic relationship by communicating a respectful interest in the background of the service user
- can provide a useful starting point for further discussions about background, family organization, migration histories and spirituality or religion
- provides an opportunity for therapists to acknowledge ethnic differences or similarities between themselves and the service user

Once discussions have begun about ethnicity, faith and culture, these can be elaborated as therapy progresses to develop a richer understanding of the degree to which culturally specific beliefs, practices and family processes could play a part in the presenting problem, or be assets and strengths that support recovery. Supervision is a good forum for therapists to think about how they can improve the way these factors are incorporated into therapy.

Therapists can explain to service users that they are being asked about their ethnic background because it is important for the service to know the ethnicity of who attends in order to ensure that members of all communities in the area are able to access mental health care. Service users should also be told that asking about their background enables their therapist to develop a better understanding of their beliefs and values in order to help them make the changes they have identified as being important to them.

### Using genograms in assessment and engagement

One useful way to begin to ask about the ethnic, migration and faith backgrounds of service users is to draw a genogram, also known as a family tree, as part of the assessment.

The therapist can begin by saying: *'Would it be okay if we drew out who is at home? It would really help me get to know you better and understand your situation.'*

This initial diagram can then be expanded to include other significant people in the family of the service user.

This can become the basis for more in-depth questions about where family members were born, migration histories, languages spoken at home, and degrees of acculturation and religious observance.

Care should be taken to ensure that the service user is comfortable with that detail of questioning and that the therapist only asks for as much information as is helpful in progressing engagement, formulation and therapeutic change.

## Working with refugees and asylum seekers

The countries of origin of asylum seekers will vary from year to year depending on patterns of political oppression, war and natural catastrophes. There are many reasons why someone might be seeking asylum. What these groups have in common is the experience of displacement, trauma and persecution. There is good evidence that there are higher rates of mental health problems amongst asylum seekers and refugees for PTSD, depression, psychosis and most anxiety disorders (Giacco and Priebe 2018).

In some areas, there are specific mental health projects to meet the needs of refugees and asylum seekers. People are increasingly housed in areas which do not have histories of receiving asylum seekers, so targeted mental health services have not been developed. These groups are likely to access mental health support through IAPT services. Some parts of England have recently been developed as resettlement areas for refugees and asylum seekers, meaning that there are likely to be considerable additional needs for specialist mental health provision in these areas. If a new resettlement area is being developed, CCGs will normally be aware of this and should plan accordingly with other partners, particularly the local authority.

As these recently arrived groups may not be aware of how to access mental health provision, it might be necessary to work with GPs or support groups to ensure that referrals are made where appropriate. Services should specifically record which service users are refugees and asylum seekers, so that access rates can be monitored. Successful work with these communities will be supported through existing networks of engagement with asylum-seeking populations, which can provide a strong foundation for developing further services.

### **An example of positive practice in engaging refugees and asylum seekers in IAPT**

Insight Healthcare IAPT in the East Midlands developed a pilot project to improve access for refugees and asylum seekers in IAPT.

The East Midlands is an area which has been chosen to assist in the resettlement of refugees and asylum seekers.

<http://www.emcouncils.gov.uk/Refugee-Resettlement>

Insight Healthcare has a strong commitment to improving access to psychological therapies to all BAME groups in the East Midlands, but in particular to refugees and asylum seekers. In order to do this, they developed a six-month joint working pilot project following a significant shortfall in the number of refugees and asylum seekers who lived in the region being referred to IAPT services.

In a joint effort with the IAPT service lead, clinical lead and a lead CBT therapist, a joint agreement was formulated with the service lead from the local primary refugee organization (Nottingham and Nottinghamshire Refugee Forum) to establish a transparent pathway for refugees and asylum seekers to access IAPT.

This innovative approach of multi-agency work involved placing the lead CBT therapist, for one day per week, in a project for refugees and asylum seekers. Their work included forging relationships with refugee forum staff and clients, assessing appropriate referrals, referring onto specialist services when required, and treating mild to moderate clinical presentations.

This project worked well and was supported by the leadership of both organizations.

Training was provided by the lead CBT therapist to professional interpreters employed by the refugee forum in order to provide an overview of IAPT and explain how mental health is

conceptualized the role of assessment and interpreting within the therapy process.

At the end of the six-month pilot, the project was evaluated, showing that there had been a clear increase in the numbers of referrals and self-referrals from refugees, asylum seekers and refugee staff to the IAPT team

Staff working with refugees and/or asylum seekers should receive additional training in, for example, understanding likely ways that distress is manifested following trauma and the role of dissociation in trauma.

Service users may well disclose experiences of torture or being trafficked, economically exploited, or subject to or at risk of female genital mutilation. This may be the first time that they have disclosed such information. When this occurs, therapists should consider obtaining the consent of the service user where appropriate to:

- ensure the full range of physical health needs are met
- work with the police to ensure patient safety, including liaising with adult safeguarding
- contact legal teams to ensure that they are fully aware of any additional information
- refer to specialist NHS or other services.

Where consent to break confidentiality has not been agreed, staff should use supervision and consult with safeguarding teams to establish whether the level of risk warrants breaking confidentiality against the wishes of the service user. Transparency about this process will help maintain the therapeutic relationship.

The psychological and social needs of this service user group are more likely to be complex than in those of the general population using IAPT services. It may be necessary to start engagement with stabilization work and provide support around meeting practical needs. This may require therapists to make links with and refer to organisations offering activity groups, faith based support, food banks, housing specialists and legal advocates.

Risk assessments for this group should include consideration of the risk of economic or sexual exploitation, as well as the impact of poverty and the lack of access to safe and stable housing.

Asylum seekers are usually unable to undertake paid employment whilst waiting for a decision regarding their refugee status. Asylum seekers often have a wealth of experience and skills that are underutilized. In our focus groups, several people said that they would value the opportunity to volunteer in IAPT services, in order to gain skills that would improve their employability once they have obtained refugee status, and to help others experiencing mental health problems. With the right support, volunteers could make helpful contributions to IAPT teams and, over time, join the mental health workforce, bringing valuable perspectives and skills with them.

*'Nothing works better for my mental health than to help others in the same situation. By helping them it helps me.'* – Asylum seeking IAPT service user

Therapists may find disclosure of some information overwhelming. Supervision can be a supportive place to reflect on the impact disclosures. Brooks (2019) has written a comprehensive overview to support the provision of good quality supervision in therapy work with refugees and asylum seekers.

## Summary of principles of working with refugees and asylum seekers

This group has higher rates of PTSD and other mental health problems compared to the general population

This group also has higher rates of psychosis and dissociative symptoms

This group may be struggling with ongoing trauma, due to racism, marginalization and uncertainty about the safety of family members and their own refugee status in England

Some refugees and asylum seekers may not want to discuss past trauma, but can still be helped by therapy approaches that focus on improving their current situation

Refugees and asylum seekers may have experienced multiple losses and traumas before arriving in England

Refugees and asylum seekers may benefit from referral to projects that support the development of practical and language skills, as well as social opportunities to overcome their isolation

Therapists may need to do more multi-agency work to support refugees and asylum seekers including working with their legal teams

Therapists might find hearing about traumatic experiences difficult and can experience vicarious trauma

Good supervision is essential in ensuring that the therapist is working as well as they can with people who are struggling with complicated and ongoing difficulties

## Working with interpreters

The need for interpreters within health settings is widely recognized as an important resource to ensure equality of access. Some BAME service users may not have sufficient language skills to make best use of therapies and other services. There are unique challenges in providing therapy through interpreters, and it is important that services have robust and considered approaches in this regard.

## Summary of useful principles when working with interpreters

That interpreters and service users are clear about the role of the interpreter in the session – this can be done by beginning the session with an explanation of the purpose of the appointment and the role that the interpreter will have

That confidentiality is explained to the service user by emphasizing that this will be respected by the interpreter as well

That service users are given the opportunity to request a different interpreter

That where possible the same interpreter is used throughout therapy

That the therapist checks that the interpreter is from a linguistic and ethnic group that is acceptable to the service user (for example, in case they are from an ethnic group that has been in recent conflict with the ethnic group of the service user)

That the gender of the interpreter is acceptable to the service user and a choice given regarding this, where possible

That where interpreters know service users from different contexts, there is clarity about their role in the session

That family members should not be used as interpreters

That therapists consider the well-being and support needs of interpreters

Services should have local arrangements in place with providers of interpreting services. Typically, these contracts are arranged at a regional level. Interpreters who are employed via these organizations will adhere to the National Register of Public Service Interpreters' Code of Professional Conduct. A link to this document can be found in the resources section. This code of conduct clarifies the responsibilities of the interpreter in terms of issues such as only undertaking work that they are competent to do, the need to be impartial, and the importance of maintaining standards of confidentiality. It also makes it clear that the role of the interpreter is to wholly translate what is said, not to offer summaries unless specifically requested to do so nor provide advice or express opinions to the service user.

