

**Improving Access to
Psychological Therapies
(IAPT)
Equality Impact Assessment
(EqIA)**

October 2008

“Relieving distress, transforming lives”

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EXECUTIVE SUMMARY

- i. This Equality Impact Assessment (EqIA) examines the impact of the Improving Access to Psychological Therapies (IAPT) programme, on different groups in the community, to inform future policy development in this area. It anticipates and recommends ways to avoid any negative consequences for particular groups who may be subject to discrimination on the grounds of: race, gender, disability, faith, sexuality or age.
- ii. The EqIA shows that the IAPT programme has made significant achievements in meeting the psychological needs of the whole community, especially in recording outcomes for people using services and in monitoring the uptake of services by local communities.
- iii. Beginning in 2006 the IAPT programme worked with two Demonstration Sites in Doncaster and Newham, where more than 5000 people were able to receive psychological treatments that were previously unavailable. From September 2007, Pathfinder pilot sites across the country examined the challenges of delivering psychological therapy services for different groups in their local communities. Data from the Demonstration Sites and these pilot sites informed this EqIA. A full evaluation of the pathfinder sites will be available on the IAPT web-site (www.nhs.uk/iapt).
- iv. The IAPT programme is evaluating the workforce to deliver these services and is also developing New Ways of Working for Psychological Therapists. This work is informing how the 10 Essential Shared Capabilities for Mental Health can be delivered, and the psychological therapy workforce can be better placed to meet the needs of the whole community.
- v. The IAPT Demonstration Sites showed that developing different models of service delivery can benefit the whole community. For example, opening up self-referral routes enabled the services to be more accessible to different community groups, especially Black and minority ethnic communities.

- vi. The EqlA has also shown some areas where there is disparity in the provision of services. For example, the data from the Pathfinder Sites has indicated that take-up of services by older people was less than expected for local communities.
- vii. Sharing good practice and raising awareness among commissioners of the importance of delivering IAPT services to the whole community is a key task. The IAPT programme has already published guidance for commissioners, core competencies for CBT training and curricula for both high and low-intensity CBT training. Further information on how to commission IAPT services for the whole community will be published in Autumn 2008.
- viii. The IAPT programme will also publish material to help services undertake their own EqlAs, understand the needs of their local communities and audit service provision and is working closely with the Department of Health's Delivering Race Equality programme.

BACKGROUND

1.1 The principle aim of the IAPT Programme is:

“To help Primary Care Trusts (PCTs) implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders”¹

1.2 The IAPT programme draws on a wider analysis of the health of communities nationally and its impact on society. The programme seeks to support the wider public health agenda and to promote effective treatment options in mental health services that are founded on good evidence.

1.3 The Government has allocated additional funding rising to £173 million by 2011, to enable commissioners to develop evidence-based psychological therapy services, stating that *‘this programme gives them an opportunity to collaborate with providers from **all sectors** to find genuinely **innovative ways** of meeting **local people’s** needs and demonstrate they are doing so through routine collection of outcomes data’²*

1.4 Nationally, this investment will enable the NHS to train 3,600 extra psychological therapists and treat 900,000 more people with half of those who complete treatment moving to recovery in those three years.

¹ Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit . DoH (2008)

² Improving Access to Psychological Therapies (IAPT) Commissioning Toolkit DoH (2008)

- 1.5 This programme will relieve distress and transform lives by offering effective intervention and treatment choice to people with depression and anxiety disorders and improving the collection, recording and measuring of patients' health outcomes, producing data that allows further research.
- 1.6 During 2007/08, national demonstrators in Newham and Doncaster saw more than 5,000 extra people, with average waiting of only 2 weeks after a clinical decision to treat, down from an NHS average of around 14 months. Well over half those treated by the Newham and Doncaster services achieved measurable recovery, in line with NICE evidence from clinical trials, and the number returning to work rose by 10%.

***“Numbers treated.** An impressive number of people have been assessed and treated by the demonstration sites. During the thirteen months covered by this report nearly 5,500 people have been referred to the two sites, of whom around 4,800 were considered suitable for the services. Approximately 3,500 of these individuals have now concluded their involvement with the services, with the remainder still in the system. Of the concluded cases, around 1,900 have received at least 2 sessions of treatment with most having pre and post treatment scores on standardized outcome measures. The numbers seen in Doncaster are particularly impressive.”³*

- 1.7 Since September 2007, 11 ‘Pathfinder’ pilot services have sought to implement IAPT services for the whole population and to explore the particular needs of one or more particular group in their local populations, including children and adolescents, new mothers,

³ LSE 2008 Evaluation of IAPT Demonstration Sites – In Press

black and minority ethnic groups, older people, offenders and those with long term conditions and/or medically unexplained symptoms.

- 1.8 In Autumn 2008, 35 new services will be implemented, with at least two in every SHA area. These sites will train at least 700 new therapists and see up to 90,000 extra clients in the year from September 2008. To enable the delivery of this programme, there has to be a graduated system of implementation. There is the potential that local service inequalities may result, with full IAPT services only available in some areas. Over time, this inequality will even out as funding for services becomes available across England.

- 1.9 A parallel piece of work is also taking place to look at New Ways of Working for Psychological Therapists (NWW4PT) across the full age range covering not just existing psychology workforce, but also those members of staff delivering psychology interventions such as nurses, as well as the proposed high and low intensity workers in the IAPT programme. This work will cover four distinct but connected areas such as the size and nature of the psychological therapy workforce to include gender, ethnicity, disability etc; the skill mix of staff; career frameworks; and multi-disciplinary team working.

2. PURPOSE OF EqIA

2.1. The purpose of the Equality Impact Assessment (EqIA) is to examine the Improving Access to Psychological Therapies (IAPT) programme to identify what effect its implementation may have on different groups within the community. It should be used to anticipate and recommend ways to avoid any discriminatory or negative consequences for a particular group, on the grounds of

- race,
- gender,
- disability,
- faith,
- sexuality or
- age

2.2 Equality Impact Assessment is an essential part of meeting the Department of Health's general duties towards equality. It considers what effect the Department's activities have on eliminating unlawful or unjustifiable discrimination, promoting equality of opportunity and meeting other requirements of the equality duties, such as promoting positive attitudes towards disabled people. It also enables us to show how positive effects can be maximised, and negative effects minimised or eliminated, by modifying policies and practices.⁴

2.3 Ensuring that all local IAPT services are subject to a rigorous EqIA is an important recommendation of the programme. As Strategic Health Authorities work with their local PCTs to determine the expansion of this programme, a thorough EqIA of local service is strongly encouraged.

⁴ DH 2008 Equality Impact Assessment: Guidance for policy makers

3. LEGISLATIVE AND POLICY FRAMEWORK

3.1 IAPT's overall approach to Equality and Diversity should be considered in the context of the following policy/guidance:

- Patient Focus and Public Involvement⁵
- Informing, Engaging and Consulting the Public in Developing Health and Community Care Policies⁶
- Delivering Race Equality in Mental Health⁷
- Our Health, Our Care Our Say⁸
- Securing Better Mental Health for Older Adults⁹

3.2 Tackling health inequalities and achieving health gain is central to the government's policy objective to ensure that the same high levels of healthcare are provided to all patients, without the exception of age, gender, race, religion, sexual orientation and irrespective of their disability. This is realised through the use of policies and legislation, which healthcare organisations must observe.

3.3 The Department of Health, through the *Standards and Planning Framework* and the *NHS Improvement Plan* calls for the

⁵ <http://www.scotland.gov.uk/Publications/2001/12/10431/File-1>

⁶ <http://www.sehd.scot.nhs.uk/publications/DC20040301Informing.pdf>

⁷

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773

⁸ <http://www.dh.gov.uk/en/Healthcare/Ourhealthourcareoursay/index.htm>

⁹

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4114989

emergence of good-quality leadership to drive these agendas in healthcare organisations. These documents emphasise partnerships with other agencies to respond to health inequalities by enhancing access, improving outcomes of health and social care provision and to better patient experiences. The basic principles of equalities and human rights are to be included in these efforts. The related standards are also prioritised by the Treasury’s cross-government Public Service Agreements (PSA) targets in relation to health inequalities.

3.4 The guidance set out in *National Standards and Local Action* emphasises:

“Health equality audits identify how fairly services or other resources are distributed in relation to the health needs of different groups, by using evidence on inequalities to inform decisions on investment in services planning, commissioning and delivery.”

3.5 The IAPT programme must also comply with a range of primary and secondary legislation. These are set out in Table 1, below.

