Ethnic Minorities
and Mental Health:
A position paper

Mental Health **Reform**
Promoting Improved Mental Health Services

Mental Health Reform
Ethnic Minorities and Mental Health: A Position Paper

Table of Contents

EXECUTIVE SUMMARY

Mental Health Reform considers that the mental health needs of people from black and minority ethnic (BME) communities, including the Traveller community, are a priority. The Government's mental health policy *A Vision for Change* recognises that culturally appropriate services are important and recommends that:

> Mental Health Services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard and mental health services should be resourced to provide services to other ethnic groups including provision for interpreters (Recommendation 4.8).[1]

Ireland's population is diverse in terms of both ethnicity and country of origin. The number of people from other countries living in Ireland continues to grow. In the 2011 census 766,770 people identified themselves as having been born outside Ireland. Although almost 300,000 were from the UK, this leaves more than 450,000 people from other countries.[2]

Mental Health Reform has previously recommended that mental health services should serve the whole community and that the HSE should engage in specific initiatives to ensure that community mental health services meet the mental health needs of all people living in local communities.[3] In keeping with international human rights treaties, the Government is obligated to protect the health of minority groups through targeted programmes. Yet to date there has been little implementation of the recommendation in *A Vision for Change* on culturally appropriate mental health services.

Mental Health Reform convened a series of meetings with representatives from BME community organisations between October 2012 and April 2013 in order to develop a set of recommendations on culturally sensitive mental health services. The meetings included representatives from Cairde, Exchange House, the Immigrant Council of Ireland, iVosta, the Irish Refugee Council, Migrant Rights Centre Ireland (MRCI), New Communities Partnership, Pavee Point, SPIRASI and the Traveller Counselling Service. This position paper was also reviewed by a combined meeting of MHR's Ethnic Minorities and Mental Health Group and Multidisciplinary Advisory Group.

Key issues that arose during the consultative meetings included:

- The current policy documents *A Vision for Change* and the National Intercultural Health Strategy 2007-2012 are weak on policy about cultural competency. There is a need for a more developed framework for the implementation of cultural competency that would specify the content of competency training and define the scope and meaning of the 'culturally sensitive' mental health services referred to in *A Vision for Change.*
- The mental health needs of people from BME communities are not being met fully. There is an over-reliance on medication in primary care mental health treatment for people from BME communities. Practical issues such as the costs of transport and medication, and the short-term nature of therapy provision, are hindering effective support for asylum-seekers, in particular.

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[1] Department of Health and Children (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*, Dublin: The Stationery Office, p.41.

[2] Central Statistics Office, Census 2011, *Profile 7 Religion, Ethnicity and Irish Travellers - Ethnic and cultural background in Ireland*, Table 11, p.59 available at http://www.cso.ie/en/census/census2011reports/census2011profile7religionethnicityandirishtravellers-ethnicandculturalbackgroundinireland/

[3] Mental Health Reform (2012) *Manifesto – Guiding A Vision for Change*, Dublin: Mental Health Reform, p.18.

- There is a perception among representatives of BME community organisations that mental health professionals seem to have little understanding of the social and cultural context for people's mental health difficulties. Representatives highlighted that people's recovery from mental health difficulties can be impacted by their position in Irish society, including experiences of poverty, racism, discrimination and other types of social exclusion.
- Representatives said that people from ethnic minority communities do not know about services and how to access them.
- Representatives felt that services have been designed and developed in a way that reflects the majority culture. For example, standard assessment tools may reflect the dominant culture and mental health professionals may be unaware of this cultural bias.
- Representatives thought that stigma is a major barrier to BME communities' access of mental health services.
- There is a lack of information about how people from BME communities view the mental health services or their usage of services.
- Representatives identified a range of communication and language barriers, including lack of good quality interpretation services, lack of capacity among counsellors to work with interpreters and differences in language used to describe mental health.

International research comparing the mental health of people from BME communities with majority populations must be viewed with caution and is inconsistent regarding the relative risk of having a mental health difficulty among people from an ethnic minority group. However for certain conditions such as post-traumatic stress disorder and psychosis the evidence is stronger for a higher risk.