The therapist should ask the service user whether the cultural group, language and dialect of the interpreter are appropriate, with alternative arrangements made as soon as possible where this is not the case.

Family members should not be used as interpreters as this may have a significant impact on the therapeutic work. It may also limit what the service user is able to discuss in the session, which is likely to lead to limited interaction as the family member will not have been trained to provide interpretation in a health setting. The Guidance for Commissioners: Interpreting and Translation Services in Primary Care (NHSE 2018) suggests that a friend or family member can be used in some circumstances and advises obtaining consent for this from the service user, independent of the proposed interpreter. Although this may sometimes be appropriate in a general health setting, the longer-term and specialized nature of therapeutic works means that this would not be a helpful arrangement in IAPT services.

Where therapists believe that a lengthy response from a service user has been summarized in such a way that some of the meaning is at risk of being lost, it can be helpful to ask the interpreter to repeat their exact response in order to check for this.

Therapists should ensure that their questions and statements are kept brief and clear in order to aid interpretation i.e., about specific processes (such as 'How is your sleep?', 'How much time per day do you spend worrying about the future?'), rather than 'How long have you been depressed?'.

The Code of Professional Practice recognizes that interpreters may sometimes need to clarify missed cultural references or inferences which may be important in understanding what is said.

An example of how interpreters and service users can be prepared for the session is given below. The space between the paragraphs is there to indicate where the therapist might pause to allow interpretation to take place.

*'Hello my name is Mille, I am the therapist you will be working with in the service. This is Layla. She is an interpreter who works with our service. Both of us will respect your confidentiality whilst you are working with us here. What this means is that anything you say to us remains private and will not be discussed with others without your permission.'*

*'Do you have any questions about how that will work?*

*'I will keep a record of our appointments and will write to your GP to let them know we have met.*

*'I will always check that you are happy with me sharing any other information with other organizations.*

*'The interpreter and I will not share information about what we have talked about today with people we know.*

*'We will not share information with other organizations that you want to keep confidential or private.*

*'The exception to this is if I am worried about your safety or the safety of others. Then I might need to talk to other people to make sure that you and other people are kept safe. I will let you know if I am going to do this and try to agree the safest and most helpful way to go about it.*

*'The interpreter is not here to give you advice or to help with your problem. Their job is to translate what I say, so that you can understand it, and then to translate what you say, so that I can understand you.*

*'Do you have any questions about this?*

*'Are you happy with this way of working together?*

*'If you would like a different interpreter, you are very welcome to request one. We will do our best to find someone else with the right language skills and background. If it is easier you can let me know outside of this appointment if that is the case. Otherwise, we will try to keep the same interpreter whilst we are working together.'*

It is particularly important that service managers appreciate the need for longer sessions when interpreters are being used and that job plans are modified accordingly. Typically, the session can be 50-100% longer when interpreters are being used. This increase in session length is clearly supported by the IAPT Manual (National Collaborating Centre for Mental Health 2018).

Where there are constraints regarding the length of time available, services should consider making it possible to offer additional sessions.

It is also possible that extended therapy sessions are demanding for the service user, interpreter and therapist. It might be useful to take a break after 50 minutes, as fatigue is likely to have a negative impact on the therapeutic process.

Where the therapist and interpreter are planning to meet after the appointment, the service user should be told about this. The rationale for this should be explained to them. An example explanation is provided below.

*'After our appointment has finished your interpreter and myself will meet for a few minutes. This is to give us a chance to check with one another about how our work together has gone.*

*'We will ask the advice of one another regarding how we can work more effectively as a team next time. Is there anything you would like us to think about when we do this?'*

It may be useful to develop a glossary of commonly used terms in the main community languages in an area. This glossary would be developed in conjunction with interpreters and mental health professionals in order to aid therapy processes by making the terms used clearer for all participants.

It is important for interpreters to have the opportunity to speak to the therapist before the session, in order to establish the expectations of their role, and after the session, in order to discuss the emotional impact of the therapy on the interpreter, as well as reflect on how the partnership worked and how the process might be improved.

Costa (2017) has written extensively in the need to train both therapists and interpreters in working together effectively in mental health settings. In particular they highlight the need to consider the inherent power imbalance in this working relationship and that therapists should take this into account when managing the therapeutic situation. The Resources section includes a link to additional written and video resources developed by Costa.

When a therapist works with someone via an interpreter, they have a responsibility to consider the well-being of both the service user and the interpreter, particularly where traumatic events are discussed. Interpreters should be protected from the impact of vicarious trauma. Post-session discussions, the use of interpreters trained in mental health and ongoing support can reduce this risk. During post-therapy discussions, interpreters should be offered the opportunity to access mental health support themselves where necessary.

Before taking on a piece of work, interpreters should be clearly informed that the service employing them specializes in mental health care and that traumatic topics may be discussed as an integral part of the treatment. Interpreters should have the opportunity to decline work on the basis of this information.

Where services find that they are using interpreters from one particular linguistic group, they should consider developing linguistically and culturally specific therapist posts or a bilingual co-worker post. Assistant Psychologist posts can also be developed with the aim of recruiting staff from particular ethnic or linguistic groups.

There is an excellent resource available online which provides full guidance for services about the use of interpreters in mental health settings (Tribe and Thompson 2008). This guidance has also been used as the basis for guidance specific to CBT (Beck 2016, Chapter 7). A recent paper by Tutani et al. (2018) looks at the advantages and challenges of work with interpreters in IAPT services and provides a thoughtful summary of these issues.

## **Working with BAME service users from faith backgrounds**

The degree to which religion, faith and spiritual beliefs shape someone's world varies as much within BAME communities as it does between them. Therapists can use the same principles of respectful enquiry that they use to ask about ethnic background in order to understand the importance of faith and spirituality in someone's life and to determine the degree to which these beliefs can be a resource to support recovery.

There is recent evidence from IAPT services that Muslim service users have markedly worse outcomes than white English and BAME service users from other religious backgrounds (Baker 2018). This may, in part, be explained by the fact that many Muslim communities are amongst the most economically disadvantaged in England (Citizens UK 2017), with poverty and economic marginalization in turn having a negative impact on recovery rates in IAPT.

Mir et al. (2015) have developed an excellent resource for culturally adapted Behaviour Activation for Muslim service users. There is a link to their manual, which includes resources in Urdu and Arabic, in the resources section at the end of this document. One advantage of this approach is that it provides a values-led approach to behavioural activation which recognizes that there is considerable variation in degrees of religious affiliation within Muslim communities and that religious practice varies between and within Muslim communities.

Caution should be exercised when initiating discussions about faith and observance with Muslim service users. Most members of Muslim communities will be aware of the Prevent programme and the statutory obligation imposed on health service staff to report service users who are at risk of radicalization. Although this programme was established to address radicalization in all religious and political groups, many Muslim communities believe they are unfairly targeted and may be wary of discussions about faith and observance in this context.

## **Working with service users who are also receiving support from community healers**

In some communities, the first line of treatment for mental health problems will be community healers, spiritual leaders and alternative health practitioners. Terms used for these practitioners vary considerably within and between communities, and their role and approach may be based within a religious, magical or alternative physical health framework (see, for example, Guruje et al. 2015 for further discussion).

Use of these practitioners may be because the cause of distress is conceived as being predominantly spiritual in nature (such as not being sufficiently observant in religious practice), or to have been caused by supernatural forces (such as ghosts or demons) or a culturally specific malign agent (such as poisoning). If someone believes the cause of their distress is one of these factors, it is likely that they will initially look to specialists in these areas for help.