Table 1: Primary and Secondary Legislation

Primary Legislation	
<ul style="list-style-type: none"> • Equal Pay Act 1970 • Sex Discrimination Act 1975 • Race Relations Act 1976 - as amended by the Race Relations (Amendment) Act 2000 • Disability Discrimination Act 1995 • Equality Act 2006 	
Statutory instruments	
Age	The Employment Equality (Age) Regulations 2006 (SI

<i>discrimination</i>	2006/1031)
<i>Disability discrimination</i>	The Disability Discrimination Act 1995 (Amendment) Regulations 2003 (SI 2003/1673)
<i>Race discrimination</i>	<p>The Race Relations Act 1976 (Amendment) Regulations 2003 (SI 2003/1626)</p> <p>The Race Relations Act 1976 places a legal obligation on services to actively promote race equality in all of its work. The Race Relations (Amendment) Act 2000 (RRAA) adds to this duty and requires services to ensure that they comply with the general duty to:</p> <ul style="list-style-type: none"> • Eliminate unlawful racial discrimination • Promote equality of opportunity • Promote good race relations <p>Specific Duties under the RRAA further require organisations to assess their functions for relevance to race equality, and where relevance is established, set out their plans to:</p> <ul style="list-style-type: none"> • Assess and consult on the policy's likely impact • Monitor the policy for adverse impact on race equality • Publish the results of the above • Ensure public access to information and services • Train all staff in their new duties under the RRAA
<i>Religious discrimination</i>	<p>The Employment Equality (Religion or Belief) Regulations 2003 (SI 2003/1660)</p> <p>The Employment Equality (Religion or Belief) (Amendment) Regulations 2003 (SI 2003/2828)</p> <p>The Employment Equality (Sexual Orientation) (Religion or Belief) (Amendment) Regulations 2007 (SI 2007/2269)</p>
<i>Sex</i>	The Sex Discrimination Act 1975 (Amendment) Regulations

<i>discrimination</i>	2003 (SI 2003/1657) The Sex Discrimination (Gender Reassignment) Regulations 1999 (SI 1999/1102)
<i>Sexual orientation discrimination</i>	The Employment Equality (Sexual Orientation) Regulations 2003 (SI 2003/1661) The Employment Equality (Sexual Orientation) Regulations (Amendment) Regulations (SI 2003/2827) The Equality Act (Sexual Orientation) Regulations 2007 (SI 2007/1263) The Employment Equality (Sexual Orientation) (Religion or Belief) (Amendment) Regulations 2007 (SI 2007/2269)
Other relevant legislation	
<ul style="list-style-type: none"> • Human Rights Act 1998 • Gender Recognition Act 2004 • Age Discrimination Directive 2006 • The Part-time Workers (Prevention of Less Favourable Treatment) Regulations 2000 (SI 2000/1551) • The Fixed-term Employees (Prevention of Less Favourable Treatment) Regulations 2002(SI 2002/2034) • Employment Rights Act 1996 (sections relating to maternity and dependant carer leave) • Protection from Harassment Act 1997 • Racial and Religious Hatred Act 2006 	

4. MONITORING AND COLLECTING INFORMATION

- 4.1 Under the Race Relations Act 1976 (Statutory Duties) Order 2001, every public body must *'monitor by reference to those racial groups, the admission and progress of students and the recruitment and career progress of staff.'* In the Commission for Racial Equality's Statutory Code of Practice on the Duty to Promote Race Equality, monitoring is defined as the collection of *'information to measure an institution's performance and effectiveness. The results may suggest how the institution can improve.'*
- 4.2 Equality monitoring is critical for the successful implementation of any policy or programme. Monitoring is a way of checking how well policies, procedures and practices are working; it can then be linked to policy development, implementation and evaluation.
- 4.3 It is an essential component of the IAPT programme that participating organisations:
- Undertake local equality impact assessments
 - Collect a range of input and outcome measures, as stipulated by the programme's data set.
- 4.4 This information is collected and reported at different levels to satisfy local service improvement, commissioning decision-making and regional and national strategic planning. A considerable amount of information is being collected across the IAPT sites; however this is titrated so that only information relating to the delivery of key performance indicators (KPIs) is reported externally for regional and national monitoring purposes. The full reporting schedule and minimum data set (MDS) can be found at

www.nhs.uk/iapt . The reporting schedule can be found at Appendix B.

4.5 It is mandatory for IAPT sites to collect a minimum data set (MDS) which addresses the Key Performance Indicators (KPIs), however the IAPT Outcomes Framework recommends that all sites collect the full IAPT data set, which the DH encourages all sites to use as best practice. Table 2 below sets out the range of equality questions asked within the MDS and the full data set.

4.6 Information from the 11 IAPT Pathfinder sites, that operated in 2007/08, was reported nationally and is helping to inform the development of the policy. In particular the MDS and full data set were refined based on the experience of these pilots.

Table 2 Service User Data Collection in IAPT Sites

Equality area	Source of Information	
	IAPT MDS ¹⁰	IAPT Full Data Set ¹¹
Age	Yes	Yes
Gender	Yes	Yes
Ethnicity	Yes	Yes
Sexuality	No	Yes
Religion	No	Yes
Disability	No	Yes Visual Speech Hearing Mobility
Language	No	Yes Able to speak English Able to understand written English Preferred Language

4.7 To begin to understand the nature of the workforce within the IAPT programme, we have also collected extensive information using a “Worker Registration Form”. As well as enabling the programme to

¹⁰ mandatory for all expansion sites

¹¹ Optional, but recommended as good practice for all expansion sites

understand the education and training needs of individuals, this information also records information in the following areas:

- Gender
- Age
- Nationality
- Ethnicity
- Sexuality
- Disability

4.8 To date, we have only collated information from the two demonstration sites which in Newham and in Doncaster (see below). We hope to be able to analyse the workforce profiles of all Pathfinder pilot sites and to compare them to the make up of their communities. We also have some benchmark data around the gender and ethnicity make up of particular groups of workers within the general NHS workforce (BPS, 2004; 2005).

4.9 The worker registration details will enable local commissioners to ensure and to demonstrate that the new workforce has not only the right skills to deliver effective services, but that the composition of the workforce is appropriate to the population served.

Worker Registration Details

Doncaster: Workforce registration forms were collated from 26 members of staff 19 of whom are female, 6 male and one with no response was given in relation to gender. Of these people 22 described their nationality as English, 2 as Scottish and 1 each as British and South African. In relation to their identified Ethnic Group 24 described themselves as British 1 as Egyptian and 1 as South African. In terms of age group 9 people were aged between 20-29, 5 30- 39, 8 40- 49 and 4 50-59. One person

was fluent in Arabic, one Afrikaans and one person could communicate in British Sign Language.

Newham: Workforce registration forms were collated from 17 members of staff 7 of whom were female and 10 male. Of these people 7 described themselves as having an English Nationality 6 as British, and one each as Welsh, Spanish and Irish. In relation to Ethnic group 11 described themselves as British whilst the other 6 described themselves as white Canadian, Sri Lankan, Asian, Celtic Mediterranean, European Union and Indian. In terms of age groups 3 were between 20 – 29, 7 30-39, 5 40- 49 and 2 50 – 59.

Several different languages were spoken in addition to English – 1 person spoke Malay Cantonese, , 1 Spanish and 1 person could speak each of the languages of Punjabi Hindi and Urdu

- 4.10 As mentioned in paragraph 1.9 above, an additional piece of work is being undertaken by the New Ways of Working for Psychological Therapists (NWW4PT) programme to describe the size and nature of the psychological therapy workforce
- 4.11 The training for both high and low intensity practitioners for IAPT services has been closely specified by the publication of national curricula. Both curricula emphasize the importance of equalities and cultural sensitivity. For the high intensity curriculum, diversity is reflected as one of eleven general course objectives: *“demonstrate ability to adapt CBT sensitively, and to ensure equitable access for people of diverse cultures and with different values”*. This implemented as a general learning objective for the introductory module around CBT. Within the low intensity curriculum, one of four modules is entitled *“Values, culture & diversity”*. In addition, trainees will also be introduced specifically to other materials

recently developed including the Ten Essential Shared Capabilities, (ESC) and Race Equality and Cultural Capability learning materials which are the main plank of training in the DRE programme.

4.12 The Ten ESC, applies to all staff, professionally qualified or not, working in mental health services across both health and social care (including IAPT workers). There are two very relevant capabilities:-

- **Respecting Diversity** which is about working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, Religion or belief and sexual orientation; and
- **Challenging Inequality** which is about addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services.

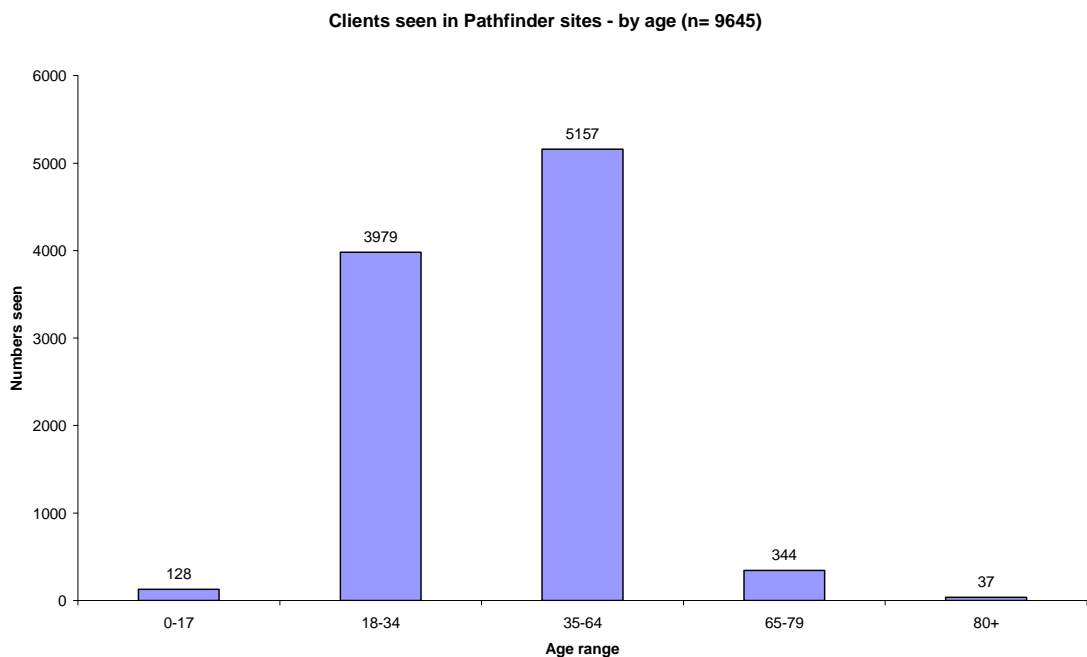
5. QUALITY AREAS

It is important to note that the separate equality areas set out below are a useful categorisation but are not separate from each other – eg an older black person with a disability may face multiple barriers.