The lack of evidence on the mental health needs of people from BME communities in Ireland is a significant hindrance to policy development and service planning. The All-Ireland Health Study has provided a valuable initial picture of the health status of the Traveller community. More research is needed to more fully understand Travellers' mental health. Similar research is needed to fill the knowledge gaps in relation to the many other BME communities living in Ireland. Such research must itself reflect a culturally sensitive understanding of mental health needs.

Research shows that in Western countries people from BME communities access mental health services less than the majority population. In the UK, black people are more likely to be admitted to inpatient units involuntarily and have longer stays. In Australia, people born outside the country are more likely to be admitted involuntarily than Australian-born people. In Ireland, adults from BME communities appear to be admitted to mental health inpatient units more than would be expected by their presence in the population. On the other hand, children and adolescents from BME communities appear to access mental health services less than would be expected by their presence in the population.

Government policies on both ethnic minorities and on mental health make commitments to ensuring that the mental health needs of people from BME communities are addressed. The National Intercultural Health Strategy 2007-2012 identified migrants, asylum seekers and members of the Traveller community as being at particular risk of experiencing poverty and social exclusion,[4] which according to *A Vision for Change* can be a factor in mental health difficulties, and recognised that discrimination and racism are important issues which may impact on the mental health of people from

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[4] HSE (2008) *National Intercultural Health Strategy 2007-2012*, Dublin: HSE, p.35.

an ethnic minority group.[5] The Intercultural Health Strategy and *A Vision for Change* contain broad recommendations to improve minorities' access to mental health support. Actions have been taken under the Intercultural Health Strategy that apply to all health services. These include:

- The HSE's Multilingual Aid Box
- Good practice guidelines for HSE staff on working with interpreters
- A Health Services Intercultural Guide

A range of other pilot initiatives and group-specific projects have also been put in place under the Intercultural Health Strategy. However, there has been no report of a specific action to implement the recommendation on culturally sensitive mental health services.

The development of cultural competence among health professionals is central to measures to improve ethnic minorities' access to mental health services. The most widely-cited definition of cultural competence is:

> "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations."[6]

National programmes to develop cultural competence and remove barriers to access have been undertaken in the US, the UK and Australia. In the UK the Delivering Race Equality in Mental Health Care action plan emphasises:

- developing a more appropriate and responsive service
- increasing community engagement with service providers
- better quality information on the ethnic profile of local populations and service users which would be more intelligently used.[7]

The Office of Minority Health of the Department of Health and Human Services in the US (OMH) has published national standards for Culturally and Linguistically Appropriate Services in healthcare (CLAS). These are a blueprint to assist service providers and individuals in implementing culturally appropriate services.[8] The principal standard is to:

> "provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practises, preferred languages, health literacy and other communication needs."[9]

In Australia, the Mental Health Commission funded the development of a National Cultural Competency Tool (NCCT) for the mental health sector which is a self-assessment tool to assist services in meeting the

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[5] Ibid., p.8.

[6] Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989) *Towards A Culturally Competent System of Care, Volume I,* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center, cited at http://www.nccccurricula.info/culturalcompetence.html

[7] Department of Health (UK) (2005) *Delivering Race Equality in Mental Health Care: An Action Plan for Reform Inside and Outside Services and the Government's Response into the Independent Inquiry into the Death of David Bennett*, London: Department of Health, p.8.

[8] US Department of Health and Human Services, Office of Minority Health 'What are the National CLAS Standards?' available at <https://www.thinkculturalhealth.hhs.gov/Content/clas.asp> [date accessed 4 July 2013]

[9] US Department of Health and Human Services, Office of Minority Health (5/3/2013) 'The National CLAS Standards' available at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 [date accessed 4 July 2013]

National Standards for Mental Health Services (NSMHS).The standards cover areas such as service planning, collaboration with stakeholders, research and evaluation, access, interpretation services and training. The NCCT includes a standard stating that the service must adhere to a Language Services Policy.[10] Government policy dictates that if possible organisations should use interpreters and translators accredited at a professional level.

