The Lead Organisation for CBT in the UK and Ireland

British Association for Behavioural & Cognitive Psychotherapies

Taking the IAPT Positive Practice Guide Forward

Part 1: Interactive Workshop (13:45 – 14:45)

Clare Baguley

Taking the BAME Positive Practice Guide Forward

Join the table that matches your allocated number*
25 mins in groups – discuss your thoughts & ideas:

- Opportunities provided by the publication of the BAME PP Guide?
- Barriers to implementing the PP Guide?
- Possible Solutions?
- Who can help?
- What will success look like?

- Write each point on a post-it note
- Place on the relevant flip chart on the wall

15 mins everyone – Take a walk around the flip charts & group the post-its into themes

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& Cognitive Psychotherapies

Commissioning Services for BAME communities

2.45–3.15

Commissioners perspective–

- What are the challenges?

IAPT BAME PPG Toolkit

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

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

WRES

Diversity and Inclusion?

- Having a diverse organisation only means that we have people with differences of identity in our organisation for example gender, ethnicity, disability sexual orientation etc.
- Having a diverse organisation is not enough in itself and should not be the aim.
- Diversity on its own is not sufficient for organisations need to be inclusive.
- So … what's the difference and why is it important

Being diverse doesn't mean your inclusive

Inclusion

- Inclusion is the degree to which an employee perceives that he or she is an esteemed member of the work group through experiencing treatment that satisfies his or her needs for belongingness and uniqueness.

(Roger Kline)

Impact of not being inclusive (Roger Kline, 2017)

- The loss and waste of BAME talent. UK Gross Domestic Product could increase by up to 1.3 per cent a year if workers from BME backgrounds progressed at the same rate as their white colleagues.
- Impact on staff morale- can also affect the entire team
- Impact on staff turnover- use the talent or you lose it!
- Impact on patient care
- Staff burnout- BAME staff can end up working harder
- Creates a “Us” and “them” divide- may have negative implications for wider community cohesion

INCLUSION

- By practicing Inclusion as a leader, you invite voices that can share a perspective not yet considered. Corporations which hire *visibly diverse talent*, but keep them working small projects and/or out of strategy meetings are simply out to appease the Equal Employment Opportunity = Tokenistic
- Commission (EEOC). This talent will, in effect, yield little to no returns because the lack of inclusion has communicated to them that they are not taken seriously and they will most probably leave or practice show up to work but have low productivity.

(https://rossinagil.wordpress.com/2014/07/28/the-difference-between-diversity-inclusion/)

Know the senior leaders

- If an organisation’s Senior Leadership is so weak that it requires strokes of egotistical self-validation to hear and see more of themselves through their recruitment and promotion processes (and how they run their services), then those organisations will surely fail.

(https://rossinagil.wordpress.com/2014/07/28/the-difference-between-diversity-inclusion/)

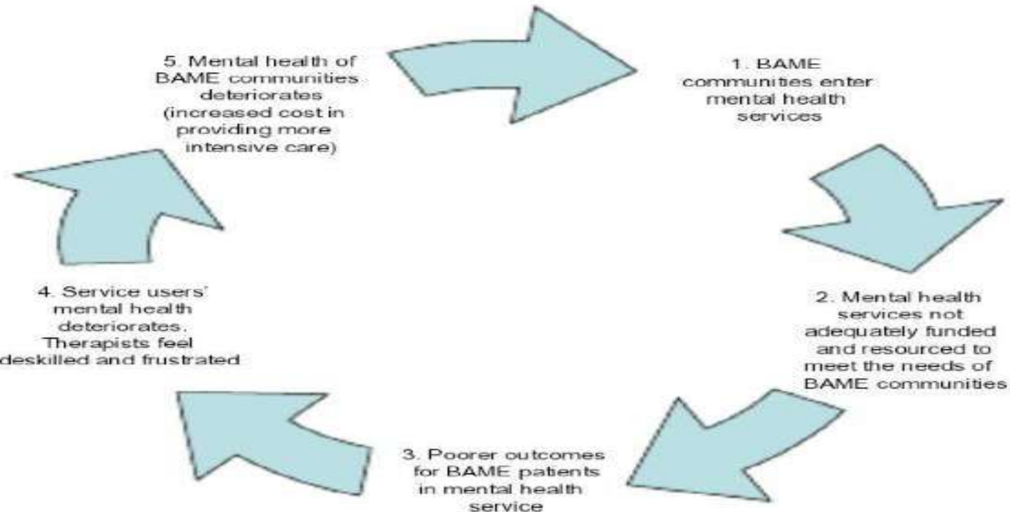

Figure 3. Vicious cycle of not adequately funding and resourcing mental health services for BAME communities.