Any data cited in this report has been gathered from the IAPT Demonstration Sites and Pathfinder Sites. This does not necessarily reflect practice in other locations.

5.1 Age

Graph 1



5.1.1 People at different stages in their life may have different psychological needs. The programme is working to understand the ways in which people of all ages can access services and how we can demonstrate that the services are effective in meeting needs across the life-course. NICE guidelines, for conditions such as

depression, are clear that they are effective, and should be offered to all adults where clinically appropriate. There has been a lot of research demonstrating clinical outcomes for adults of working age¹². However, these tools are often not validated, or appropriate, for other age groups. The SIGs are working to establish what the most appropriate measures are and how we can ensure that there is equity of access to services. This includes access across the age spectrum.

- 5.1.2 As Graph 1 illustrates the majority of clients seen within the 2008/09 IAPT pathfinder sites were from the younger adult population. Although included in the data collection, children and young people are unique. To address this, programme funding was targeted at a specific service (in Bury) to consider the needs of this population. However, the overall programme funding is for the provision of services for people over the age of 18.
- 5.1.3 The programme recognises the challenges of providing services for younger and older people. Special interest groups for children and young people and older adults were established

5.2 Services for Children and Young People

- 5.2.1 Issues of access for children and young people is a particular area in which the programme is dedicating specific resources. Depression and anxiety disorders, as identified within the IAPT programme, may not necessarily be treated within traditional child and adolescent mental health services. It is, therefore, important

¹² There is debate about the use of the terminology 'adults of working age' which lacks meaning in the context of age regulations on employment. There are now 1.3million people working beyond state pension age – ref ONS 2008

that the issues are identified and strategies are developed to ensure that children and young people are given the opportunities of access for the treatment of these debilitating conditions.

5.2.2 The 2004 National Service Framework for Children, Young People and Maternity Services¹³ includes a standard specific to the Mental Health and Psychological Well-being of Children and Young People. Standard Nine states that:

“All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality, multi-disciplinary mental health service to ensure effective assessment, treatment and support, for them and their families.... [and] that all children, young people and their families have access to mental health care based upon the best available evidence and provided by staff with an appropriate range of skills and competencies.”

5.2.3 Mental illness is a serious problem among children and young people with one in ten experiencing some form of diagnosable mental disorder¹⁴. The proportion of children with mental health problems is higher now than it was 30 years ago, though the prevalence showed no increase between 1999 and 2004.

- One in ten children has a clinically significant mental health problem

¹³

[http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Children/DH_4089111#](http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Children/DH_4089111#_2)

¹⁴ Report on the Implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services

- 5.8% of 5–16-year-olds have clinically significant conduct disorders
- 3.7% of 5–16-year-olds have clinically significant emotional disorders
- 1.5% of 5–16-year-olds have clinically significant hyperkinetic disorder

5.2.4 During the last 25 years the prevalence of many childhood mental health disorders (particularly conduct disorders, anxiety and depression) has increased in the Western world, independently of rates of clinical recognition. Referral rates of young people to specialist CAMHS in England have also greatly increased over recent years, with total caseloads rising nationally by 31 per cent between 2003 and 2005.

5.2.5 Through consultation with the Children and Young People's (C&YP) SIG a number of key challenges to accessing services have been raised. The group have helped to produce an informative chapter for the broader IAPT commissioning guidance which will be published in the autumn.

5.2.6 Through the SIG and the work of the C&YP Pathfinder Site in Bury, the programme has helped to develop:

- A set of outcome measures for IAPT services for young people
- Links with other initiatives, such as Targeted Mental Health in Schools
- Working with the voluntary sector to promote access through different routes

5.2.7 More detail about the work of the Bury service will be available in the forthcoming commissioning guide and evaluation of the work of the 11 pathfinder sites.

5.2.8 The C&YP group have also debated the mental health needs of young people from the lesbian gay, bisexual and transgender (LGBT) community, and colleagues in Brighton and Hove PCT have established a group looking specially at this issue.

5.3 Services for Older People

5.3.1 Most older people experience good mental health and well-being, however a significant number of older people suffer from a range of mental health problems, including depression and anxiety disorders. Services developed under the Improving Access to Psychological Therapies programme (IAPT) should be available to everyone who will benefit from them Including older people.

5.3.2 It is estimated that 3 million older people in the UK suffer from symptoms of mental health problems that affect the quality of their lives. It is believed that 25% of all people over the age of 65 (one in four) living in the community have symptoms of depression that are serious enough to warrant intervention, however only a third of older people with depression discuss it with their GPs, and only half of them are treated for depression. Of those who are offered treatment, only a very small proportion receive psychological therapy. Older people have some of the highest suicide rates compared to other age groups.

5.3.3 Graph 1 shows that there appears to be a disproportionate use of services by younger adults. Four percent of IAPT service users were aged 65 or over despite this age-group accounting for 18% of the national population and closer to 25% of the national population over the age of 18. The older people SIG have drawn a number of

hypotheses as to why fewer than expected older adults were seen within the Pathfinder services:

- General inaccessibility of services for the older age group
- Focus of competencies and skills of staff not appropriate for older adults
- Reluctance from primary care to refer older people
- Depression/anxiety not recognised as widely within the older population, rather seen as a natural process of aging. The majority of disabled people are older people and there is therefore an important link with the work undertaken on Long Term Conditions.

5.3.4 The IAPT programme has been working with a number of pathfinder sites to consider the challenges of providing services for older adults. Commissioners are required to consider services for older adults as an integral element of their overall service provision. To assist commissioners further, guidance will be published in the autumn.

5.4 Disability

5.4.1 Of the people who have been assessed by the IAPT pathfinder sites, to date disability status was recorded has been 62% but there has been only an 8% recording for mobility status.

5.4.2 In general, the programme has taken a broad view to the potential impact on people with a range of disabilities. A SIG has been established to examine the impact of providing services for people who suffer from a range of debilitating long-term conditions (LTCs), and for those with medically unexplained symptoms (MUS). The programme is also in discussion with British Society for Mental

Health and Deafness, with a view to understanding the needs of those who communicate using British Sign Language (BSL) and how services can be made more accessible. For those users of BSL this is more of an issue of communication than disability.

- 5.4.3 There is a substantial literature base concerning the co-morbidity of long-term conditions such as diabetes, ischaemic heart disease and chronic obstructive pulmonary disease, and common mental health needs. The impact of this is significant both to the individual, their carers and relatives and to the broader health economy.
- 5.4.4 Co-morbidity of depression and anxiety with LTCs results in increased physical healthcare costs. Patients also present with physical symptoms, when in fact they are suffering from a common mental health condition, for example 69% of depression in primary care presents with physical symptoms (Simon et al 1999). 20% of people with acute chest pain actually have panic disorder as a cause for their symptoms (Huffman 2003). Delay in the correct diagnosis, and therefore treatment, results in unnecessary suffering, unnecessary investigations, and unnecessary health service cost.
- 5.4.5 The programme is working to address the broader access requirements of individuals with a range of other disabilities. A piece of focused work, specifically looking at the needs of people with learning disabilities, will be incorporated into the forthcoming commissioning guidance. More work will also be needed to consider the needs of people with sensory impairment and those

with physical disabilities. In light of the Dementia Strategy¹⁵, it will be increasingly important to consider the needs of people with cognitive impairment. Depression is common in people with dementia – and it has been demonstrated that psychological therapies work for people with these co-morbid conditions.

5.5 Race

5.5.1 Britain is a multi-cultural society. Historically, people from black and minority groups have suffered from poorer health, have reduced life expectancy and have greater problems with access to health care than the majority white population¹⁶.

5.5.2 Mental health is an area of particular concern for the minority communities in this country. The Mental Health National Service Framework¹⁷ is unequivocal in stating that users can expect services to be non-discriminatory. Additionally, the Race Relations (Amendment) Act 2000¹⁸ imposes an explicit duty on all public authorities to actively promote race equality.

5.5.3 Ensuring that access to psychological therapies is not hindered based on people's ethnicity, culture or faith is one of the leading priorities for the *Delivering Race Equality in Mental Health Care* action plan (DRE)¹⁹. BME access to, and experience of,

¹⁵

<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/NationalDementiaStrategy/index.htm>

¹⁶ National Institute for Mental Health in England (NIMHE) (2003) Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England. London, Department of Health

¹⁷ Department of Health (2000) National Service Framework for Mental Health: Modern Standards and Service Models. London, Department of Health

¹⁸ Race Relations (Amendment) Act 2000, London, The Stationary Office

¹⁹ Department of Health (2005) Delivering Race Equality in Mental Health Care, London, Department of Health

psychological therapies will be assessed as part of the central monitoring of both the IAPT and DRE programmes. Using the DH/CSIP DRE dashboard (see Appendix A), the DRE and IAPT programmes will be able to work closely with PCTs to audit the use of psychological therapy services by black and minority ethnic communities.