GPs and mental health services may be approached for help once these avenues have been explored. Typically, service users do not disclose the use of community healers to therapists. This may be due to worries about being negatively judged or misunderstood for using these approaches. Once a relationship based on trust and regard has been established, it is legitimate to ask about this topic. Service users can be reassured that the therapist is respectful about their choices and understands that this is a legitimate practice within their community.

Community-specific approaches can be therapy-enhancing, neutral or therapy-interfering, and it can take a degree of expertise to determine which of these is the case. Community-based interventions may be financially, emotionally or physically abusive, although this only applies to a minority of cases. The usual safeguarding procedures should be followed where this is suspected. Therapists may not be familiar with practices discussed by service users. Where this is the case, it is reasonable to seek information from service users themselves, from interpreters and from chaplaincy services, or to ask professional colleagues who are from that community for cultural advice about a particular practice.

Cashwell (2018) provides a useful framework for thinking about these issues in supervision, and this forum is likely to be a useful place for therapists to consider when they need to alert adult or child safeguarding teams, as well as understand the way that therapy may need to be adapted following religiously or spiritually framed abuse.

## **Working with BAME service users who have experienced racism and discrimination**

There is compelling evidence to suggest that experiences of racism have a cumulative effect in terms of increasing the risk of someone developing a mental health problem (Wallace et al. 2016). Racism and discrimination can take the form of direct verbal or physical aggression, institutional racism such as unequal access to education or career opportunities, discrimination in terms of treatment by the criminal justice system, unequal access to resources such as housing, and what are referred to as micro-aggressions, that is, subtle and discriminatory social interactions.

Given that these experiences may be contributors to mental health problems, it is also likely to be helpful for therapists to develop a degree of sensitivity and confidence when asking service users about their experiences of racism and discrimination. Many BAME therapists report that this information is provided without asking, whilst white therapists generally report that this information is seldom offered, unless they ask about it specifically.

It may be difficult for therapists of any background to ask service users questions about racial discrimination. Hearing about discrimination can be uncomfortable, and it is an especially human quality to avoid topics that provoke strong and difficult emotional responses.

Therapists from BAME backgrounds are likely to have experienced both direct and indirect racism. Discussions about racism with service users might be particularly difficult for therapists from BAME backgrounds who have experienced racism themselves. Supervision should be a place where the impact of these disclosures can be discussed. If necessary, outside supervision from a BAME supervisor could be arranged if this makes managing the consequences of these discussions easier.

Questions about experiences of racism are important, but may need to wait until a good therapeutic relationship has been established. This will be facilitated by asking questions about the ethnic and religious background of the service user in a way that instils trust and confidence in the cross-cultural competence of the therapist. For further reading on this topic, see Beck (2016).

## **Working with lesbian, gay, bisexual and transgender service users from BAME backgrounds**

The number of people identifying as lesbian, gay, bisexual and transgender (LGBT) in BAME communities will vary. This is partly due to the fact that this framework is not necessarily applicable in all cultures and contexts in terms of understanding sexuality. It may also be linked to some communities providing less opportunity for the expression of sexualities that are outside a heterosexual context. An excellent overview of some of the issues relating to cross-cultural perspectives on sexualities and mental health can be found in Kalra and Bhugra (2010).

There is evidence to suggest that rates of some mental health problems are higher for people who identify as LGBT (Semlyen 2016). Overall, 3% of service users referred to IAPT identified as LGBT (Baker 2018). Recovery rates in IAPT for people who identify as LGBT are lower than those in people who identify as heterosexual (39% of people who identify as bisexual and 46% of people who identify as lesbian or gay, compared to 51% of people who identify as heterosexual, are classified as recovered following treatment).

When IAPT therapists ask about significant relationships, family composition and partners, it is

helpful to ask questions in a way that is open and does not assume heterosexual relationships. Therapists should also not assume heterosexual orientation on the basis of someone being in a heterosexual marriage. Leaving a degree of openness around assumptions provides an opportunity for thinking about other kinds of relationships that the service user may be in or wish to have.

There are several organizations providing excellent support and advocacy services to LGBT members of many BAME communities. Some of these are mentioned in the resources section at the end of this document. When signposting to LGBT support organizations, it is important to check with BAME service users whether they would prefer to access general or ethnically specialist LGBT support services where there is a choice.

## **Working with service users who are carers for others**

There is evidence to suggest that people in some BAME communities, particularly women, manage the considerable burden of additionally caring for others. This may be because community values emphasize that this is a valued and expected role, but also because support services have historically failed to meet the needs of many BAME groups. These carer roles can result in economic insecurity, less access to jobs and training, and difficulties prioritizing their own appointments above those of others (see, for example, Woodward 2018 for further reading on how this impacts on women in the British Pakistani community).

Where assessments in IAPT services identify service users with responsibilities for caring for others within the family, it is important that they are signposted to agencies that will be able to assess their needs for help and consider how these may impact on engagement in therapy. These may be statutory services, such as adult social care or third-sector organizations with expertise in supporting BAME families to apply for and access help.

## **Working within disorder-specific treatment protocols**

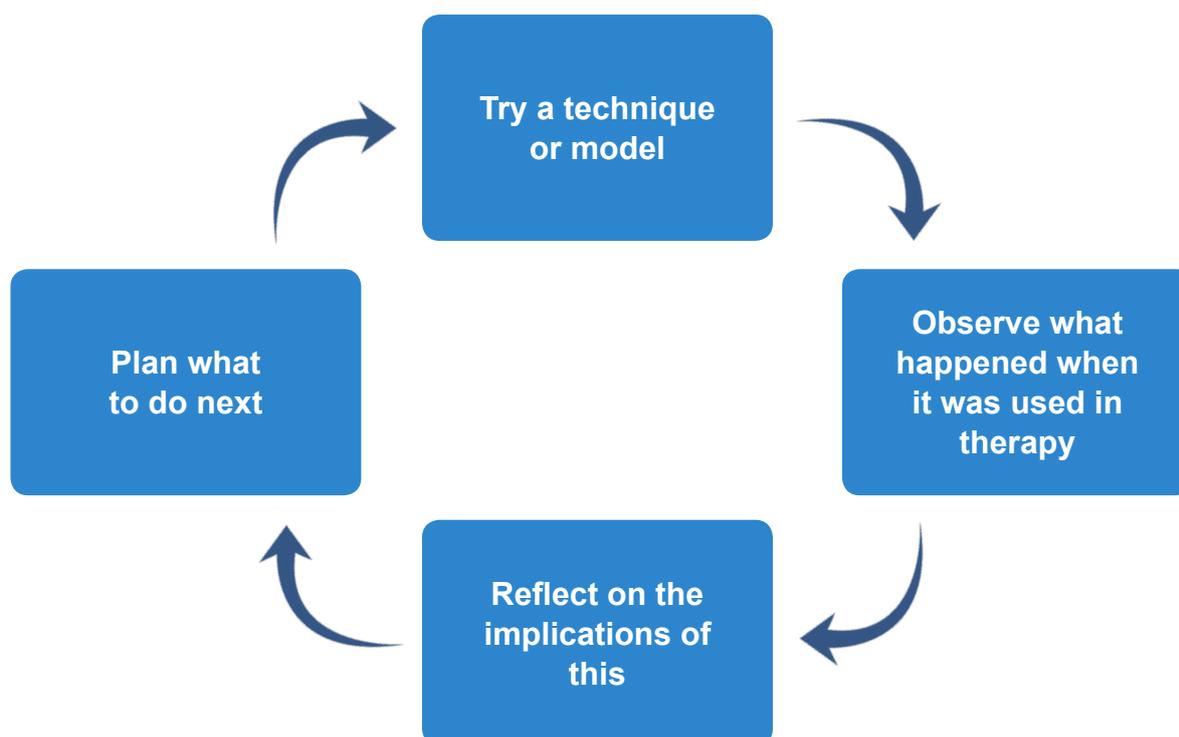
One of the cornerstones of much of the training and service provision in IAPT has been the development of evidence-based, disorder-specific treatments, which are in line with NICE guidance. These models of treatment are based on the identification of mental health problems in largely white communities in Europe and North America.

In recent years, research has begun to look at the degree to which these ways of identifying mental health problems and the treatment approaches used are meaningful in BAME communities in Europe and North America and in populations outside of these geographical areas.