Other measures that have been undertaken in different countries include tools to measure cultural competency (UK), developing a culturally-sensitive Recovery Star assessment tool (UK), running specialist transcultural psychiatry clinics (Ireland) and hiring specialist community health workers (Ireland).

In Ireland mental health professionals desire to provide a culturally competent service and to be trained in the skills and attitudes that would support culturally sensitive provision. The potential exists to draw upon international good practice examples to strengthen mental health professionals' cultural competency here.

Recommendations

The following recommendations have been developed with MHR's Ethnic Minorities and Mental Health group. The recommendations are organised according to the themes that were raised in the group's discussion.

Barrier/issue	Recommendations
Lack of cultural competence within mental health and primary care services	1. The HSE should develop a programme and implementation plan to develop cultural competence in primary care and specialist mental health services that includes guidance and a training programme for staff, and should clarify lead responsibility for this programme within the Mental Health Division's Senior Management Team. 2. The Mental Health Commission should develop standards for cultural competency in mental health service delivery in partnership with BME communities and should develop a system for monitoring these standards. 3. Professional bodies responsible for training of mental health professionals, and the Irish College of General Practitioners (ICGP), should ensure that cultural competence is incorporated into the curriculum for trainees and in continuing professional development programmes. 4. People from BME groups should be involved in planning and delivering cultural competency training.

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[10] Multicultural Mental Health Australia (2010) *National Cultural Competency Tool (NCCT) For Mental Health Services* Parramatta, NSW, Australia: Multicultural Mental Health Australia, pp.3-54, p.5.

Need for mental health capacity among key community leaders, e.g. pastors	5. The National Office for Suicide Prevention (NOSP) should fund a dedicated strand of mental health capacity-building for ethnic community leaders. 6. The Department of Justice (DOJ) should include a specification in their Service Level Agreements with direct provision service providers to provide mental health awareness training for their staff. This should form part of any revised reception conditions for asylum seekers. 7. The NOSP should fund mental health workers for BME communities.
Lack of information on ethnic minorities' mental health needs, service provision and experiences of mental health services and supports	8. The HSE should include an ethnic identifier in data collected on mental health service utilisation in inpatient, day and residential services. 9. Research should be commissioned to assess the prevalence of mental health difficulties among ethnic minorities in Ireland. 10. Research should be commissioned to explore the experience of mental health services and supports by people from BME communities.
Stigma and cultural barriers to help-seeking from within the ethnic community	11. The SeeChange anti-stigma/discrimination campaign should develop a strand of action targeted at reducing the stigma around accessing mental health support among people from BME communities.
Cross-cutting gender issues and issues for other marginalised groups (e.g. LGBT, people with disabilities, etc.) are not recognised	12. Plans and initiatives to address ethnic minority mental health should take account of the interface with gender issues and issues for other marginalised groups (e.g. the LGBT community, people with disabilities, etc.). 13. Cultural competency training should incorporate understandings of cross-cutting marginalisation and multiple marginalised identities.
Language and communication barriers	14. Government should ensure that skilled interpreters who understand how to interpret in a mental health setting are available for free to individuals accessing primary care and mental health services, including within the Counselling in Primary Care service. 15. The HSE should ensure that primary care and mental health service staff use accessible language about mental health treatment when providing information to patients/service users, drawing on existing HSE guidance. 16. Mental health service staff should receive intercultural communication skills training including training in how to

	work with interpreters. 17. The HSE should establish 'cultural liaison officers' similar to the Disability Liaison Officers that can provide guidance to staff on how to ensure cultural sensitivity in service delivery.
Need to address the social determinants of mental health for people from BME communities	18. Cross-sectoral actions to address the social determinants of mental health for people from BME communities should be progressed as part of the Healthy Ireland framework for improved health and wellbeing and any follow-on from the *National Intercultural Health Strategy 2007-2012*.