5.5.4 By routinely collecting ethnographic information the programme has been able to analyse the take up of services against the profile of the local community. To consult on the issues and to help find some solutions for issues pertinent to appropriateness, engagement, access and uptake of IAPT services for BME groups, a special interest group has been formed. The programme is preparing guidance which will help commissioners consider the needs of different communities and how they can be helped to access psychological services.

5.5.5 There is now sufficient and increasing amounts of epidemiological data to assist public health agendas and preventative initiatives in tackling health inequalities²⁰. In the case of BME communities rising rates of chronic diseases amongst some BME populations are concerning. We know, for example that:

- death rates from Chronic Heart Disease among the population of England and Wales born in South Asia are 50% higher than the average,
- The death rate for strokes amongst The African Caribbeans is 50% higher than average,
- Women born in India and East Africa have a 40% higher suicide rate than the general population,

²⁰ Raleigh, S. V., Polato, G, M. Evidence of health Inequalities, Health Care Commission.

- Perinatal mortality amongst Pakistani born women is double the UK national average.²¹
- BME populations are nearly six times more likely than the general population to report having diabetes, with risk ratios amongst Pakistani men and women being high²².
- Pakistani/Bangladeshi men and women are three to four times more likely than the general population to describe their health as bad or very bad²³.

5.5.6 The evidence of frequent consultations with GP practices by BME communities, in many cases presenting with 'non specific symptoms,' has often suggested underlying and undetected distress,²⁴ which results in trajectories which are less than favourable, i.e. presenting to mental health services at crisis point, often subject to the powers of the Mental Health Act²⁵, frequently via the criminal justice system²⁶, resulting in increased lengths of stay in hospital. These pathways can lead to increased isolation from their families and the community being caught up between stigma and inequality thereby increasing the feelings of isolation that they may face in general.

5.5.7 Furthermore, the annual Count Me In Censuses over the past 3 years (2005, 2006 and 2007), continues to demonstrate that some black and minority groups are three or more times likely than average to be admitted as inpatients in mental health services. Both Count Me In and the Healthcare Commission community

²¹ Sharma, S.(2006). Reaching Out to Black and Ethnic Minority Communities: Addressing Their Health Needs.

²² Diabetes U.k (2006)

²³ Social Focus in Brief: Ethnicity (2002), National Statistics.

²⁴ Goldberg, D & Huxley, P.(1980), Mental Illness in the Community. Tavistock Publications.

²⁵ The Health Commission

²⁶ Mckenzie, K

patient survey indicate that Asian patients are less likely to be offered CBT. Research findings have consistently demonstrated higher rates of mental ill health amongst BME communities and that these are related to a variety of complex factors, such as socio-economic status, living alone, migration, family and social support etc.

- 5.5.8 Whilst the antecedents of higher rates of physical and mental illness in BME communities are complex, it does, however, starkly demonstrate the state of inequality in health status that prevail between the BME communities compared to the general population.
- 5.5.9 In considering such evidence, the need for Black and Minority Ethnic (BME) communities to be enabled to access meaningful talking therapies as a measure of improving health outcomes and thereby their quality of life becomes self evident.
- 5.5.10 Working with colleagues from the London Borough of Newham, the IAPT programme has been able to examine the use of IAPT services in an area with a the large BME population. Table 3 records the numbers of people in different ethnic groups that self-referred or were referred by their GP into the IAPT service. This data can be compared with the GP detection rates for mental health problems obtained from the GP practice records. Inspection of the table shows that, compared to the detection rates, GPs tend to refer more white and less black people to IAPT services. This bias was not seen in self-referrals, a point that was highly significant in the Government's decision to open up all IAPT services to self-referral.

Table 3 : Patient ethnicity by referral source in Newham

Ethnic group	GP referral		Self-referral		GP detection
	N	%	N	%	%
White	357	52	96	47	41
Asian / Asian British	178	26	48	24	28
Black / Black British	110	16	45	22	25
Chinese or other	18	3	5	3	2
Mixed	25	4	9	4	3
Total	688	100	203	100	100

5.5.11 The Newham data showed that self-referrers were clinically as severe as those referred by a GP, had a condition with more than twice the chronicity, and importantly the ethnic profile of the self-referring group matched the local population better than those people referred by their GP (see Table above).

5.5.12 Making the service in Newham more accessible to the local community has been key to the success of delivering equality of service. The service took a number of measures set out below:

- Self-referrals
- Community networking- publicity
- Extended opening hours
 - *Tues to Thursdays (8.45am – 8.00pm)*
 - *Sundays (10.00am – 4.00pm)*
- Working in primary care settings
- Diverse workforce (language specific therapists)
- Use of interpreters as appropriate
- Language specific literature (leaflets & posters)
 - *Translations of PHQ-9 & GAD into Urdu, Punjabi, Bengali, Arabic, Gujarati*
- Telephone answering service recorded in:
 - *English, Bengali, Punjabi, Urdu, Hindi, Arabic & Gujarati and available up to midnight (managed by Mental Health Matters)*
 -

5.5.13 The Newham service also took advantage of a number of specific marketing and advertising strategies to raise its profile for the whole community:

- Full page advert/articles in Newham Magazine – goes to every home in the borough
- Distribution of leaflets around the borough – GPs, libraries, community/leisure centers, job centers, learning zones, colleges, local shops, pharmacies, supermarkets etc.
- Community Events – Newham Town Show, Local Forums
- Promotional materials – mugs, pens, balloons, etc.
- Radio programme – in local languages
- Meetings with religious leaders

5.5.14 A key learning point from the Newham pilot was that in order to open up access and ensure self-referral routes into services are fully utilized, it is critical to ensure that the profile of the service is raised amongst the full range of local communities.

5.5.15 Although excellent work has already been undertaken in Newham and other services, there may still be issues in ensuring that services meet the needs of other communities whose details may not be captured using current ONS ethnicity categories. An example would be the needs of people from the emerging European states or the Irish community.

5.5.16 Irish people are often an unseen ethnic minority despite being one of the largest communities in Britain with 850,000 Irish born and over 5.5 million second and third generation. They also have the oldest age profile of any group – even greater than ‘White British’. They are unseen because they mostly have English as their first language and are not always immediately identifiable as being an ethnic minority: indeed some Irish people themselves would not immediately identify with this “label”.

5.5.17 In Irish culture, there is a particularly strong stigma around mental health and a reluctance to turn to the state or statutory providers for help. Irish people in Britain suffer disproportionate levels of mental

distress, well above those for all other migrant groups (except for psychosis rates in the African-Caribbean population) and research has found that:

- suicide and undetermined deaths among Irish people in Britain are as much as 40% higher than the population average
- Irish people in Britain have excessive rates of hospital admission for all diagnostic categories of mental illness.

5.5.18 The reasons for these high rates of mental distress are complex. Many older Irish people arrived in Britain the 1950s and 60s, moving from a poor country with few employment prospects. Some did not do so well economically in Britain and find themselves' lonely and isolated towards the end of their lives. The Protestant and Catholic experiences of migration from Northern Ireland, and the trauma caused by "The Troubles", add another layer of complexity. Today, many younger Irish people are arriving in Britain highly educated and starting in well paid careers, yet Ireland remains a country where family and the sense of home and local community are extremely important: losing these ties continues to lead to mental distress.²⁷

5.5.19 It is important that the psychological needs of the Irish, and other white minority communities, are addressed through appropriate engagement, access and service delivery. Current ethnic monitoring is not sensitive enough to accurately gauge the use of IAPT services by these groups. Therefore local intelligence will be paramount in ensuring appropriate service design.

5.5.20 Equality of access, especially for Black Ethnic Minority (BME) communities is also an area where psychologists can contribute.

²⁷ Information provided by Immigrant Counseling and Psychotherapy (ICAP)

People from BME communities experience particular difficulties accessing psychological therapy services. The barriers range from practicalities such as the range of languages used for health information through to attitudinal challenges faced by mainly Eurocentric-focused health professionals understanding the cultural diversity of both the expression and treatment of mental health problems (Williams, Turpin & Hardy, 2006²⁸).

5.5.21 Much has been published recently around race equality and discrimination within health services (see DH, 2007b²⁹), which needs to inform the IAPT programme. The BPS has also published guidance around training staff to work in more culturally sensitive ways (Patel et al., 2000³⁰), together with the challenge of recruiting more ethnically diverse psychologists (BPS, 2004³¹).

5.5.22 With respect to psychological therapies, there is an extensive literature around providing culturally appropriate counseling and therapy, much of it having been written in the US, which ought to inform the practice of psychologists and psychological therapists

²⁸ Nadirshaw, Z. (1999) Rethinking clinical psychology: A race against time for minority ethnic communities in mental health settings. London: Department of Health, Williams, P.E., Turpin, G & Hardy, G (2006) Clinical Psychology Service provision and ethnic diversity within the UK: a review of the literature. *Clinical Psychology and Psychotherapy*, 13, 324-338

²⁹ DH (2007b) Positive Steps: Supporting race equality in mental healthcare. London: Department of Health.

