**Good Practice Case Study**

**Introduction**

iCope – Increasing access for Bangladeshi community members

I am a Bengali-English speaking Clinical Psychologist working for Camden and Islington NHS Foundation Trust. I work for iCope Psychological Therapies Service which forms part of the Improving Access to Psychological Therapies National Programme (IAPT). iCope provides NICE recommended psychological therapies for some of the estimated 37,00 people in Camden experiencing anxiety and depression. We are integrated with primary care and offer treatment to people in over 90% of Camden GP practices.

The service takes a stepped care approach to providing therapy with the principle of offering people least intensive most effective treatment first. The ‘low intensity’ psychological interventions include Guided Self Help using CBT based materials, psycho-educational groups, computerised CBT, and community linking. The ‘high intensity’ psychological therapies include Cognitive Behavioural Therapy, Interpersonal Therapy, Mindfulness Based CBT, and Compassion Focused Therapy.

Every year there are about 9,000 referrals in Camden, 6,000 people access the service and over 5,200 receive treatment in the service. An objective is to make our services more accessible to under-represented groups including older people, black and minority ethnic (BME) groups, and people with long-term health conditions.

It is an expressed objective of the Trust to make our services more accessible and tailored to meet the needs of the minority groups it serves. I am part of a BME working group (7 clinicians) and our aim is to increase access for BME community members, targeting predominantly the Bangladeshi, Black, Chinese and Irish Community. Working alongside two Bengali-English speaking Psychological Wellbeing Practitioners (Ruhana Hussain and Shah Alam), we have developed some services that has enabled for us to offer culturally appropriate therapy service to the Bangladeshi community.

**The Challenge**

The Bangladeshi community is one of the largest minority communities with a population in Camden of 11,700 (5.7%). The vast majority of the Bangladeshi community came to Britain during the 1950s from the rural area of Sylhet. Sylheti is the main dialect spoken. Around 90% of the population are Muslims.

The Bangladeshi community is one of the most deprived BME communities with high prevalence of housing problems, poor education, unemployment and low paid jobs, financial problems, immigration and integration stress, isolation, marital problems and relational difficulties between parents, children, and extended families. There is evidence to indicate that these factors often result in stress that can lead to emotional problems (anxiety and depression).

There is generally a low take-up of mental health services by the Bangladeshi community members. Our service target for year 2015 was 4% for Bangladeshi people entering treatment and we achieved 2.4%. There are number factors for this:

1. A lack of knowledge of local mental health services
2. The taboo of mental illness which hinders help-seeking behaviour
3. Language and communication difficulties making it challenge for Bengali speaking individuals to access therapy services
4. Services not offering culturally specific treatment that allows for mental health problems to be conceptualised in social, historical, familial and cultural contexts.

Language and communication difficulties can be a particular barrier for the Bangladeshi community. This barrier may be exacerbated rather than helped by interpreters. For instance interpreters may lack an understanding of mental health issues and may not interpret all of the information. The presence of interpreters may also cause concerns about confidentiality and feelings of unease in some service users.

Not offering culturally specific treatment is another key challenge, one that could influence the low take-up of therapy services, engagement and recovery. The main therapeutic model we use in iCope is Cognitive Behavioural Therapy. This approach is situated within a Western medical model, which does not always translate to individuals from BME groups.

**How It Worked**

In the last year and with the hope of tackling some of these challenges within the Bangladeshi community, we have participated in some projects and developed several helpful services.

**Increasing knowledge of local services and removing stigma**

This challenge is not an easy one to tackle. The BME group has worked hard to raise awareness of mental health problems within the Bangladeshi community, to remove stigma and increase knowledge of mental health services. We work closely with a range of community organisations to ensure pathways to help for common mental health problems are easy to use for members. On an annual basis, we attend and set up iCope stalls at Bangladeshi festivals in Camden to a) raise awareness of mental health problems b) discuss what psychological therapy involves and how they can access this via their GPs and c) orientate people to other community organisations for resources and with the aim of addressing isolation.