CHAPTER 1: INTRODUCTION

Mental Health Reform considers that the mental health needs of people from black and minority ethnic (BME) communities are a priority. The Government's mental health policy *A Vision for Change* recognises that culturally appropriate services are important and recommends that:

> Mental Health Services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard and mental health services should be resourced to provide services to other ethnic groups including provision for interpreters (Recommendation 4.8).[11]

In its guiding principles, *A Vision for Change* also states that services must be accessible to everybody and that they must be culturally inclusive.[12]

Historically, Ireland has been a net exporter of its population. It is only in recent times that large numbers of people have immigrated into Ireland. The speed of this transformation has not been matched by relevant health and social care policies.[13] The treatment of asylum seekers in direct provision exemplifies the way that the Irish public has not fully reconciled to its responsibilities towards newcomers to the country. Inadequate access to housing, health and welfare services, education, and employment opportunities can negatively impact mental health among migrant groups.[14] As was recommended in the Intercultural Health Strategy, a whole-of-government approach is needed to address the mental health of people from BME communities.[15]

From a human rights perspective, The UN Committee on Economic, Social and Cultural Rights has made specific comments on the right to health for people from marginalised groups. General Comment 14 states that:

> "All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned."[16]

The number of people from other countries living in Ireland continues to grow. In the 2011 census 766,770 people identified themselves as having been born outside Ireland. Although almost 300,000

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[11] Department of Health and Children (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*, Dublin: The Stationery Office, p.41.
[12] Ibid., p.15.
[13] Murphy, R. & Leavey, G. (2014) Ethnic minorities and mental health. In A. Higgins & S. McDaid (eds) *Mental health in Ireland: Policy, practice and Law,* Dublin: Gill and MacMillan.
[14] Lakeman, R., Matthews, A., Munck, R., Redmond, M., Sanders, T. & Walsh, J. (2008) *New Communities and Mental Health in Ireland: A Needs Analysis*, Cairde: Dublin City University.
[15] Health Service Executive (2008) *The National Intercultural Health Strategy 2007-2012*, Dublin: HSE, p.19.
[16] United Nations Economic and Social Council (11/08/2000) *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights General Comment no.14,* E/C.12/2000/4, p.5, available at http://www2.ohchr.org/english/bodies/cescr/comments.htm

were from the UK, this leaves more than 450,000 people from other countries.[17] At the end of 2012, almost 5,000 asylum seekers were living in direct provision in Ireland.[18]

Table A: Country of origin of individuals in Ireland in Census 2011, by region[19]

EU countries	555,594	America	47,116
Other European countries	22,427	Australia	5,964
Africa	54,419	New Zealand	2,052
Asia	79,021	Other countries	177

The range of ethnicities represented in the population of Ireland is also diverse. Table B shows the range of ethnicities reported in the 2011 census. The ethnicity 'Roma' is not included in the census and there is no official information on the number of Roma living in Ireland, however Pavee Point has estimated that there are 3,000 Roma people living here.[20] The majority of Roma in Ireland come from Romania, Poland, Hungary and the Czech Republic.[21]

Table B: Population of Ireland in 2011 by ethnic or cultural background[22]

Irish	3,821,995	Chinese	17,832
Irish Traveller	29,495	Any other Asian background	66,858
Any other white background	412,975	Other including mixed background	40,724
African	58,697	Not stated	17,497
Any other black background	6,381		

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[17] Central Statistics Office, Census 2011, *Profile 7 Religion, Ethnicity and Irish Travellers- Ethnic and cultural background in Ireland*, Table 11, p. 59, available at
http://www.cso.ie/en/census/census2011reports/census2011profile7religionethnicityandirishtravellers-ethnicandculturalbackgroundinireland/
[18] Joyce, C. and Quinn, E. (2014) *The Organisation of Reception Facilities for Asylum Seekers in Ireland,* Dublin: Economic and Social Research Institute/European Migration Network, p.vi.
[19] CSO (2011), op. cit., Table 11, p.59.
[20] Pavee Point Travellers' Centre (November 2011) *Response to the Consultation by the Working Group on the Establishment of the Human Rights and Equality Commission*, Dublin: Pavee Point Travellers' Centre, p.2.
[21] Department of Justice and Equality Traveller Policy Division (2011) *Ireland's National Traveller/Roma Integration Strategy*, Dublin: Department of Justice and Equality, p.3.
[22] Central Statistics Office, *op.cit*., Table 9, p.56.