³⁰ Patel, N., Bennett, E., Dennis, M., Dosamj, N., Mahtani, A., Miller, A. et al (Eds) *Clinical Psychology, 'Race' and Culture: A training manual*. Leicester: British Psychological Society

³¹ BPS (2004) *Widening Access Within Undergraduate Psychology Education and its Implications for Implications for Professional Psychology: Gender, Disabilities and Ethnic Diversity*. Leicester: British Psychological Society {ethnicity for psychologists, plus other demographics for health care professions}

within the IAPT programme (Maxie et al., 2006³²; Hays & Iwamasa, 2006³³; Hays, 2001³⁴).

5.6 Religion and Belief

5.6.1 No specific work has been done to date on the potential impact of the IAPT programme with regard to religion and belief. However, there are a number of projects nationally considering work with religious leaders from various faiths as well as how therapies can be adapted to meet the needs of different faith communities. e.g. In Yorkshire and Humber they are exploring the role of Imaams in providing psychological therapies and awareness raising in the Muslim community.

³² Maxie, A.C., Arnold, D.H. & Stephenson, M (2006) Do therapists address ethnic and racial differences in cross-cultural psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 43, 85-98

³³ Hays, P & Iwamasa, G.Y. (2006) *Culturally responsive cognitive-behavioural therapy: Assessment, practice and supervision*. Washington: American Psychology Association

³⁴ Hays, P. (2001) *Addressing cultural complexities in practice: A framework for clinicians and counsellors*. Washington: American Psychological Association

The Yorkshire and Humber project will be an evaluated pilot study to test a CBT skills model appropriate to the Muslim community. The pilot will train Imams and female Muslim scholars in basic CBT skills which will enable trainees to support Muslims with depression and anxiety and build a competent first point of contact for people within their communities. This work will not be a bolt on to services but will be integrated in to the care pathway using the stepped care model. Two independent companies using slightly different approaches will provide the training but both based on NICE Guidance for Anxiety and Depression. Each company will take one site and recruit six Imams and six female scholars onto a training programme specialising in Islamic education. On completion, the trained participants will return to their communities with the knowledge and skills to provide advise on accessing psychological therapies. Both training programmes will provide:

- Supervision
- Data collection
- Evaluation

A separate piece of work will be commissioned by CSIP to evaluate the approach and effectiveness of the two models.

5.6.2 There is the potential that IAPT services may not be appropriate to people of different faiths, as religious perceptions of mental illness may vary, and different dogma may dissuade people from accessing psychological interventions. The impact of this will have to be explored over time and more work needs to be undertaken in this area.

5.7 Gender

5.7.1 Information is being gathered to determine whether the services are equally meeting the needs of both men and women. Across all of the established SIGs discussion is ongoing as to the impact of the

programme on how people of different gender access services. Of the current numbers of people who have been assessed by the pathfinder services, 35% were male and 64% female, however, 1% was recorded as not know or not specified. Within the two Demonstration sites, Doncaster seems to have been like the pathfinders with 35% of referrals being male whereas Newham had 40% of referrals being male.

5.7.2 The prevalence for depression and anxiety disorders among adults living in private households shows that 18% of women and 12% of men scored above the symptom threshold for neurotic disorders. This means if there is no bias in referrals we would expect to see 60% women and 40%³⁵ men in the services, which is what we found in Newham.

5.8 Sexual Orientation

5.8.1 The programme is working closely with the pathfinder service in Brighton and Hove, where they are focusing on the psychological needs of young people from the LGBT community. It is anticipated that the needs of this community group have hitherto not been fully met. The work in Brighton and Hove will begin to show the ways in which access and engagement can be improved.

5.8.2 Early analysis of recording from the pathfinder sites has shown that more than 50% of people accessing services did not record their sexual orientation. It is not know whether this was a choice made by the user of the service or whether workers undertaking initial assessments felt uncomfortable asking questions about sexuality.

³⁵ Psychiatric Morbidity Survey (2000) pages 23- 25

5.8.3 The needs of the older LGBT community will need to be further considered within the programme.

6. Action Plan

- 6.1 To support the programme in promoting the equality of service provision and to inform the development of policy, a number of key steps have already been taken.
- 6.2 In 2007, the IAPT Programme commissioned an equalities screening exercise, helping us to identify where improvements could be made. The resultant action plan has informed much of the work of the programme.
- 6.3 Links with the National Delivering Race Equality Programme have been forged and the National DRE Director is an active member of the IAPT Programme Broad. Ensuring that issues of equality are considered and embedded at all levels of the programme has been identified as critical.
- 6.4 Over the past 18 months a range of Special Interest Groups (SIG) have been established (detailed above). These have brought together service user representatives, academics, clinicians, policy makers and the voluntary sector. These groups have proved invaluable for consultation, and have helped to shape the policy direction of the programme.
- 6.5 The IAPT Programme has been working with the SIGs to produce additional guidance for commissioners. This comprehensive document will be available in Autumn 2008. This will be an important milestone for the Programme, raising the awareness of different groups within the community and enabling them to commission services that reflect their needs.

- 6.6 To enable the embedding of equality issues into the pilot phase of the IAPT Programme, we commissioned ISI Ltd to undertake a series of workshops. These focused on helping pilots undertake robust EqlAs to inform their local service provision.
- 6.7 ISI Ltd were also commissioned to produce an equalities toolkit for the Programme. This will be available on the IAPT website (www.nhs.uk/iapt). This toolkit will help providers and commissioners of new IAPT services undertake EqlAs and consider the broader needs of people from different communities..
- 6.8 Monitoring and reporting are an important element in ensuring that services are responsive to local need. The IAPT Minimum Data Set (MDS) requires services to collect certain equality information, this is mandatory for all new IAPT sites. A more comprehensive full data set collects the full range of equality information. It is recommended that this be used as a matter of best practice.
- 6.9 The development of the IAPT Programme will be monitored by the National Programme Board through the production of key performance indicators (KPIs). The reporting schedule is detailed at Appendix B. More detailed information regarding equality areas will be collected and monitored locally.
- 6.10 Responding to the national service provision across all equality areas will be important in informing future policy direction. Working closely with the National DRE programme, a local audit of usage of IAPT services by BME groups will be undertaken. A DRE Dashboard is currently under construction. Understanding and responding to the needs of BME communities has been identified as a priority by SHA Chief Executives.

6.11 Each of the four areas of activity in the NWW4PT programme have been tasked specifically to look at the Equality agenda and the outcomes will be fully reflected in the proposed Best Practice guidance scheduled for publication in the Spring of 2009

Appendix A - DRE Dashboard

SUMMARY DRE Dashboard

1. **Measurable and data is currently collected** = can monitor or potentially monitor over time. This heading is broken down into two further categories in order to take account of:
 - One-off measurements – information collected as a result of DRE-commissioned work, and which can establish a baseline for future development to enable monitoring for outcomes; and
 - Year-on-year measurements – i.e., data which is already collected or is capable of capture and analysis if appropriate systems, processes, mechanisms, linkages are developed and put into place.
 - 1.1 **One-off measurements**
 - Prescribing
 - Prison MH care (Count Me In pilot projects, DRE work on pathways)
 - 1.2 **Year-on-year measurements**
 - Early Intervention services
 - Home Treatment Services
 - Assertive Outreach Services
 - Access to psychological therapies
 - Referral routes e.g. from GP or criminal justice routes or others
 - Admissions (**rates**)
 - Section (**rates**)
 - Community Treatment
 - Confidence/Satisfaction (HCC survey)
 - Suicides (of those in contact with mental health services)
 - Deaths in restraint
 - Deliberate Self Harm monitoring
 - CDWs (**numbers**)
 - Workforce (**ethnic diversity of staff; staff trained in RECC**)
2. **Measurable – but needs more discussion and development** - with SHA and PCT mental health leads and mental health trusts.
 - Admissions (**length of stay**)
 - Delayed discharges
 - GPs QOF data
 - Objective experience
 - Seclusion
 - Confidence/Satisfaction – e.g. develop in relation to WCC, further CMI data
 - Self-reported mental health
 - PSA targets on social inclusion
 - CDWs (**impact**)
 - Workforce (**use of CDWs**)
3. **Narrative outcomes** – capturing the richness of the work in the DRE programme

A framework to enable cohesive capture of narrative outcomes is being developed through work with Michael Clark and Gyles Glover with race equality leads. It will complement and help to tell a more comprehensive 'story' in relation to the hard data.