I am currently working jointly with Camden Hub, a Mental Health Wellbeing Centre aimed at supporting people who are socially isolated and experiencing mental health difficulties. Together we produced a video to be aired in GP practices across Camden. The video is in Bengali language with expert speakers including a psychologist (myself), NHS Mental Health Commissioner Nadia Haque, religious leader Mufti Ahsan Ahmed, and the Mayor of Camden Nadia Khan. The mission of the project is to de-stigmatise mental health problems and offer religious permission to access support outside of family. The content orientates the viewer to mental health problems, signs and symptoms, and how to access psychological therapies via their GP. The video editing is almost complete and will be aired in the GP surgeries across Camden in 2017.

  

 **Offering culturally specific services in Bengali Sylheti dialect**

There are a number of ways we have worked hard to offer a service that is relevant, useful and appropriate to the needs of the Bangladeshi members.

**Therapies**
We offer psychological therapy in Bengali Sylheti dialect (one Clinical Psychologist and two Psychological Wellbeing Practitioners). The Bengali speaking therapy service offers high intensity step 3 psychological therapies and guided self-help and community linking.

Therapy in Bengali considers the impact of cultural, familial and social contexts in the emergence and maintenance of emotional problems. We have been adapting the CBT approach to include systemic theory and practice. I have completed a Foundation Course in Systemic Approaches and have developed peer supervision group to discuss complex cases, theory-practice links and challenges of working with this population group. Additionally, we have individual supervision for our BME role.

On a low intensity level, we adapted a 6-session ‘Feeling Good Group’ and two Bengali speaking Psychological Wellbeing Practitioners (Shah and Ruhana) facilitated the group. We called this pilot the ‘Staying Well Group’. 5 Bengali speaking clients attended. Each weekly group covered a topic (e.g. CBT framework, challenging thoughts, changing behaviours, relaxation, staying well) where theory was discussed and clients were given tasks to practice.

Finally, we jointly work with Camden Diabetes Integrated Practice Unit (Royal Free Hospital) to administer the ‘Stress Management and Diabetes’ session in Bengali as part of the DESMOND Type 2 Diabetes Education Programme. This is a self-management and diabetes education programme for people diagnosed or living with diabetes. This intervention is particularly crucial to administer to the Bangladeshi community where diabetes is most commonly diagnosed but poorly managed.

**Research**
Research is underway to improve access, engagement and recovery for Bangladeshi community. Some of the research we are focusing on include:

* Working systemically with Bangladeshi clients
* ‘Staying Well Group’ pilot interviews and report
* Bangladeshi clients experience of receiving psychological therapies
* Examining Bengali clients access to iCope and recovery rates (completed)
* Guidelines on adapting CBT assessment and treatment and improving clinicians ability to engage Bangladeshi clients

**Resources**
We use translated PHQ/GAD measures and the IAPT adapted Enablement Instrument (Howie et al., 1998) to measure outcome for this population.

I have produced the first Mindfulness Based Relaxation audio recording in Bengali Sylheti dialect. The process involved attending a 8-week Mindfulness Based CBT group within iCope, creating a script of relaxation and mindfulness based exercises that are culturally relevant, translating this into Bengali language, recording, and jointly working with Camden Hub to design, print and disseminate across Camden.


 **Impact**

As these projects and services have recently emerged, we have yet to establish results that will show the impact. However, I would like to take this opportunity to mention how people have responded to the work that we have been doing.

**The Mental Health Video**
This is will be aired in GP surgeries. We have received positive feedback about the video from the GP surgeries across Camden, NHS commissioner, Mayor of Camden, and service managers. We look forward seeing the effects this has on our referral rates and access (to be monitored and evaluated).