As can be seen from the two tables, Ireland's population is diverse in terms of both ethnicity and country of origin.

Mental Health Reform has previously recommended that mental health services should serve the whole community and that the HSE should engage in specific initiatives to ensure that community mental health services meet the mental health needs of all people living in local communities.[23] In keeping with international human rights treaties, the Government is obligated to protect the health of minority groups through targeted programmes.[24] Yet to date there has been little implementation of the recommendation in *A Vision for Change* on culturally appropriate mental health services.

This position paper considers the specific issues for reform of the mental health services to ensure they adequately serve people from BME communities. The second chapter summarises the issues that have been raised to MHR over the course of a series of meetings with representatives from BME communities. The third chapter outlines the mental health needs of people from an ethnic minority group; the extent to which people from BME communities access mental health services and the barriers that hinder their access. The fourth chapter outlines Irish policy on mental health and ethnic minorities. The fifth chapter describes potential solutions for increasing access to mental health support for this target group based on international examples. The paper concludes with a set of recommendations for improving BME communities' access to mental health support.

A brief note on terminology

Mental Health Reform adopts the use of the terms 'mental health difficulties' and 'mental health conditions' in this position paper except where it is important to use the terminology consistent with the original research cited for the purpose of accuracy. The term 'mental health difficulties' is used when referring to situations where individuals' mental health impacts negatively on their life. The term 'mental health condition' is used to refer to situations where an individual has a condition that could fall under a mental health diagnosis and who may or may not be impacted negatively by this condition.

It should be noted that throughout the document the term 'BME communities' refers to ethnic minorities including the Traveller community.

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[23] Mental Health Reform (2012) *Manifesto – Guiding A Vision for Change*, p.18.
[24] Ibid., p.18.

CHAPTER 2: ISSUES ARISING FROM MENTAL HEALTH REFORM'S ETHNIC MINORITIES AND MENTAL HEALTH GROUP

Mental Health Reform convened a series of meetings with representatives from BME community organisations in order to develop a set of recommendations on culturally sensitive mental health services. The meetings included representatives from Cairde, Exchange House, the Immigrant Council of Ireland, iVosta, the Irish Refugee Council, Migrant Rights Centre Ireland (MRCI), New Communities Partnership, Pavee Point, SPIRASI and the Traveller Counselling Service. This section provides a summary of the issues raised at the four meetings held between October 2012 and April 2013 and the combined meeting of this group with MHR's Multidisciplinary Advisory Group in November 2013.

A. Policy

Representatives thought that the current policy documents *A Vision for Change* and the National Intercultural Health Strategy 2007-2012 are weak on policy about cultural competency. The HSE needs to name issues of culture and ethnicity in its policies on mental health; simply stating that mental health services are open to everyone is not enough. Certain aspects of the Intercultural Health Strategy were viewed positively, for example the recommendation to roll out an ethnic identifier throughout the health service. However, representatives thought that there is a need for a more developed framework for the implementation of cultural competency that would specify the content of competency training and define the scope and meaning of the 'culturally sensitive' mental health services referred to in *A Vision for Change*. Representatives thought that evaluation would be an important part of any future policy document and the example of the CLAS (Culturally and Linguistically Appropriate Services) standards in the US was mentioned.

It was noted that, broadly speaking, experiences of oppression in society will cause, complicate and exacerbate mental health issues for people from BME communities. Anything within society that lessens this oppression is likely to have a positive impact on the mental health of members of these groups. A 'social determinants of mental health' perspective that recognises the role that poverty, social exclusion, racism and discrimination can play in generating mental health difficulties and hindering positive mental health can help to ensure that policy addresses this wider oppression as part of strategies to improve the mental health of BME groups.