- Self-reported mental health
- FIS
- Community Engagement projects
- EPIC sites
- 3rd Sector involvement
- Better use of information

DRE Dashboard

11 July 2008

**DRE Dashboard & Indicators Framework
Version 4.4– 25. 6.08**

Area	Definition of indicator(s)	What the indicator means	What the expected direction of travel would be	Data source(s) and levels of coverage (national/local)	Feasibility and next steps	DRE Characteristic(s)
Access (1/3)						
Early Intervention services (1.2)	1. Numbers of service users by ethnicity 2. DUP	1. We would expect rates of using services to reflect the ethnicity of local populations and their incidence of psychosis. 2. We would expect DUP to be no longer for ethnic minority groups	As services provide equal access we would expect this to influence the proportions of BME users to fully reflect their psychosis incidence. Overall an upward trend in the proportion of BME users is likely.	1. LDPR (Q4 2008-9) 2. Possibly datasets from services and related research (LEO, Worcester, EDEN, MiData, FERN) 3. MHMDS	1. Request one off Q4 collection from K&I team in DH (DLD) 2. Discuss with EI leads and researchers (MW). 3. Review progress with MDS data (DLD/MW)	1,2,3,4,10
Home Treatment Services (1.2)	Numbers of people receiving home treatment in period in relation to ethnic diversity and mental health needs of local community	We would expect rates of using services to reflect the ethnicity of local populations and their incidence of severe mental illness/their inpatient admission rate	As services provide equal access we would expect this to influence the proportions of BME users to fully reflect their need for acute care for SMI. Overall an upward trend in the proportion of BME users is likely.	1. LDPR (Q4 2008-9) 2. Possibly the Karen Linde/Steve Onyett crisis “database” as a source.	1. Request one off Q4 collection from K&I team in DH (DLD)	2,3,10
Area	Definition of	What the	What the expected	Data source(s) and	Feasibility and next steps	

	indicator(s)	indicator means	direction of travel would be	levels of coverage (national/local)		
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Access (continued 2/3)						
Assertive Outreach Services (1.2)	Numbers of people using services in relation to ethnic diversity and mental health needs of local community	We would expect rates of using services to reflect the ethnicity of local populations and their prevalence of psychosis/SMI.	As services provide equal access we would expect this to influence the proportions of BME users in AO to fully reflect their needs. Overall an upward trend in the proportion of BME users is likely.	1. LDPR (Q4 2008-9)	1. Request one off Q4 collection from K&I team in DH (DLD)	3
3Access to psychological therapies (1.2)	Numbers of people using services in relation to ethnic diversity and mental health needs of local community. (Also, access for those with severe mental health – see <i>objective experience</i> below.)	1. Expect people in secondary services to be offered equal access to psychological therapies 2. Expect IAPT sites to provide equal access	Depends on baseline IAPT findings later in 08-09 <ul style="list-style-type: none"> Expect BME – relevant focus re CBT Expect visible BME vol sector presence as low intensity training providers 	1. HCC survey 2. Data from IAPT sites collected as part of programme 3. Up to date demography data for localities – possibly from LAs or Public Health Observatory 4. DRE clinical trailblazer (Hampshire IOW re BME/CBT manual)	Request baseline data and tracking information from IAPT expansion sites Share and discuss dashboard with expansion sites	1, 2,3,4,7,10, 11,12
Referral routes e.g.	Numbers coming from the	People coming to secondary	As other issues improve we would	HCC Count Me In	Share and discuss dashboard with PCTs, SHAs to identify practicalities in re performance	1,2,3,4

from GP or criminal justice routes or others (1.2)	different referral routes to be proportionate across ethnic groups.	services via 'preferred/better' routes rather than more coercive ones	expect to see more equality of people coming from GP referrals.	Autumn Assessment outcomes planning	management	
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Area	Definition of indicator(s)	What the indicator means	What the expected direction of travel would be	Data source(s) and levels of coverage (national/local)	Feasibility and next steps	
Access (continued 3/3)						
Admissions (1) & (2)	1. Admission rates (1.2) 2. Section rates (1.2) 3. Length of stay (2)	Current debate is that admissions and sections adversely used for some BME groups. Some debate about different levels of needs, so may not want admissions and sections to reduce too quickly in short term as it may lead to unmet need.	In the longer term we would expect that as other equality, trust and access issues are addressed admissions and sections would come more in line across ethnicities taking relative morbidities into account.	Count me In Detailed MH trust analysis and action based on Count Me In	Raise profile of and discuss Dashboard with mental health trusts, SHA MH Commissioners, PCT MH Commissioners (MW)	1,2,3,4
Community Treatment (1.2)	Numbers of BME people subject to SCT	Enables analysis of impact on BME communities for incidence, effectiveness of intervention	Transfer of compulsion from hospital to community is a good thing. Would expect	This is part of the PRP commissioned research on the new Act	Share and discuss dashboard with Mental Health legislation team to identify appropriate mechanisms, e.g. through training (MW)	1,2,3,4

			downward trend in numbers admitted to hospital			
GPs QOF data (2)	Increased use of ethnic monitoring	Enables more targeted use of resources, e.g., interpreting/translation	Increased use of data to involve communities and provide svcs	World Class Commissioning assurance framework	Needs further discussion with PCT MH commissioners (MW)	1,2,3,4

Area	Definition of indicator(s)	What the indicator means	What the expected direction of travel would be	Data source(s) and levels of coverage (national/local)	Feasibility and next steps	
Experience						
Objective experience (2)	Indicators of services offered and used – includes some issues of access above	Inequalities in services being offered should be eliminated, and choice increased.	Any inequalities in what is offered to be removed. Choice and culturally appropriate services may mean differences in service use.	Count me in and Patient Survey	Discuss with IAPT team re GP access and employment advisers (MW)	1,2,3,10,11,12
Prescribing (1.1)	Prescribing rates for anti-psychotics	We would expect rates of prescribing to reflect needs.	If significant disparities are found taking morbidity account, disparities should diminish over time	DRE commissioned research on prescribing in relation to BME communities, based on 10 trusts around the country. Report is due in Autumn.	Disseminate outcome of DRE Prescribing & Race Audit (South London & Maudsley NHS Foundation Trust) (MW)	1,2,10,12
Seclusion (2)	Reduced rates of seclusion Proportionate use of seclusion	greater use of more appropriate treatment/proportionality in use of seclusion	Downward trend	Reports to trust boards	Share and discuss dashboard with mental health trusts & NHS Confederation (MW)	6
Prison MH care (1.1)	Better recording of ethnicity of BME prisoners	Enables identification of more appropriate forms of engagement	Better information about care pathways and how to effect change	Count Me In pilot prison projects DRE commissioned work on pathways	Share and disseminate information (MW)	9
Confidenc	1. Overall	How people feel	We would expect	1-4 HCC survey	Share dashboard with HCC & PCT MH	1,2

e/Satisfaction (1.2) & (2) re WCC	expressed satisfaction 2. Do people feel treated with dignity 3. Do people say they trust services 4. Do people feel listened to	they treated by the services.	equality in how people feel about how they treated, and, overall, satisfaction to increase for all groups over time.	Repeat qualitative Count Me In work WCC competencies 3, 5, 6	Commissioners & SHA MH Leads (MW)	
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Area	Definition of indicator(s)	What the indicator means	What the expected direction of travel would be	Data source(s) and levels of coverage (national/local)	Feasibility and next steps	
Outcomes for people						
Self-reported mental health (2) & (3)	How people report their health and recovery to be.	How people feel about their health	Greater confidence in services through making use of user narratives/recovery in service planning & provision	DRE Recovery Star pilot project (MH Providers Forum) DRE Black Wellness Initiative	Disseminate findings from DRE Star Recovery, Black Wellness Initiative, (MW)	1,2,3,4,8,10
PSA targets on social inclusion (2)	1. Settled accommodation 2. In occupation	Are people having equal opportunities in terms of these important social inclusion criteria?	We would expect to see equality in outcome for the PSA targets		Data collection still being agreed for PSAs. Need to ensure ethnicity coding is part of this. (??)	2,10
Suicides (1.2)	Number of suicides	A decline in suicides in services means safer services.	We would hope for overall reductions and no inequalities	Confidential Inquiry		9
Deaths in restraint	Number of deaths	A decline in deaths in restraint	We would hope for overall reductions	Confidential Inquiry		5,7

(1.2)		in services means safer services.	and no inequalities			
Deliberate Self Harm monitoring (1.2)	Patterns of self-harm and outcomes.	Enables identification of trends/incidence. Greater awareness of difference patterns of DSH in different groups	earlier intervention Reducing patterns of self harm	DSH multi-centre monitoring programme commissioned to run until end of Suicide strategy and this provide local data from 3 areas, of which ethnicity will be part.		10
Area	Definition of indicator(s)	What the indicator means	What the expected direction of travel would be	Data source(s) and levels of coverage (national/local)	Feasibility and next steps	
Community Engagement (1/2)						
CDWs (1.2) & (2) re 2	1. Numbers of CDWs 2. Their work and its impact	CDWs are there to build bridges between communities and services –to improve trust, confidence and outcomes	Targets met in terms of numbers. Increased awareness of CDWs as a resource – e.g. through improved induction processes	Routine data for numbers. Evaluation of CDWS will illuminate impact.	Share and discuss dashboard with PCTs (MW)	11,12
FIS (3)	Patterns of Community Engagement in FIS sites	Community engagement in FIS sites should help with trust, access and outcomes equality	We would expect high levels of CE in FIS sites.	Part of FIS evaluation already commissioned	Disseminate findings and link into SHA planning & performance management through SHA Mental Health Leads (MW)	1,2,11
Community Engageme	Numbers of projects and	Community engagement	We would expect good reports of	Data sources on numbers form UClan.	Disseminate findings and link into SHA planning & performance mechanisms; share and discuss	1,2,8,12

nt projects (3)	their impact	projects are to increase evaluation capacity in communities, and enhance their engagement in local service planning and provision	impact from the CE projects Would expect CE learning to progress beyond DRE-specific sites	Data on impact	with PCTs, mental health trusts, SHA Mental Health Leads (MW)	
EPIC sites (3)	Patterns of CE in EPIC sites	CE to improve local care pathways	Demonstrable use of CE learning into mainstream commissioning and provision	This a part of the already commissioned evaluation of EPIC sites	Disseminate findings and links into SHA planning and performance mechanisms; share and discuss with PCTs and mental health trusts (MW)	1,2,3,8,10
Area	Definition of indicator(s)	What the indicator means	What the expected direction of travel would be	Data source(s) and levels of coverage (national/local)	Feasibility and next steps	
Community Engagement (continued 2/2)						
3rd Sector involvement (3)	DRE Recovery Star Pilots Levels of involvement in DRE regionally	Learning from the voluntary sector	Incorporation of learning	Outcomes of DRE Recovery Star Pilots Local intelligence from RELs	Disseminate findings and links into SHA planning and performance mechanisms; share and discuss with PCTs and mental health trusts	1,2,3,8,10,11,12
More appropriate and responsive services (see also issues of access above)						
Workforce (1.2) & (2)	1. Ethnic diversity of workforce 2. Staff trained in cultural capability 3. use of CDWs	A more culturally diverse and capable workforce should engage better with clients and in the longer term reduce	Increased numbers of staff undergoing RECC training Appropriate use of CDWs – strategically &	1. Count me in 2. DRE information regionally and nationally 3. SHA performance management returns 4. Comprehensive	Disseminate findings and links into SHA planning and performance mechanisms; share and discuss with PCTs, mental health trusts & SHA MH Leads	1,2,11,12