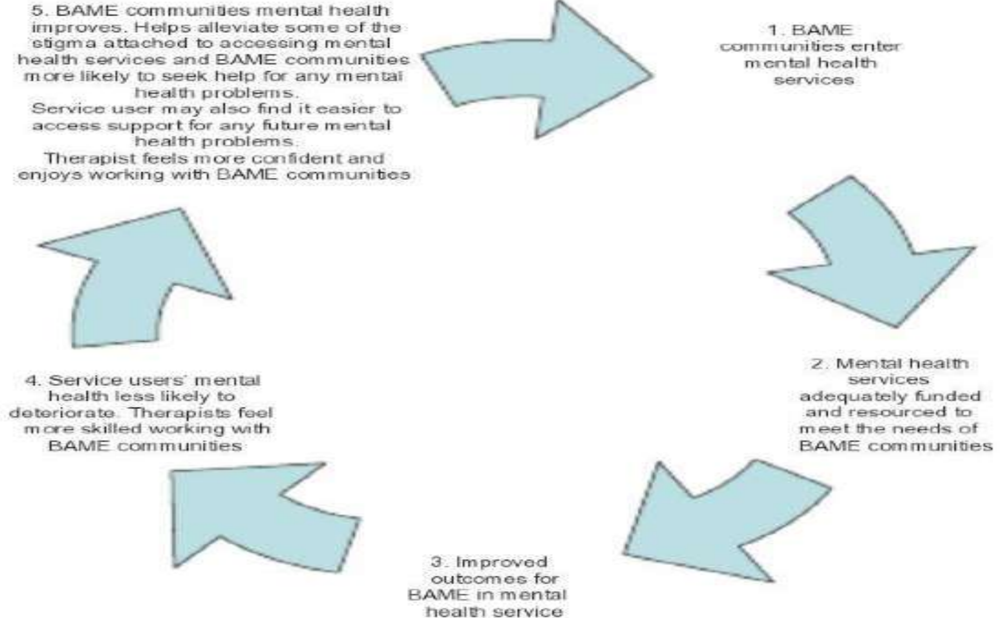

Figure 4. Virtuous cycle of adequately funding and resourcing mental health services for BAME communities.

The main differences between Culturally Adapted and Culturally Responsive CBT

	Culturally Adapted CBT	Culturally Responsive CBT
Applicable to a specific population	Yes	No - generalisable
Delivered in community languages	Yes generally	No – usually in English
Therapists of the same ethnic background as Service users	Yes generally	No
Based on 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 but perhaps to a lesser extent	Yes

Please use the Toolkit

- www.babcp.com/IAPT-BAME-Guide

What can you do to ensure your local IAPT service is working inclusively?

- Consider what resources might be required to support your managers

- Maybe we can share best practice information with others?

Workforce Race Equality Standard

- *Requires the majority of providers to demonstrate progress in **closing the gaps** between White and BME treatment and experience against nine indicators on **grading, appointments, discipline, bullying, career progression, access to development and whether Boards are representative of local populations.***

Black and Minority Ethnic (BME) staff in the NHS, 2018 – scale of the challenge

1.4 million people work in the NHS

20% staff from BME backgrounds

28% GPs from BME backgrounds

40% of Hospital Doctors are from BME backgrounds

21% Nurses and Midwives (qualified and unqualified) rising to more than 50% in London

But…

- 8 BME CEOs (from 231 NHS trusts)
- 9 BME Chairs
- 10 BME Executive Directors of Nursing
- 37 BME Medical Directors
- Less than 6% very senior managers from BME backgrounds
- 7% BME board representation

This is a significant improvement from 2015

NHS Workforce Race Equality Standard

- Mandatory for all NHS organisations
- Uses key indicators as measures of progress
- Expects progress on closing metrics between white and BAME experience and treatment
- From April 1st 2015 all NHS organisations will required to make changes
- Metrics seek to drive inquiry, behaviour attitudinal and sustained change

Table 1: WRES data for all NHS trusts in England: 2016 - 2018

WRES indicator	2016	2017	2018
2. Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	1.57	1.60	1.45
3. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff	1.56	1.37	1.24
4. Relative likelihood of BME staff accessing non-mandatory training and CPD compared to white staff	1.11	1.22	1.15
5. Percentage of BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	29%	29%	29%
6. Percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months	27%	26%	28%
7. Percentage of BME staff believing that trust provides equal opportunities for career progression or promotion	74%	76%	72%
8. Percentage of BME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	14%	14%	15%
9. BME board membership	7%	7%	7%

Sir Robert Francis QC – Freedom to speak up: a report into whistleblowing in the NHS

More BME staff are unsatisfied with the outcome of workplace investigations than white staff (40%:27%)

BME staff are more likely to be victimised by management than white staff (21%:12.5%)

BME staff are less likely to be praised by management after raising a concern than white staff (3%:7.2%)

BME staff are more likely than white staff to not raise a concern for fear of victimisation (24%:13%)

Impact on patient care…!