B. Barriers to access and lack of holistic services

Representatives thought that the mental health needs of people from BME communities are not being fully met. Access can be a problem. For example, members of the Traveller community are advised not to use A&E services when in a mental health crisis but then are also deterred from accessing GPs and therefore forced to wait until a crisis arises and go to A&E. The quality of GPs' response to people from BME communities varies across the country. It also seems that in some areas GPs do not refer people from the Traveller community and other ethnic minorities into mental health services.

The group identified discrimination as an issue. A representative communicated that there is a view among Travellers that service providers want to deal with them as quickly as possible. Another representative reported that some GPs issue repeat prescriptions to Travellers so that the GP can avoid seeing them.

Representatives reported an over-reliance on medication in response to BME communities' mental health needs. They felt that GPs readily prescribe anti-depressants and one representative commented that a lot of people are just provided with prescriptions.

Representatives also said that mental health professionals seem to have little understanding of the social and cultural context for people's mental health difficulties. People's recovery from mental health difficulties can be impacted by their position in Irish society, including experiences of poverty, racism, discrimination and other types of social exclusion.

Representatives communicated that people from ethnic minority communities do not know about services and how to access them. Some people look to their own community leaders for help and would not seek help from a GP or mental health professional.

C. Lack of cultural competence

Representatives felt that services have been designed and developed in a way that reflects the majority culture. For example, standard assessment tools may reflect the dominant culture and mental health professionals may be unaware of this cultural bias. Participants advised that cultural competence is about more than giving information. The group felt that there is a lack of awareness among staff in primary health care services about cultural issues. They suggested that negative attitudes of staff can impact negatively on people's willingness to avail of services.

Representatives advised that cultural competency needs to extend to how health service staff accommodate people from BME communities, for example by ensuring that common practices of people from BME communities are accommodated within services. They advised that the word 'family' can have different interpretations; some families from ethnic communities can be large and their attendance to visit family members in hospital needs to be considered.

D. Stigma and shame

Representatives of the group identified stigma as a major issue. They stated that the term 'mental' is associated with negative views. One representative expressed that people from BME communities can internalise shame within their community. Another reported that because her job is not directly related to mental health, service users feel less shame in asking for her help. Representatives highlighted the problem of stigma and shame within the Traveller community. This was one of the core issues raised at a national consultation meeting that discussed issues faced by the Traveller community. It was reported that Travellers' experience of shame affects their help-seeking behaviour and this may be a contributing factor to the high rate of suicide among Travellers.

E. Lack of information on BME community service users' views about services

Representatives thought that BME communities' experiences of mental health services should be heard. There is virtually no information currently about how people from BME communities view the mental health services. There is also little information about the usage of mental health services by people from BME communities apart from the statistics on inpatient services, nor is there evidence of the prevalence of mental health difficulties among BME communities in Ireland.

F. Access to counselling

Representatives welcomed the information that the HSE's national Counselling in Primary Care (CIPC) service is being rolled out. They thought that it would be important to ensure that the service will be culturally appropriate and that the counsellors would work in a culturally inclusive manner. Representatives advised that counsellors need to be trained in the use of interpreters. It was pointed out that the short-term therapy provided by the CIPC service is likely to be insufficient for many asylum

seekers and refugees who have very complex emotional and psychological needs. Provision needs to be made for more long-term therapeutic support to asylum-seekers and refugees with complex needs.

G. Communication barriers

Representatives described a range of communication and language barriers. One representative pointed out that the term 'mental health' means different things in different cultures. She advised that someone from an African culture can have a different perspective and interpretation of the term 'mental health'. Within her culture, people look for help and healing from their pastor. Another representative commented that people from another culture would be more comfortable talking about bereavement than to talk about a 'mental health' issue. So, people from BME communities may not share Western conceptualisation or use Western language about mental health.

Representatives advised that while the National Intercultural Health Strategy guidelines for interpreters are satisfactory, consistent implementation of the guidelines is needed. Current difficulties include an absence of regulation over interpreting services and lack of competency among mental health staff in how to work with interpreters.