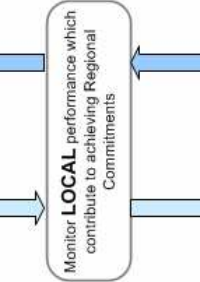





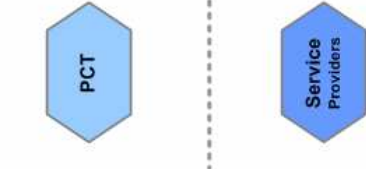
		inequality of sectioning	operationally – e.g. comprehensive induction and development in place	induction plans in place for CDWs		
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Better use of information

Better use of information (3)	Visible use of learning from DRE & other areas to inform planning, commissioning and delivery	Improved services based on better use of information	Increased satisfaction with services	HCC survey, World Class Commissioning assurance framework for PCTs, Count Me In, Learning from FIS,CE, Clinical Trailblazers	Share and discuss dashboard with PCTs SHAs	1,2,3,4,12

**DRE Dashboard
25.6.08**

Appendix B – Reporting Schedule for IAPT Programme

IAPT Performance Reporting Framework Overview				
Level	Function and Flows	Indicators	Reporting	Amount of Data
		<p>National Commitment</p> <ol style="list-style-type: none"> PCT Coverage <ul style="list-style-type: none"> - Number of IAPT expansion sites (PCTs) (year 1) - Expected number of sites (year 2 and 3) Building a skilled workforce <ul style="list-style-type: none"> - Number of trainees and trained staff (high and low intensity) - Number of supervisors (or similar) Extending Access to NICE compliant services <ul style="list-style-type: none"> - Number of people attending an initial assessment, leaving treatment, and number of people recovered (of those leaving) Helping People Back to Work <ul style="list-style-type: none"> - Numbers moving off sick pay and benefits 	<p>Regional data is aggregated to produce a NATIONAL COMMITMENT PROGRESS REPORT which is presented to the IAPT Programme Board on a bi-monthly basis</p>	●
		<p>Regional Commitment/Key Performance Indicators</p> <ol style="list-style-type: none"> PCT Coverage <ul style="list-style-type: none"> - Number of IAPT expansion sites (PCTs) (year 1) - Expected number of sites (year 2 and 3) Building a skilled workforce <ul style="list-style-type: none"> - Number of trainees and trained staff (high and low intensity) - Number of supervisors (or similar) Extending Access to NICE compliant services <ul style="list-style-type: none"> - Number of people attending an initial assessment, leaving treatment, and number of people recovered (of those leaving) Helping People Back to Work <ul style="list-style-type: none"> - Numbers moving off sick pay and benefits 	<p>PCT submissions are aggregated by the Information Centre to produce REGIONAL KEY PERFORMANCE INDICATORS REPORTS which are presented to the IAPT Programme on a Quarterly basis</p>	●
		<p>Local Performance Indicators</p> <ol style="list-style-type: none"> Building a skilled workforce <ul style="list-style-type: none"> - Number of trainees and trained staff (high and low intensity) - Number of supervisors (or similar) Extending Access to NICE compliant services <ul style="list-style-type: none"> - Number of people attending an initial assessment, leaving treatment, and number of people recovered (of those leaving) Helping People Back to Work <ul style="list-style-type: none"> - Numbers of people moving off sick pay and benefits 	<p>PCT KEY PERFORMANCE INDICATORS REPORT are submitted via Omnibus on a Quarterly basis</p>	●
		<p>1. Access Standards</p> <ul style="list-style-type: none"> - Average mean waiting times for assessment, treatment and movement between steps of care - Equity - number of people referred and treated relative to the population and ethnic groups - Population coverage - number of people who access psychological therapies <p>2. Health and Wellbeing Outcomes</p> <ul style="list-style-type: none"> - Effectiveness - pre and post outcomes scores for 90% of people treated, and recovery rates - Helping people back to work - numbers of people moving off sick pay and benefits <p>3. Service Standards</p> <ul style="list-style-type: none"> - Acceptability - levels of satisfaction and choice 	<p>Various local reporting templates to demonstrate service achievements and health and well-being outcomes are collated on local systems</p>	●

Appendix C

Special Interest Groups (SIGs) Members List

Black and Minority Ethnic (BME) Special Interest Group

Matt Fossey (Chair)	Department of Health/CSIP
Stephanie Gray	Department of Health/CSIP
Marcel Vige	MIND
Prof Swaran Singh	Warwick University
John Cowley	BACP
Brendan McLoughlin	London Development Centre, CSIP
Dele Olajide	South London and the Maudsley (SLAM) NHS Trust
Narinder Gharial	Confederation of Indian Organisations
Asha Day	CSIP
Joe Mairura	CSIP
Adrian Webster	Head of Lambeth Psychology, South London and the Maudsley NHS Trust
Deborah Cameron	Addaction
Amra Rao	Newham Psychological Therapies Service
Frank Keating	Royal Holloway, University of London
Prof Kam Bhui	Queen Mary College, University of London
Tracy Lee	Derbyshire County PCT
Faith Stafford	BACP
Georgina Horobin	Mental Health Commissioner, Derbyshire County PCT
Jim Fowles	Department of Health- Mental Health DRE Lead
Sachdev Seyan	Hertfordshire Partnership NHS Foundation Trust
Dominic Glover Shahana	West London MHT
Ramsden	Deputy Director, Delivering Race Equality Programme, CSIP
Mpume Mpote	Black Wellness
Shahara Miah	Assistant Commissioning Manager, Mental Health, Ealing PCT
Ian Davis	Head of Integrated Commissioning, Ealing PCT/ London Borough of Ealing
Micheal Lilley	Director, My Time
Stephen Maynard	Stephen Maynard and Associates
Marie Bradley	Consultant Practice Therapist, Common Mental Health Problem Service
Bev Stewart/ Michelle Jones	Open Doors Forum Community Development Worker, Bedfordshire and Luton Mental Health and Social Care Partnership Trust.
Christina Jassi	British Society for Mental Health & Deafness
Jonathan Isaacs	Community Development Worker, Barnet
Ross O'Brien	Community Development Worker, Barnet
Baljeet Ruprah- Shah/	Head of Mental Health & Wellbeing Service, Ealing PCT
Jane Rosoman	Clinical Lead, Mental Health & Wellbeing Service, Ealing PCT
Mark Kenwright	Head of CBT Service, WLMHT

Older People Special Interest Group

Matt Fossey (Chair)	DH/CSIP
Stephanie Gray	DH/CSIP
Ann-Marie Nielsen	Bucks Pathfinder
Jeff Love	Stoke Pathfinder
Sharon Taafe	Stoke Pathfinder
Jane Garner	RCPsych
Sandra Evans	RCPsych
Caroline Williams	Sussex Partnership NHS Foundation Trust and South Thames PSIGE/DCP
Steve Boddington	South London & Maudsley (SLAM) Foundation Trust
Sean Haldane	BPS
Kate Mahony	BPS
Clare Crellin	Sussex NHS Partnership Trust
Elsbeth Stirling	PSIGE, DCP.
Nadine Schofield	CSIP
Mandy Rudd	Senior Nurse
Carolyn Chew-Graham	GP and Senior Lecturer, University of Manchester
Robert Baldwin	Manchester University
KCM Wilson	Liverpool University
A Hill	Salford University
Lesley Carter	CSIP
Adrienne Little	SLAM/ BPS
Philip Hurst	Age Concern England
Sube Banerjee	Institute of Psychiatry, Kings College London
Tom Howell	CSIP
Toby Williamson	Mental Health Foundation
Debbie Clarke	Consultant clinical psychology and lead for Hertfordshire Older Adults SIG
Rachel Glynn- Williams	Chartered Psychologist Clinical Psychologist, Coventry and Warwickshire Partnership Trust.
Amanda Gatherer	DH
Gillian Russell	UKCP
Jason Hepple	Cognitive behavioural psychotherapist and co facilitator -BABCP
Gwyn Higginson	

Long Term Conditions (LTC) & Medically Unexplained Symptoms (MUS) Special Interest Group

John Hague (Chair)	SCMH
Matt Fossey	DH/CSIP
Stephanie Gray	DH/CSIP
Frank Holloway	Institute of Psychiatry
Claire Hallas	Health Psychology Lead, Royal Brompton & Harefield NHS Trust
Nikki Oatham	Psychology Lead, Kent and Medway Trust
Tracy Morton	DH