Therapists should be prepared to use a flexible approach when using treatment protocols in working across cultures and to have realistic expectations regarding the possible limits of applying mental health models developed for one culture to another. The service user and therapist should work collaboratively to find out what aspects of the model are helpful for the service user at that time.

Therapists will be familiar with the Kolb learning cycle (Kolb 1983), which can be a useful framework to share with service users whilst collaboratively understanding what aspects of disorder-specific treatments are helpful.

Figure 1: The Kolb cycle



This model can be used when applying disorder-specific approaches in IAPT among BAME service users. The therapist can try a particular approach and observe what happens when this model is used. If this appears to be helpful, then they can reflect, with the service user and later with their supervisor, on what to do next to build on this success and plan accordingly. If it is not successful, they can reflect on this with the service user and their supervisor and plan what alternative approach might be helpful.

## Using routine outcome measures across cultures

One important cornerstone of the IAPT programme is the use of sessional routine outcome measures (ROMS). The use of these measures has been essential in demonstrating the effectiveness of services and supporting service improvement. Services are obliged to report on the outcomes of service users as part of their contracts. ROMS can also be an important part of reflecting on and measuring change as part of therapy, and their effective use can enhance engagement and outcomes for service users.

Not all ROMS used in IAPT services have been tested for reliability and validity for all of the BAME communities who use services. This means that staff should be cautious when using ROMS across cultures. They may not be as accurate a measure of distress and change for some BAME communities as they are for white majority service users.

There is, however, a substantial body of research looking at the reliability and validity of the main IAPT measures in many communities. For example, the PHQ-9 has been found to have good reliability and validity in East Africa (Gelaya et al. 2013), India (Kochlar et al. 2007), Pakistan (Gholizadeh et al. 2017) and China (Chen et al. 2010). Similarly, the GAD-7 has been found to be reliable and valid for Malaysian samples (Sidik et al. 2012), Spanish-speaking populations (Garcia-Campayo et al. 2010) and Arabic-speaking populations (Sawaya et al. 2016).

Scoring above or below a certain cut-off point on a measure should not be used as a reason to deny a BAME service user therapy a particular service. Clinical judgement and patient choice are likely to be much more useful as aids when deciding which treatment pathway is best.

It is important for therapists to explain the use of outcome measures to BAME service users and check that the levels of distress they indicate reflect the subjective experiences of the service user.

There will be times when interpreters are used to complete ROMS. The reliability and validity of the measures are likely to be much lower when this happens. Translated versions of some measures are available, which have also been assessed for reliability and validity in some languages. These translated versions should be used where possible. A useful summary of the considerable challenges in translating measures can be found in Flaherty et al. (1988).

## Completing risk assessments

A thorough risk assessment is a cornerstone of effective working in IAPT services. All therapists have a good understanding of the need to assess risk to self and others as part of therapeutic work. The same principles of risk assessment should apply when working with BAME service users, but some additional considerations are likely to be helpful.

Some BAME communities have taboos about suicide which could make the disclosure of suicidal thoughts more difficult. It may also be the case that the service user's appraisal of those thoughts is more catastrophic (for example, 'I am going to be punished by God and go to hell for having these thoughts'), thus leading to even greater risk and distress (Service User Focus Group 2019).

When asking about these topics, therapists should acknowledge that it can sometimes be difficult to disclose these thoughts, re-emphasize the confidential nature of the service, and use the warmth and positive regard, which is the basis of all therapies, to explain that these questions are being asked in a non-judgemental way. It can also be helpful to normalize these thoughts with service users.

Risk assessments of service users from BAME backgrounds should include whether they are subject to racial discrimination and racial harassment. When this is the case escalation to the police or adult social care should be considered in collaboration with the service user and Trust safeguarding teams.

## Importance of supervision in cross-cultural work

Good-quality supervision is an important part of ensuring the provision of high-quality therapy (IAPT Manual, National Collaborating Centre for Mental Health 2018). The IAPT Manual is clear about the benefits of supervision in services, and there may be an increased need for this where therapists are working across cultures and trying new approaches to treatment.

The core skills needed to supervise cross-cultural work are those that supervisors will have already developed and cultivated as therapists and supervisors. These skills include working collaboratively, formulating the problem clearly, using Socratic methods to encourage the therapist to think about issues and develop their own solutions, and understanding the current level of expertise on the part of the therapist, as well as the degree to which they can develop skills at that point in their development as a therapist.

Supervisors also need to be aware of the understandable tendency in all of us to avoid topics that make us uncomfortable or anxious. Therapists who are new to cross-cultural work might be reluctant to introduce topics concerned with ethnicity and diversity during supervision in case they get things wrong and are perceived as culturally insensitive or even racist. This is less likely to happen in teams where there is a culture of diversity that is valued and where staff are used to supporting one another in discussions about the challenges this work can bring. These reflections can be facilitated by viewing recordings of therapy in supervision. This is a key part of the supervisory process in most IAPT training courses and services.

Supervisors might benefit from accessing a peer discussion group about supervising across cultures, using their own supervision to reflect on these issues, or attending specific training workshops about supervising across cultures. Supervising cross-cultural therapy is considered in further depth in Patel (2004) and specifically relating to CBT in Beck (2016, Chapter 10).

### **Summary of good practice in supervision**

Supervisors do not need to be experts in cross-cultural CBT to provide good enough supervision in this area

Core supervisory skills in Socratic Dialogues, supportive challenges and shared curiosity can help therapists improve practice

Supervisors can prompt discussions about ethnicity and culture where these are not prioritized by the therapist

A good supervisory relationship will facilitate discussions that may at first seem risky or difficult

## SECTION 3: ENGAGEMENT WITH SERVICE USERS AND COMMUNITIES

*'You will not get to know us if we do not get to know you.'* – IAPT service user

### Understanding local communities

Effective work with BAME populations must start with commissioners and IAPT providers understanding the communities they serve. Right Care packs are useful resources for this; there are local packs relating both to equalities and health inequalities, and to mental health. Joint Strategic Needs analysis and census data can be a good starting point; however, commissioners and providers should also use the expertise of local public health departments or the local authority in order to develop an accurate picture of the ethnic composition of the area they serve.

#### Summary: Engaging communities

This is particularly important where particular communities are not accessing IAPT services

Staff from those communities and third-sector colleagues may have ideas about how to start this work

It may take time to build good alliances and trust

Religious organizations can be important links. Secular organizations are also important as not all members of communities are religiously affiliated

It is important to hear from a variety of voices within communities in terms of age, gender, sexuality and religious affiliation

Steering groups should also include white members of staff

Outreach work can use a variety of community organizations, media and formats

The steering group needs to include some senior members of staff

Service steering groups can be community-specific or represent all communities

Different areas may need to use different criteria for describing the ethnicity of the communities they serve. For example, in an area with a large South Asian community, it might be helpful to distinguish between people who identify as being from different regions in order to meaningfully understand patterns of service use (for example, distinguishing between those who identify as Pakistani and those who identify as Kashmiri). In areas with small BAME communities, it might be more helpful to collapse ethnic categories (for example, considering Black African communities rather than each nationality).

Once a clear picture has been achieved, the ethnic composition of referrals to the service and of attendance rates can be compared with these figures. This can be an invaluable way of establishing which, if any, communities are under-represented in the service, information which should form the basis of an action plan to ensure equality of access.

One barrier to this process may be that the ethnicity of existing service users is not accurately collected by services as part of the IAPT data set. An audit of ethnicity on the service information

recording system can be quickly undertaken to establish whether this is the case. Managers can then work with staff to identify barriers to this being asked and recorded. Once subsequent changes have been made, the recording of ethnicity can be re-audited to ensure service improvement. CCGs could also play an important role in ensuring that ethnicity data are appropriately recorded and submitted as part of the national data set.

## **The role of commissioners in ensuring that services prioritize equality of access and outcomes**

There has been over three decades of research, recommendations and legislation highlighting the need for mental health services to provide equality of access and outcomes for BAME communities. At times, when services are working at capacity or struggling to meet demand, it can be difficult to ensure resources are available to meet the diverse needs of the communities being served and to prioritise the work needed to ensure this.

Commissioners have a vital role to play in holding services to account and ensuring that contracts specify expectations around BAME mental health, that resources for outreach work, interpreters and training are identified, and that services are accountable, so that this work is delivered to a good standard as part of routine contract oversight.