Representatives reported that it is very difficult to get counsellors who will work through an interpreter. There is also a frequent difficulty that the translator may not be a native speaker and so may lack the competency in the language required to interpret complex situations relating to mental health. Also interpreters may not have an adequate understanding of mental health issues and this could affect their interpretation. The group suggested that interpreters need training in cultural competence and an understanding of mental health issues. Differences were highlighted between Irish and Australian policy. Currently in Ireland it is necessary to bring your own interpreter when attending a GP. In Australia there is a budget for the provision of interpreters.

H. Issues for specific groups

- The Traveller community

At a national consultation three issues were highlighted which affect the Traveller community. Firstly participants said that shame around going for help was a major issue. Secondly the negative expectations people had based upon their past experience of discrimination was an issue. Thirdly there is a problem with communication. Some Travellers find it difficult to communicate with their GP, to understand the language used by doctors and to understand the diagnosis they are given and the purpose of medication prescribed.

- Asylum seekers, refugees and undocumented migrants

Specific issues raised concerned the changing asylum process, barriers to service access for asylum seekers, and the precarious status of undocumented migrants. The asylum process is changing and applications may be processed more quickly. While this could be positive, representatives expressed concerns that the new process may not adequately take into account how individuals may have become institutionalised by the system. The new statutory instrument to deal with the backlog of subsidiary protection claims and the forthcoming Immigration, Residence and Protection Bill will not address the needs of those people who have already spent several years in the system of direct provision. Representatives reported that male and female asylum seekers regularly link feelings of anxiety, depression and more serious mental health difficulties to their experience of long term communal living and forced inactivity (without the right to work) in the direct provision system of accommodation.

There are practical barriers that hinder access for asylum-seekers. For people in direct provision, the process of having to request money for bus and train fares is an additional obstacle to accessing services. The process is also demeaning because the request for fares must be made for each appointment. In some areas hostels are so far away from towns that there are very few buses providing transport and this makes accessing clinics very difficult. The cost of medication can also be prohibitive for people on an income of just €19.10 per week.

Some asylum-seekers and refugees, including men and boys, may have experienced sexual violence in conflict. The risk of sexual violence in conflict for men and boys has been little recognised, and this group is extremely vulnerable to mental/emotional distress. Mental health professionals need to be alert to the possibility that asylum-seekers and refugees coming from areas of conflict, including men and boys, may have experienced sexual violence. Staff need guidance on how to recognise related mental health difficulties and respond or refer appropriately.

Separately, concern was expressed about undocumented migrants. Some people from BME communities who are living in Ireland may have precarious status, being undocumented, and may not be eligible to attend a GP, leaving them without access to primary health care services. This situation can also affect minors. Individuals in this situation may be able to get emergency treatment but then be unable to obtain long-term medication or other treatment due to not having a medical card or social welfare income. Overall, in practice the law excludes undocumented migrants, including children, from the entitlement to access to healthcare for all but urgent medical treatment where it is deemed appropriate by the provider. It was pointed out that under the Health Act, all persons, including undocumented migrants, are allowed access to urgent medical treatment. In practice, there is some confusion due to lack of clarity around what constitutes urgent medical treatment/ emergency care. The willingness to subsidise the cost of urgent medical treatment is dependent on the provider's discretion and thus depends on the hospital.

- Cross-cutting equality groups

Representatives acknowledged that people from BME communities may experience multiple levels of disadvantage based on different identities such as gender, LGBT status, disability, etc. These cross-cutting identities need to be recognised within policy on cultural competency.

CHAPTER 3: MENTAL HEALTH NEEDS OF PEOPLE FROM BME COMMUNITIES

This section considers the evidence for the mental health needs of people from an ethnic minority group. Internationally, research has been carried out in order to examine if the mental health needs of people from an ethnic minority group differ from the majority population. It is important to view international research on the prevalence of mental health difficulties with caution for a number of reasons. Firstly, the history of BME communities in Ireland is very different to many of the countries where prevalence studies have been conducted. Secondly, the findings of cross-cultural prevalence studies must be considered in the context of criticisms about western bias in diagnostic systems. For example, Fernando has long criticised cross-cultural prevalence research. He has also argued that institutional racism within psychiatry is partly responsible for the high prevalence of schizophrenia diagnoses among people of African-Caribbean ethnicity in the UK.[25] The following discussion is thus presented tentatively as a way of providing an initial overview of mental health needs among people from BME communities, while recognising that the diagnoses referred to provide a problematic proxy for the level of mental health need.