Elsbeth Guthrie	Manchester University/ RCPsych
Prof Christopher Dowrick	University of Liverpool
Wendy Clarke	Manchester University
Dr Richard Byng	Peninsula Medical School
John Cape	Head of Psychology, Camden and Islington
Jeremy Clarke	New Savoy Partnership
Prof Paul Salkovskis	Institute of Psychiatry
Prof Richard Morriss	Nottingham University
Linda Gask	Manchester University
Louise Robinson	BACP
Steven Mackie	BACP
Edward Greenwood	Rethink
Phil McEvoy	Salford PCT
Sylvain Laxade	Salford PCT
Judith Sheehan	North Tees and Hartlepool PCT
Suzanne Withington	Stoke PCT
Hazel Thorp	Dorset PCT
Alan Cohen	SCMH, CSIP Primary Care Lead
Tom Dodd	CSIP Primary Care & Dual Diagnosis
Alex King	BPS Faculty of Clinical Health Psychology.
Hilary Rankin	BPS Faculty of Clinical Health Psychology.
John Larsen	Head of Evaluation, Rethink
Dr Nicky Veronica Thomas	Consultant Health Psychologist, Guy's & St Thomas' Hospitals Foundation Trust
Professor Michael Chester	Consultant Cardiologist & Director National Refractory Angina Centre
Phillip Kinsella	CBT Therapist, QMC, Nottingham
Caroline Maxted,	Research Asst Psychologist, MUS Project Plymouth
Andrew Nicholls	Hertfordshire Partnership Foundation Trust
Chris Powell	UKCP
Rupert Noad	Clinical Neuropsychologist, MUS Project Plymouth

Offenders Special Interest Group

Matt Fossey (Chair)	DH/CSIP
Stephanie Gray	DH/CSIP
Lorraine Khan	SCMH- Youth Offender Project
Dave Knight	DH- Offender Health
Kerry Manson	Consultant Clinical Psychologist, HMP Liverpool
Elizabeth Tysoe	HM Inspectorate of Prisons
Louise Falshaw	HM Inspectorate of Prisons
Nicholas Pascoe	Prison Service
Brian Docherty	Prison Service
Richard Bradshaw	DH Offender Health
Ruth Shakespeare	Public Health Team
Lynn Emslie	CSIP

Anne Richardson/ Mignon French	DH Offender Health
Simon Coombes	Dorset Pathfinder
Jo Bailey	National Offender Management Service (NOMS)
Graham Durcan	SCMH- Criminal Justice Programme
Charlie Brooker	University of Lincoln
Gwen Adshead	West London MHT
Mrk Westacott	Consultant Clinical Psychologist

Veterans Special Interest Group

Bob McDonald (Chair)	DH, Senior Mental Health Policy Lead
Matt Fossey	DH/CSIP
Stephanie Gray	DH/CSIP
Richard Williams	DH Adviser on Emergency Preparedness
John Hall/Ian Allred	HASCAS
Jonathan Iremonger/ Chris Williams	Ministry of Defense
Mary Robertson	Camden & Islington PCT
Jenny Priest	Policy Adviser- The Royal British Legion
Dave Rutter	DH Stakeholder and Partner Relationships
Dr Anne Braidwood	Ministry of Defence

Children & Young People Special Interest Group

Matt Fossey (Chair)	DH/CSIP
Stephanie Gray	DH/CSIP
Jenny Hunt	BPS, Chair Child and young people, BPS
Paul stallard	Bath University
Ruth Armstrong	BPS/ Newham Child and family consultation service
Avis Johns	Young Minds
Susan Pattison	Newcastle University/ BACP
Andrew Hill	Salford University
Irene Sinclair	South London and Maudsley NHS Foundation Trust and BPS
Mary John	Surrey University
Maria Crowley	Sussex Partnership Trust
Philip Dodgson	Sussex Partnership Trust
Barry Nixon	Workforce Lead, CAMHS
Sue Bailey	University of Central Lancashire
Rachel Calam	Child Psychologist, Manchester uni
Jonathan Green	Manchester University
Karen Cromarty	BACP
Miranda Wolpert	UCL
Charlotte Wilson	University of East England
Peter Jenkins	Salford University
Anna Dalton	Bury PCT
Helen Lambert	Bury PCT
Claire Maguire	Bury PCT
Elaine Bousfield	Kooth.com project, Xenzone
Wendy Mcdonald	Manchester University

Nicola Dummett	BABCP Children, Adolescents and Families Special interest Branch
Dawn Rees	CSIP CAMHS
Carmel Richardson	Sussex Partnership
Ann York	DH- CAMHS Adviser
Denise Fisher	Liverpool John Moores University
Aileen Moore	Waller Trainer, Sheffield PCT
Bernadette Devine	Brighton IAPT Project Manager
Laura Donington	UKCP
Catherine Gallop	Exeter University
	BABCP, Children, Adolescents and Families Special Interest Group, Birmingham.
Joanna Grave	
Chip Chimera	The Institute of Family Therapy

Perinatal Special Interest Group

Matt Fossey (Chair)	DH/CSIP
Stephanie Gray	DH/CSIP
Jane Verity	DH Maternity Lead
Margaret Oates	Nottingham University & RCPsych
Pat Seber	BACP
Pauline Hall	Clinical Psychologist, Salford Pathfinder
Dr Suzanne Glendenning	Salford Psychology Services
Michelle Cree	Consultant Clinical Psychologist, Derby City General Hospital
David Goodban	CSIP CAMHS Regional Development Worker
Prof Steer	Imperial
Faye Macrory	Consultant Midwife, Manchester Specialist Midwifery Service
Jan Cubison	Sheffield Perinatal Mental Health service
	Clinical Director, Consultant Obstetrician, Liverpool Woman's NHS Trust
Helen Scholefield	Trust
Janice Rigby	SLAM
PO Svanberg	Health-led parenting project
Carol Tiernan	RCM
Angela Hulbert	RCM
Mervi Jokinen	RCM
Brid Kelly	Herts
Phil Mollon	Hertfordshire NHS Trust
Angelika Wieck	Consultant Psychiatrist, Manchester
Jane Hamilton	Perinatal Psychiatrist in Maternal Health
Marion Fantom	Specialist Midwife, Manchester
Mel Parr	Psychology Lead for Hertfordshire Pathfinder Site
Sarah Barratt	Assistant Psychologist, Salford
Marjorie Finnigan	Perinatal Mental Health Worker
Michael Lilley	Director, My Time CIC
Pauline Slade	Clinical Psychologist, Sheffield
Suzanne Truttero	DH, Midwifery Adviser

Appendix D – Terms of Reference for SIGs

Improving Access to Psychological Therapies

Special Interest Groups Terms of Reference

Sept 2007

Aims

The Special Interest Groups aim to:

- influence and help develop best practice for the pathfinder sites and other PCTs who wish to develop services.
- advise on services and patient pathways for the different special interest areas
- develop metrics to demonstrate effectiveness in the special interest areas

from the scope of:

- Perinatal depression
- Children and young people
- Older people
- Black and Minority ethnic communities
- Long Term Conditions (LTC) and Medically unexplained symptoms (MUS)
- Offenders
- Veterans

Objectives:

- To bring together learning and ideas.
- To advise, where appropriate, on evaluation
- To advise, where appropriate, on commissioning

- To develop the practical application of the stepped care service model for special interest groups
- To define the evidence-based psychological interventions (including admission and discharge criteria) appropriate at each level of 'caseness' within the stepped care model
- To advise DH on the development of the existing evidence base and as appropriate support the DH in working with NICE on the development and review of future guidelines
- To consider a pragmatic approach to the collection of appropriate clinical data/evidence to support the CSR submission and future roll-out of the programme
- To determine longer term strategies for evidence collection for the special interest groups that could be subjected to academic scrutiny
- To do the above, the groups will also need to ensure that the opinions of service users and carers are properly integrated into the process

Key principles

The special interest groups will operate in accordance with the following set of principles and values:

- Service user and carer focus
- Social Inclusion
- Whole systems working
- Enabling service excellence
- Promoting Learning and Innovation
- Equalities

Mode of working

The groups will share knowledge and views, and carry out their duties in an atmosphere of courtesy and respect. The groups will seek to act as inclusively as possible and will consider evidence from a wide range of opinion, including stakeholders within and outside the NHS.

Frequency of meetings to be decided.

The groups will be chaired by X or Y. The agenda will be co-ordinated by Y (IAPT Special Interest Group Lead) and signed-off by the Chair. Notes

and action points will be forwarded with agenda papers to the group one week in advance of the meetings.

Flexibility

The panels may be asked to undertake work not within the scope of the ToR. The panels are expected to be flexible to any such appropriate requests that will be of benefit to the IAPT programme, and any such requests should be raised at the earliest convenient meeting.

Accountability

The panels will be accountable to the IAPT Programme Board in an advisory role, via the chair, reporting on issues arising.

Acknowledgements

The IAPT Programme would like to thank the following for their help and assistance in producing this Equality Impact Assessment:

All members of the IAPT Special Interest Groups

The national IAPT Programme Team

All of the IAPT Pathfinder Sites

Hazel Sawyers and Denise Bobb of ISI Ltd

Louise Howell

Department of Health Mental Health Branch

Gary Fereday of ICAP

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