**The Mindfulness Based Relaxation CD**
This is in its early days in terms of distribution. Thus far, it has been distributed in 3 community centres (December 2016) and will be screened in 8 other community centres in the upcoming year. These centres have high attendance of Bangladeshi women. Over 50 copies were given to women and 55 left at the centres. In terms of feedback, anecdotally it has been very positive. We have not yet processed evaluation sheets, which have more in depth feedback.
**Diabetes and Stress Management Sessions**I facilitated a presentation on diabetes and stress management to Bangladeshi men and women living with diabetes. Ruhana will continue to provide this service. All 12 participants who attended were well engaged and found it helpful to have a Bengali speaking psychologist running the session. The session was measured using the IAPT adapted Enablement Instrument (Howie et al., 1998). The results indicate the session was helpful.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Question - "As a result of the session today, do you feel…?" | Much better |  Better | Same or Less | Total |
| 1. Able to understand stress | 12 | 0 | 0 | 12 |
| 2. Able to understand how stress can make diabetes worse | 11 | 1 | 0 | 12 |
| 3. Able to cope with stress | 7 | 5 | 0 | 12 |
| 4. Confident about managing your diabetes | 7 | 5 | 0 | 12 |
|  |  |  |  |  |
| Question | Yes | No | Total |  |
| 5. Was this session helpful? | 12 | 0 | 12 |  |
| 6. Would you recommend this session to other people? | 12 | 0 | 12 |  |

**‘Staying Well Group’**
The preliminary feedback suggests that the attendees found it helpful being in a group with practitioners speaking their language. They found psycho-education, 5 areas CBT model, relaxation, and behavioural activation most helpful. Currently we are preparing to interview the attendees and produce a qualitative report to improve and facilitate future groups.

**High Intensity Individual Therapy (CBT and Systemic Approaches)**
The feedback we are receiving for the therapy sessions have been inspiring and moving. To find an approach that works and actually leads to real changes in Bangladeshi men and women has been refreshing! Below is a comment from a husband of a woman that was referred for individual work for depression.
“I am not sure what happened since our last session but we talk more at home. We (wife and husband) are spending more time together instead of her spending her whole day spending money in the saree shop. My son is also focusing on himself rather than worrying about her. He started working full time and is now helping to pay rent. Arguments between them (wife and son) has reduced and I feel that I have more control over what happens in our family” … (clients feedback was in agreement and the PHQ, GAD and Enablement Scale indicated recovery and improvement)

**What Next?**

**Continuing Services**

* Improve and establish good outcome measures that captures recovery and change
* Continue offering Bengali Therapy Service (step 3 and step 2 level) and use the Enablement Scale to measure recovery and change
* Continuing attending Peer Supervision to improve our learning and work
* On-going research and continuing providing support and supervision for this

**The Staying Well Group**
The write up of the pilot includes conducting one to one interviews for further qualitative findings and feedback from attendees and making adaptions and improvements for future groups. We aim to conduct two of these groups annually and evaluate the effectiveness of the groups.

**Workshops**
Currently a Bengali assistant psychologist (Hafiza Ali) is doing a dissertation on the problems that are predominantly reported by Bangladeshi clients at assessment stage. Following from the findings, I aim to facilitate workshops on these issues on a quarterly basis.

**Resources**

* Produce more audio / translated materials
* Write up Good Practice Guide for our service so English speaking clinicians offering therapy to Bangladeshi clients may adapt or improve their approaches. The guide will focus on some of these areas:
* Practical support and liaising with other agencies
* Establishing a social support network.
* Orientate to systemic ideas (clients as resources, relational importance, social and cultural stories)
* More psycho-education, visual and concrete, setting clear goal and focus on behaviour change
* More skills training/workshops (i.e., assertiveness, confidence)

Reference:
The mental health needs of the Bangladeshi community in Camden: an action research project 2003 – Camden and Islington NHS Trust

Howie, J, G., Heaney, D, J., Maxwell, M., Walker, J, J. (1998). A comparison of a Patient Enablement Instrument (PEI) against two established satisfaction scales as an outcome measure of primary care consultation. *Family Practice*, 15, 165–71