There are excellent resources available for commissioners to support the process of establishing robust service specifications and monitoring (Joint Commissioning Panel for Mental Health 2014). Without active Commissioner involvement, it is unlikely that services will meet their obligations to BAME communities.

### **Touchstone: An example of positive practice in engaging BAME communities in Leeds**

Touchstone is a third-sector organization that specializes in direct therapeutic work with people from BAME communities. When Touchstone joined the Leeds IAPT consortium, only a small percentage of referrals were from BAME backgrounds. Within one year of involvement, this percentage rose to 15%. They were successful in recruiting a diverse team of clinicians and, as they have grown, have retained a team that is 50% BAME.

Touchstone developed an actively managed direct referral line, which works alongside the main referral route to Leeds IAPT. Whilst this referral route is not solely for BAME referrals, the majority of referrals to Touchstone IAPT each year have been from BAME communities.

Currently 20% of all referrals to Leeds IAPT are from BAME communities, and this is largely due to the success of Touchstone. Clinics are held in areas with large BAME populations, with virtually all the clinics placed in community venues.

The direct referral pathway has also increased the level of engagement among specific disadvantaged groups, such as asylum seekers (20% of all direct referrals in 2018) and people who do not speak English (25% in 2018). Touchstone have also had co-located clinics alongside the direct referral route, such as their Step 2 and 3 clinics at the Leeds Jewish Welfare Board.

The team has regularly offered a range of whole-team and individual training to support work with BAME communities over the years, with protected monthly peer CPD time to allow training to be cascaded. Specific projects have evolved out of some of this training, related to providing quality care to clients from BAME Communities, such as depression recovery groups delivered in the Leeds Grand Mosque and a stabilization pilot for asylum seekers with complex PTSD.

### *Stabilization pilot*

The team received specialist training delivered by a local refugee and asylum seeker therapy service who deliver trauma-focused therapy to refugees and asylum seekers. The team then developed a model where clients were prepared for trauma-focused therapy in secondary care by delivering a 'stabilization' phase in IAPT. The model included preparation sessions with a CBT therapist, followed by Step 2 skills work, either using a group-based format or in a one-to-one setting where interpreters were needed. Service users then received further sessions with a Step 3 therapist to decide whether they should be referred for specialist trauma-focused therapy run by the psychology service to directly address the trauma.

An eight-week consolidation period was agreed for clients involved in this pilot. Sixty asylum seekers were treated within this pilot, with 21 leaving treatment before completing the skills work. Of those who completed with Touchstone IAPT, 10 reached recovery and 18 more saw reliable improvement, while 13 were referred onto community mental health/psychology services. The pilot has now ended and will be evaluated when the 13 clients complete their Stage 2 trauma treatment with the psychology service.

### *Adapted behavioural activation interventions for Muslim communities*

In 2017, the team started to deliver the first evidence-based, adapted intervention within its service for clients from ethnic minorities and religious backgrounds. This was an adaptation of the behavioural activation for Muslim communities model, as developed by Ghazala Mir at Leeds University. The team profiled the adapted interventions in a number of ways. Interviews on BBC Radio Leeds and Muslim community television highlighted the use of this adapted therapy. The team then adapted the Leeds IAPT depression recovery course to include the faith-based adaptations and delivered three cohorts of the six-week Step 2 class in the Leeds Grand Mosque.

### *Diversity audit*

IAPT recruitment has been challenged locally by carrying out an audit of the ethnic diversity of staff currently delivering the Leeds IAPT service. The resulting Diversity and Inclusion Working Group led by Touchstone IAPT has agreed some relatively minor changes to recruitment practices, which have already borne fruit in terms of both an increase in job applications from BAME communities and the proportion of BAME staff shortlisted and appointed. More applications from staff from BAME communities has been encouraged by providing training on identifying unconscious biases on the part of recruiters and running mentoring sessions to prospective trainee PWP and CBT candidates at the application stage to improve interview skills.

## **Who should IAPT services engage with?**

Direct work with patients, public and service user groups will improve relationships and outcomes, and NHS commissioners and providers have statutory responsibilities to ensure that engagement takes place (Health and Social Care Act 2012; NHS England 2017). Commissioners should note that their statutory responsibilities to involve patients and public cannot be delegated, and that they retain a responsibility to ensure engagement takes place where services are commissioned (NHS England 2017 – Statutory Guidance). NHS England has a range of statutory and non-statutory guidance and resources available on their online Involvement Hub, including specific resources for working with BAME communities.

Links with religious organizations can be a good basis for community engagement work. These are likely to be productive relationships, and there are many good examples of where this has worked. Chaplaincy teams in NHS Trusts can be productive resources to support making these links.

If this is the only route into a community, it may be that many members of the community who are not religiously affiliated are not reached. Religious organizations may also under-represent women, younger people and LGBT members of communities, so it is important that secular organizations are also brought into this process. These can include youth groups, political organizations, cultural organizations and third-sector organizations working with LGBT members of those communities.

In many colleges and universities, there are student societies and welfare organizations with good links to specific BAME communities. IAPT services can make links with these organizations in order to develop good working relationships and raise awareness of services that are available.

If communities are identified as being under-represented, there is likely to be a need for engagement work with referrers in order to understand any barriers to referral and engagement that they might be aware of.

IAPT providers should work with VCSE organisations which are in contact with these communities and likely to have an established relationship of trust and credibility. These organizations can act as a bridge between services and communities and help services to improve the level of reciprocal understanding in order to facilitate engagement.

Outreach work can include direct work with communities to raise awareness of mental health problems and the support that is available. This can include engaging with community radio stations, print publications and online or social media resources as well as attending community festivals and events. Within many communities, there are already existing initiatives around mental health, and it is likely to be more effective if IAPT services contribute to and work alongside these, as they will already have established credibility and possess a good sense of what is likely to be effective.

There may be differences in the degree to which communities are accessible to IAPT services. Some communities have very visible and active representative groups, while others, especially more marginalized and newly arrived groups, are less likely to have community leads who are readily amenable to joint work with mental health services.

Further examples of how this work can be done can be found in Beck and Naz (2019), who specifically look at engagement work with South Asian communities.

### **Creative ways of working with BAME communities to improve access**

#### *Drama*

The BAME Working Group at the Pennine Care Healthy Minds service performed an award-winning play in Urdu and English for various audiences including BAME and white working-class communities. The aim of the play was to initiate a dialogue with communities in the Borough of Rochdale about depression, the impact it can have on people's lives and how their local IAPT service could help.

The play itself was about a young Muslim man who returned from university to live with his family once more after the death of his father. The play touched on sensitive issues of loss, the impact on the family network, suicidal ideation and drug use in a way that was acceptable to local communities because the play had been developed by people from those same communities.

The play was well received and improved access rates of BAME communities in that particular service.

### *Community radio*

Some IAPT services in Lancashire have used local radio stations to discuss mental health, promote their local IAPT services. These radio stations are often well established in local communities and have regular shows where health issues are discussed. Stations sometimes broadcast in community languages or in both English and community languages, making them widely accessible.

Some communities may have specific short-term radio stations (such as Ramadan Radio in East London) which broadcast both spiritual and lifestyle shows for a specific period. These can be excellent platforms to communicate with the wider community. Some radio stations predominantly broadcast music, but may have opportunities for mental health staff to appear as guests on shows and talk about what IAPT services can offer.

### *Outreach at conferences*

As part of the BABCP 2018 Annual Conference in Glasgow, a CBT therapist co-facilitated a workshop with an Islamic scholar and a psychiatrist. The workshop was titled 'Coping with stress and anxiety: A practical approach from a psychological and spiritual perspective'. A video of this workshop has since been made available on YouTube. It can be viewed here: <https://www.youtube.com/watch?v=7i4l8AgIO30>

A podcast of this event is also available on the BABCP website.

### *Social media*

Using different social media platforms is a powerful means to engage with BAME communities. Facebook and Twitter may be good places to begin a dialogue with members of some BAME communities.

## **BAME community steering groups and forums**

It may be helpful to establish a community steering group to guide the process of engagement. This could involve professionals from other agencies who are from the communities in question, third-sector staff, service users and other members of the public. This steering group could be specific to one community or represent several communities.