A report by Sir Robert Francis QC *Freedom to speak up – a report into whistleblowing in the NHS*

- Further confirmation that discrimination against BAME staff directly impacts patient care and safety.
- BAME staff are more likely to be ignored by management 19.3% in comparison with their white colleagues 14.7%.
- BAME staff are more likely 21% to be victimised by management than white staff 12.5%
- The number of both BAME and white staff who are praised by management after raising a concern is 3% BAME, 7.2 per cent for white staff.
- 24% of BAME staff compared to 13% of white staff did not raise a concern for fear of victimisation

BABCP Press releases

- BAME mental health

https://www.babcp.com/About/Press/BAME-Service-Response.aspx

- Men's mental health

https://www.babcp.com/About/Press/Twitter-Takeover.aspx

Babcp.com resources

- https://podcasts.apple.com/gb/podcast/coping-stress-anxiety-spiritual-cultural-perspective/id1336023443?i=1000422084799
- https://www.babcp.com/files/About/BABCP-Public-Engagement-Review-and-Strategy.pdf
- https://www.babcp.com/files/About/BABCP-Standards-of-Conduct-Performance-and-Ethics-0917.pdf

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SERVICE MODELS AND FORMS OF DELIVERY

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

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Abstract

Conversations around improving access to psychological therapies for BAME (Black, Asian and minority ethnic) service users have been ongoing for many years without any conclusion or resolution. BAME service users are often under-represented in primary care mental health services, and often have worse outcomes, leading to them being portrayed as 'hard to reach', and to deterioration in their mental health. They are over-represented in secondary care mental health services. The authors of this article argue that more resources are required in order to understand the barriers to accessing mental health services, and improve both access and recovery for BAME service users. This paper examines concepts such as race, ethnicity and culture. It aims to support service managers and therapists to develop their confidence to address these issues in order to deliver culturally competent psychological therapies to service users from BAME communities, with a focus on primary care. It is based on our experiences of working with BAME communities and the feedback from our training events on developing cultural competence for CBT therapists. The paper also discusses the current political climate and the impact it may have on service users and the need for therapists to take the wider political context into consideration when working with BAME service users. Finally, the paper stresses the importance of addressing structural inequalities at a service level, and developing stronger ethical guidelines in the area of working with diversity for CBT therapists in the UK.

Key learning aims

(1) To examine concepts such as race, ethnicity and culture and to provide a shared understanding of these terms for CBT therapists.
(2) To assist CBT therapists and supervisors to develop their confidence in addressing issues of race, ethnicity and culture with BAME service users within the current political climate and to deliver culturally competent therapy.
(3) To assist service managers to promote equality of access and of outcomes for service users from BAME communities.
(4) To understand how unequal expectations of therapists in services impacts on CBT therapists from BAME communities.
(5) To widen understanding of some of the structural inequalities at service level which the CBT community needs to overcome, including recommending stronger ethical guidelines around working with diversity in the UK.

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ORIGINAL RESEARCH

The need for service change and community outreach work to support trans-cultural cognitive behaviour therapy with Black and Minority Ethnic communities

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Abstract. Recently there have been a number of developments in cognitive behaviour therapy (CBT) that have led to cultural adaptations of specific interventions and a greater awareness of how in general CBT might be adapted for Black and Minority Ethnic (BME) service users. These developments, however, involve change at the level of the individual therapist and particular treatment approach, but involve very few considerations of what needs to happen at the levels of teams or services in order to best meet the mental health needs of British South Asian and other BME populations. This paper summarizes the way that services need to understand how minority populations use services and how to involve those populations in developing services in order to ensure their needs are best met.

Key words: CBT, participation, Black and Minority Ethnic (BME), outcomes, British South Asian

The CBT Journal- SI on Cultural adaptations https://www.cambridge.org/core/journals/the-cognitive-behaviour-therapist-

Have awareness of your privileges and biases
Empower and create spaces those who are more disadvantaged than use

Part 2: What Are Our Collective Actions? 3.15-3.55

- What are our top actions?
- Who will do what & when?
- What can we do as collective / network?
- What will be your own personal action from today?
- Next steps