Forums and steering groups should reflect the ethnic profile of the local population, wherever possible. Including staff from white majority backgrounds can be an excellent forum for those staff to directly hear the voices of minority community members and develop an understanding of and relationship with their respective communities. Service leads may need to be proactive in encouraging staff engagement with these meetings.

The group should include staff with enough seniority to ensure that suggestions or decisions made by this group can be communicated to decision-making boards with the authority to enact change or account for why change has not taken place.

In most cases, it will be appropriate to pay expenses and/or make a payment for involvement to service user representatives on steering groups and forum members. NHS England has a 'payment for participation' policy, which NHS England staff must follow, and other organisations may like to replicate.

## SECTION 4: WORKFORCE AND STAFFING

### Service-wide values to support work with BAME communities

Cross cultural work needs to be supported by a values-led culture in services. D'Ardenne et al. (2011) have outlined what these values might look like within a team, these are summarized below.

#### Key values to support effective work across cultures

A staff team that is itself diverse

A staff team that works to develop knowledge about the local communities it serves

A staff team that has a curiosity about and respect for the cultures it serves

A staff team that acknowledges the value of non-Western approaches to understanding mental health problems

A staff team that prioritizes thinking about diversity in staff meetings

A staff team that values reflective practice around working with diverse communities

A system that checks the preferred language of the assessment before this takes place

A staff team that values the role of interpreters and works to support them in their roles

A team that ensures that service user preferences for the gender and ethnicity of their therapist is taken into account wherever possible

A team which places a high value on respect for and curiosity about all new cultures

Support for these values should come from senior members of staff, including managers and supervisors; however, the values should be embraced by all members of staff. Teams with a strong shared ethos and vision are likely to be more effective. Recruitment of new staff should include ensuring that they have a demonstrable commitment to working with equality and diversity.

Existing staff should be supported to access training around working with diversity, while job plans should include some degree of community outreach for most team members. These initiatives will support staff from all backgrounds in developing confidence and competence in working flexibly with evidence-based therapy models in order to adapt them to the specific needs of the communities served.

Often, in services, the expertise needed for working with diversity and across cultures is assumed to be held by staff from BAME backgrounds. Making BAME staff the leads on diversity issues also means that they are less likely to be able to take on leadership roles around other issues of service development or therapy specialties, thus restricting their career development in other areas. Lastly, this can signal to other members of staff that diversity issues are not a priority for them.

Care should be taken to ensure that services do more than just nominate diversity champions; responsibility for working in a culturally responsive and effective way should be held by everyone in the team if it is to be effective. A team which prioritizes cross-cultural thinking and community engagement will find itself managing more referrals, as more people from BAME communities will choose to engage in therapy and achieve better outcomes.

## Developing BAME-specific services and teams

Developing a team dedicated to working with specific communities or even all BAME groups enables teams to foster a high level of specific skills and adapted interventions. These teams typically have a staff group that is more ethnically diverse than generalist teams. They can also more readily develop a team culture and expertise that supports work with diverse communities. This work might include the provision of therapy or group interventions in languages other than English. There are many good examples of teams that have developed along these lines in the NHS.

One potential drawback of BAME specialist teams is that working with BAME communities becomes an activity that the wider IAPT service does not need to engage with. Staff may also believe that this work needs an unattainable level of skill or adaptation. This can lead to staff viewing this work as beyond their skill set, outside of their remit and something they do not need to develop specific competences in. The experience of Touchstone, however, suggests that these skills and competences can be cascaded to the wider service if support exists at senior levels.

Commissioners should ensure that, wherever possible, BAME specific services have equitable levels of funding, continuity and sustainability as general IAPT services.

IAPT teams with specific remits to work with BAME communities are likely to become important centres of expertise in terms of community links and cross-cultural therapeutic work. These teams should be encouraged to disseminate their expertise across the wider IAPT service through publications, training, supervision and consultation. Recognizing the expertise of these teams is an effective way of improving staff engagement and providing opportunities for role development.

### Key points in developing and supporting staff

It is important to invest in staff training to improve access and outcomes for BAME communities

IAPT services need to develop a more ethnically diverse workforce to reflect the population served

This may need targeted projects to identify and recruit BAME staff

BAME staff are under-represented at senior levels, training and mentorship programmes should be used to address this

BAME are more likely to be subject to disciplinary procedures. Services need to ensure that this does not occur due to direct or indirect discrimination

## Staff training needs

Managers should invest in training for staff to support work with diverse communities. This might include training on work with specific groups or attending conferences where diversity issues were considered as a part of keynotes or symposia. This will encourage specific staff to develop particular areas of expertise. Any additional training should be supported through further consideration of these issues in supervision to embed this training in practice.

Supervisors are also in a unique position to be able to comment on the training needs of therapists, as they will have a good sense of areas where staff under their supervision are struggling and be able to suggest topics for whole-team or individual training. Staff should have their training needs

considered as part of the appraisal process.

Naz et al. (2019) have provided a useful framework for services to use in terms of planning and thinking about service-level training. This framework recognizes that training which directly addresses inequality and racism can sometimes be difficult for staff from a white background to engage with, as well as suggesting helpful ways for this to be constructively thought about in teams.

## Supporting and developing BAME staff in IAPT services

The 2015 IAPT workforce census showed that 83% of this workforce were white British, 8% were Asian or British Asian, and 4% were Black, including those from Black British and Black African backgrounds (NHS England 2015). Census data from that period show that 79% of the population were White British, suggesting that this group is over-represented in the workforce by 4% and that BAME staff are under-represented by the same amount.

There is compelling evidence that, across the NHS, BAME staff are less likely to benefit from the same opportunities for career progression as white majority staff (Kline 2015). BAME staff are less likely to access training that supports career progression and less likely to apply for or be appointed to senior positions within organizations. BAME staff are less likely to be involved in key decision-making processes and so the insights that they may provide about service improvement are less likely to be heard and acted upon. This situation is unlikely to have developed through systematic or direct discrimination and more likely to be a result of biases and assumptions in the way in which senior staff think about workforce development.

The NHS Workforce Race Equality Standard (WRES 2014) sets out clear guidelines for how services should monitor and address inequalities in the BAME workforce both in terms of access to career development and the seniority of positions held. There is compelling evidence that service user outcomes are improved across the board when services genuinely commit to and invest in equality within their staff teams.

Managers should review access to further training and CPD. This should include access to supervision and leadership training to prepare people for senior positions. Where this access is clearly unequal, it may be necessary to specifically work to increase the training opportunities for the BAME workforce. These initiatives could include coaching and mentoring programmes within wider organizations or supporting access to courses on leadership and service development programmes.

It might be necessary for teams to develop community specific training posts to diversify the workforce and provide opportunities for BAME staff to achieve career progression. These targeted posts are generally acceptable under current employment legislation and can help overcome initial barriers around entering the IAPT workforce, which some BAME candidates face.

Where areas serve diverse populations, interview panels should include at least one BAME staff member and a service user from one of the BAME communities in the locality. Service users should be paid for their time when contributing to these panels.

This additional support should also include careful consideration of the increased likelihood that BAME staff will experience bullying at work (Kline 2015), some of which could be the result of direct discrimination. There is also an increased likelihood that BAME IAPT staff will experience racist responses from services users, and there is a growing recognition of the need for services to respond robustly to this (Nagpaul 2018).

There is compelling evidence that BAME staff are more likely to enter disciplinary proceedings and experience more severe consequences as a result of these proceedings. In these circumstances, it is important for service managers to ask themselves about whether some degree of bias might have impacted on the decision to proceed with this disciplinary process. These biases are less likely to occur where senior staff groups are more ethnically diverse.

Services sometimes involve current and past service users in steering groups or co-facilitating therapy groups. The Incredible Years parenting programme has developed an excellent model of training and employing parents who have completed the group programme as co-facilitators. Some facilitators go onto further training and develop full-time careers in this field. IAPT services could view the development of peer-led groups and programmes as a way of identifying the next generation of skilled and committed therapists and developing a more diverse workforce. Where IAPT services run group-based interventions, BAME service users or other active community members can be trained to co-facilitate these groups. This model of co-facilitation is a productive means to ensure that the content of groups meets the needs of diverse communities. BAME service users who have completed individual therapy can be asked if they would like to be involved with this activity.

Hakim et al. (2019) have described the training journey of BAME staff who moved from community mental health worker roles into PWP roles. They discuss how access to training as therapists enhanced their clinical roles and improved the quality of services available to the BAME communities served by the teams. Based on this work, IAPT services should make links with BAME-specific services in their locality and look to recruit trainees from those staff who are interested in developing their skills as therapists.

It might be a good idea for IAPT services to set up a pool of service users from different local communities, whom they can employ on a sessional basis to help facilitate these groups. IAPT services can also offer training opportunities to these former service users or members of the local BAME community who are involved in related work. In the long term, this is also likely to help develop the BAME workforce.

## **Supporting continual improvement through feedback from BAME service users**

Services will benefit from a culture of continued improvement by accessing and acting on feedback from service users of all backgrounds. Even where it is collected, service user feedback is often under-utilized or not used at all, and there are considerable organizational challenges to making best use of this valuable information (Flott et al. 2017). As the IAPT Manual (2018) is clear that the Patient Experience Questionnaire should be used to collect information on service user satisfaction with services, this should be issued in the first instance.

All service users should also be aware of the NHS complaints system. It may be particularly difficult for BAME service users to give feedback because of language barriers, a lack of familiarity with the NHS feedback and complaint systems, or cultural differences relating to whether it is acceptable to complain to those seen to be in positions of authority. Services committed to quality improvement may need to take additional steps to ensure that the views of BAME service users are heard and that these views are used as a basis for change.

## Conclusion

Developing IAPT services that are culturally responsive and meet the needs of the diverse communities they serve is a complex undertaking. It involves improving staff access to training and supervision, improving the ways that information is collected and understood, ensuring that the workforce itself is diverse and developing BAME staff so that they can take up senior positions. Staff may need more time to work with interpreters or time for community work, which takes away from direct clinical work. This may mean a reduction in face-to-face contacts for some staff at times.

The benefits from this work are considerable. A staff group that is supported and empowered to work in flexible and responsive ways is likely to have a greater sense of job satisfaction and engagement. Communities that are involved with service development will have better mental health, be more engaged with education and employment opportunities, and make better use of the services on offer.

A service-wide approach to improving access and outcomes is possible. There are many initiatives in IAPT that have shown impressive improvements. Learning from these and incorporating good practice into all services will ensure that national rates of access and recovery are the same for BAME and white service users and that all communities can benefit from better mental health.

## SECTION 5: AUDIT TOOL

The purpose of this tool is to establish the degree to which services are culturally responsive. It is intended to support IAPT services in improving the work they do with BAME communities.

This tool will be most effective if it is discussed with staff, BAME service user representatives and community organizations 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?
<b>1. Improving access</b>	
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	

<b>2. Adapting therapy</b>	
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	
<b>3. Improving engagement with service users and communities</b>	
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	
<b>4. Workforce and staffing</b>	
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	

## SECTION 6: RESOURCES AND REFERENCES

### Section 1: Service-level changes to improve access

<https://publichealthmatters.blog.gov.uk/2017/07/06/mental-health-challenges-within-the-lgbt-community/>

<https://www.refugeecouncil.org.uk/>

### Section 2: Adapting therapy

#### **The Cognitive Behaviour Therapist Special Issue on Cultural Adaptations of CBT**

<https://www.cambridge.org/core/journals/the-cognitive-behaviour-therapist/special-issues/cultural-adaptations-of-cbt>

#### **LGBT BAME**

<https://www.naz.org.uk/>

<http://www.lgbtconsortium.org.uk/>

<https://lgbt.foundation/news/improving-access-to-psychological-therapies-for-bame-people/117>

<https://www.stonewall.org.uk/search/BAME>

#### **Refugees and asylum seekers**

<https://www.freedomfromtorture.org/>

A useful guide to working with dissociation can be found in David et al. (2018). An article in the Cognitive Behaviour Therapist Special Issue on Cultural Adaptations of CBT, currently in press, looks specifically at the treatment of dissociation in refugee populations (Brady et al. 2019).

#### **Signposting refugees and asylum seekers to practical help**

<https://www.redcross.org.uk/get-help/get-help-as-a-refugee>

#### **Behavioural activation with Muslim Service users**

<https://medicinehealth.leeds.ac.uk/dir-record/research-projects/980/addressing-depression-in-muslim-communities>

#### **Working with faith groups**

The role of religious beliefs in CBT have also been considered recently by Kada (2019) who looked at adaptation when working with the Orthodox Jewish community.

Further reading on the important topic of faith, spirituality, culture and CBT can be found in Rathod et al. (2015). This comprehensive book was written primarily for therapists working in the field of psychosis but many of the principles and ideas can be applied in IAPT services.

An excellent resource looking at the impact of spiritually abusive practices in the case of LGBT service users with mental health problems can be found in Ginicola et al. (2017).

## **Training**

The BABCP run regular training on cross-cultural mental health

<https://www.babcp.com/Training/Events.aspx>

Freedom from Torture provides training on work with asylum seekers and refugees

<https://www.freedomfromtorture.org/training>

Training by the Refugee Council

[https://www.refugeecouncil.org.uk/training\\_conferences/training](https://www.refugeecouncil.org.uk/training_conferences/training)

Naz, S., Gregory, R. & Bahu, M. (2019, in press). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. the Cognitive Behaviour Therapist Special Issue on Cultural Adaptations of CBT.

## **Translations of key materials for mental health care**

The University of East London webpage links to several large and well established sites that have translated mental health materials and resources

<https://www.uel.ac.uk/research/refugee-mental-health-and-wellbeing-portal/resource-centre/translated-mental-health-resources>

## **Working with interpreters**

Excellent guidance on interpreters in mental health

<http://roar.uel.ac.uk/3150/1/British%20Psychological%20Society%20guidelines%20working%20with%20interpreters.pdf>

Training programme for interpreters

<https://www.nice.org.uk/sharedlearning/update-of-crossing-the-language-barrier-with-a-dedicated-mental-health-interpreting-service>

The Pasalo Project has an excellent resource on work with interpreters and runs training courses for therapists.

<https://www.pasaloproject.org/>

Royal College of Psychiatry translations of information about mental health

<https://www.rcpsych.ac.uk/mental-health/translations>

Code of Professional Conduct

<http://www.nrpsi.org.uk/for-clients-of-interpreters/code-of-professional-conduct.html>

National Occupational Standards of Interpreters – Review

[http://www.nrpsi.org.uk/downloads/National\\_Occupational\\_Standards\\_for\\_Interpreting\\_Review.pdf](http://www.nrpsi.org.uk/downloads/National_Occupational_Standards_for_Interpreting_Review.pdf)

## **Guidance for commissioners**

<https://www.england.nhs.uk/publication/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care/>

<http://www.movertongue.org.uk/>

<https://www.youtube.com/watch?v=k0wzhakyjck>

<https://www.youtube.com/watch?v=ZwWT7xmCFRI>

## Section 3: Engagement with service users and communities

Mind. 2013. 'Mental health crisis care: commissioning excellence for BME groups'. Available at: <https://www.mind.org.uk/media/494422/bme-commissioning-excellence-briefing.pdf>

NHS England. 2017. 'Patient and public participation in commissioning health and care: statutory guidance for CCGs and NHS England'. Available at: <https://www.england.nhs.uk/publication/patient-and-public-participation-in-commissioning-health-and-care-statutory-guidance-for-ccgs-and-nhs-england/>

NHS England. 2017. 'Involving people in their own health and care: statutory guidance for clinical commissioning groups and NHS England'. Available at: <https://www.england.nhs.uk/publication/involving-people-in-their-own-health-and-care-statutory-guidance-for-clinical-commissioning-groups-and-nhs-england/>

NHS England. 2017. 'Patient and public participation equality and health inequalities – full analysis and associated resources.' Available at: <https://www.england.nhs.uk/wp-content/uploads/2017/04/ppp-equalities-analysis.pdf>

NHS England. 2017. 'Involving people in their own health and care equality and health inequalities – full analysis and associated resources'. Available at: <https://www.england.nhs.uk/publication/involving-people-in-their-own-health-and-care-equality-and-health-inequalities/>

NHS England. 2017. 'Diverse and Inclusive Participation'. Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/07/bitesize-guide-divers-inclusive.pdf>

NHS England. Various dates. Bitesize Guides to Participation. Available at: <https://www.england.nhs.uk/publication/bite-size-guides-to-participation/>

Bespoke advice is available for NHS colleagues from the NHS England Public Participation Team: email [england.engagement@nhs.net](mailto:england.engagement@nhs.net)

### Traveller community

[www.gypsy-traveller.org](http://www.gypsy-traveller.org) has useful resources developed within the traveller community including some on mental health

<https://www.mqmentalhealth.org/research/profiles/support-young-gypsies-travellers>

<https://www.gov.uk/government/publications/gypsy-and-traveller-health-accommodation-and-living-environment>

## Section 4: Workforce and staffing

### Supporting BAME staff

NHS Workforce Race Equality Standard

<https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/>

The NHS BAME staff network

<https://www.nhsbmenetwork.org.uk/>

The Leadership Academy

<https://www.leadershipacademy.nhs.uk/inclusion-week/empowering-bme-nhs-leadership/>

<https://www.leadershipacademy.nhs.uk/programmes/the-stepping-up-programme/>

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## APPENDICES

### Developing this guidance

The initial draft was developed by the authors, based on a review of current research evidence and principles of good practice. This draft was then taken to five systematic focus groups across England. These two-hour-long group sessions were facilitated by members of the project team. Service users were encouraged to look at the recommendations and make suggestions as to how they could be improved, as well as propose service improvements to ensure that this Positive Practice Guide would be a credible document to help improve BAME access and outcomes in IAPT services. Focus group participants were paid for their time. One of these initial focus groups comprised professional interpreters who work mainly, but not exclusively, with asylum seekers and refugees. These participants primarily commented on the sections regarding working with interpreters but also on other sections of the document. Unless stated otherwise, the focus group was held in English. The groups were recruited to reflect a wide representation of users from different ethnicities and ages, as well as an equal a gender mix as possible. Recruitment to the groups did not specifically recruit LGBT participants and future work would likely benefit from representation in this regard.

The self-designated ethnicity of the initial round of focus group participants is reported below:

Ethnicity	Number of participants
Polish (focus group was held in Polish)	7
Black Somali	1
Mixed heritage white/Jamaican	1
Chinese	1
Indian	2
Black British	3
Pakistani	3
Kashmiri	2
Black African	3
Kurdish	2
Arab	4
Afghani	1
Tigrinya	3
Eritrean	1
<b>Total participants</b>	<b>34</b>

The document was extensively re-written to incorporate this initial feedback. This revised document was then taken to a range of professionals working in IAPT and related fields. These included IAPT service leads and managers, a group of PWPs from BAME backgrounds, GPs, staff from organizations working with refugees and asylum seekers, and commissioners of mental health services. The document was also made available to the board of the BABCP for comment. This revised document was then taken to three other service user focus groups with further revisions made on the basis of their feedback.

Details of the ethnic composition of this second round of focus groups is reported below:

Ethnicity	Number of participants
Sri Lankan	4
Iranian	3
Black Jamaican	1
Black Somali	4
Black Zimbabwean	1
Black Nigerian	1
Albanian	1
Ukrainian	1
<b>Total participants</b>	<b>16</b>

The document was then revised on the basis of feedback from further stakeholders and interested parties.

The organizations and individuals who provided feedback were:

Touchstone, ROSHNI-2, MAAN Somali Mental Health project Sheffield, Bridging Communities, Freedom from Torture, the Helen Bamber Foundation, the Home Office, Nottingham and Nottinghamshire Refugee Forum, the Refugee Council, the Haven Project (Hull), the Red Cross, the Race Equality Foundation, the Equality and Health Inequalities Unit, the Lai Yin Association, the Southwark Day Centre for Asylum Seekers, Taraki, Dr Amir Hannan, Dr Lucy Maddox, Prof Paul Salkovskis, Dr Richard Thwaites, Prof David Clark, Sasha Bhat, Richard Holder, Kameran Shoaib, Siama Badar, Samina Choudhry, Enum Jabeen Ahmed, Resna Hoque and James Spiers.

We would also like to thank the following organisations for helping to recruit Focus Group participants: Sheffield African Caribbean Mental Health Association, Kashmir Youth Project, Sikh Your Mind, Sheffield Health and Social Care BME Staff Network Group.

## ABOUT THE AUTHORS

### Dr Andrew Beck

Andrew is a Consultant Clinical Psychologist, who has been a senior lecturer on the North West IAPT training programme (2010-2017) and the chair of the BABCP Equality and Culture Special Interest Group (2014-2017). He is a current member of the BABCP Scientific Committee and President-Elect of the BABCP. He was course lead for the first stand-alone CBT training course in India (2009-2017). He is an external examiner on the University of Chennai Psychology PhD programme, as well as the service lead for IAPT in East Lancashire CAMHS (2015-present). He was an Honorary Senior Lecturer on the University of Manchester doctorate programme in Clinical Psychology and the child and families module lead (2007-2017).

Andrew is the author of *Transcultural Cognitive Behaviour Therapy for Anxiety and Depression* (Routledge 2016). He has widely published in the field of cross-cultural mental health and offers training, both nationally and internationally, on this topic. He has service development and evaluation experience within the NHS as well as held several senior leadership posts within teams experiencing change and development. He is guest editor of the *Cognitive Behaviour Therapist* Special Issue on Cultural Adaptations of CBT. Andrew is from a white English background and has been married into a Punjabi Sikh family for 20 years.

### Saiqa Naz

Saiqa is a cognitive behavioural therapist (Specialist Psychotherapy Service, Sheffield) and Chair of the BABCP Equality and Culture Special Interest Group (2017-present). She is also co-chair of the Greater Manchester Muslim Foundation and Treasurer of the Borough of Rochdale Multi-faith Partnership.

Saiqa has delivered workshops on developing cultural competence in CBT for PWP's and cognitive behavioural therapists at the University of Nottingham and the University of Sheffield, as well as therapists working in different IAPT services. She has collaborated with faith organizations such as the Madina Institute and Planet Mercy to promote mental health. She has published on community engagement and training issues in academic and professional journals including the *Cognitive Behaviour Therapist* and *CBT Today*.

Saiqa was shortlisted for an NHS England Windrush Award for Clinical Excellence for Allied Health Professionals in June 2018. Saiqa is from a British Pakistani background.

### Michelle Brooks

Michelle Brooks is a Lecturer at the University of Derby, an IAPT CBT and EMDR therapist, clinical supervisor and doctoral researcher in IAPT CBT practice. Working with refugees, asylum seekers and cultural competence is a key specialist area in Michelle's clinical practice. In 2016/2017, she developed a successful multi-agency seven-month project specifically aimed at improving access and referral pathways to IAPT for refugees and asylum seekers in the City of Nottingham and Nottinghamshire.

Michelle is also part of a national training project for Freedom from Torture, a national human

rights organization which works with refugees, asylum seekers and survivors of torture. In this role, Michelle has assisted in the co-design and implementation of national specialist training targeted at IAPT therapists, in order to help them work with culturally diverse groups who have experienced PTSD as a result of their experiences. Michelle has also delivered national BABCP training for IAPT therapists who work with diverse groups, including refugees and asylum seekers. Michelle is Black British.

## **Dr Maja Jankowska**

Maja is a chartered psychologist and an associate fellow of the BPS, as well as a cognitive behavioural therapist. She is a bilingual therapist who caters for the needs of the Polish community in Bedfordshire. She is also a teacher and trainer, with a passion for teaching and raising standards in psychology, therapy and counselling (in the context of her role as a senior lecturer in psychology and external examiner for psychology and psychotherapy university courses).

She is often invited as an expert to validate and revalidate courses, including CBT and counselling higher-education provision, both nationally and internationally. Maja also peer reviews for various academic and practitioner journals, including the Cognitive Behaviour Therapist. Her interests have always been interdisciplinary and intercultural. She has also run many projects catering for the needs of ethnic minorities and bilingual/multilingual children and adults.

Maja is Polish and lives in Bedfordshire with her Black Caribbean partner and their daughter.

## **CONFLICTS OF INTEREST**

All of the authors receive income from training in various aspects of working therapeutically across cultures

Andrew Beck receives royalties from the sale of the book Transcultural Cognitive Behaviour Therapy for Anxiety and Depression, which is cited several times in this document.