A. International evidence on prevalence of mental health difficulties

While findings are somewhat inconsistent, evidence suggests that the rate of diagnosis of severe mental health difficulties is higher in migrant and minority ethnic groups while the rate of more common mental health difficulties is similar to the majority population.[26] Studies in the US have found that compared to white Americans, black American, Asian American and Latino American groups all had a lower rate of both lifetime and past year mental health difficulties.[27] However an earlier study found higher rates of mental health difficulties (both lifetime and current) among people from BME communities.[28] The Adult Psychiatric Morbidity Survey conducted in the UK did not find a higher prevalence of common mental health difficulties in people from ethnic minorities except in South Asian Women.[29] Also in the UK, the Roma Mental Health Advocacy Project conducted a small-scale mental health needs analysis with Roma people. The study found that the most common mental health difficulty among the Roma community was depression (61%) followed by schizophrenia and other psychotic disorders (11%) and anxiety (11%),[30] all of which levels would be significantly higher than in the general population.

Post-traumatic stress and refugees

There is evidence to suggest that refugees are at increased risk of post-traumatic stress disorder, though there have been criticisms of the validity of the diagnosis. In a recent systematic review examining 6,743

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[25] See for example Fernando, S. (2010) *Mental Health, Race and Culture*, London: Palgrave MacMillan.

[26] Morgan, C. (2011) 'Mental health, Ethnicity, and Cultural Diversity: Evidence and Challenges' in Thornicroft, G., Szmukler, G., Mueser, K. and Drake, R., (eds), *Oxford Textbook of Community Mental Health*, New York: Oxford Community Press, pp.87-92.

[27] Ibid., p.88.

[28] Robins, L.N. and Reiger, D.A. (eds) (1991*) Psychiatric Disorders in America: The Epidemiologic Catchment Area Study*. New York: The Free Press, cited in Morgan (2011), p.88.

[29] Deverill, C. and King, M. (2009) 'Common Mental Disorders' in McManus, S., Meltzer, H., Brugha, T., Bebbington, P., and Jenkins, R. (eds) *Adult Psychiatry Morbidity in England, 2007: Results of a Household Survey*, London: The NHS Information Centre for Health and Social Care, pp.53-70 available at
https://catalogue.ic.nhs.uk/publications/mental-health/surveys/adul-psyc-morb-res-hou-sur-eng-2007/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf

[30] The Roma Support Group (April 2012), *Roma Mental Health Advocacy Project Evaluation Report*, London: Roma Support Group, pp.2-106, p.50.

adult refugees resettled in Western countries, the authors found that 9% of adult refugees were diagnosed with post-traumatic stress disorder.[31] The same systematic review found prevalence among 260 refugee children from three countries of 11% for post-traumatic stress disorder. The authors conclude that refugees who have resettled in Western countries are ten times more likely to have post-traumatic stress than the general population.[32]

Schizophrenia diagnosis

Although, again, it is important to acknowledge the risk of cultural bias in the process of diagnosis, there appears to be evidence that people from some BME communities are more likely to be diagnosed with schizophrenia. In the US a study found a higher risk of a diagnosis of schizophrenia among migrant groups than the US-born population.[33] The highest risk was found in those from so-called 'developing countries', second generation migrants and those where the majority population is black. A study in England found that people from BME communities have an increased risk of having a diagnosis of any psychotic illness but it also found that this risk is especially high for African Caribbean and Black Africans for schizophrenia and mania.[34] A more recent UK study found a nine-fold increased risk for a diagnosis of schizophrenia among black Caribbeans. The authors argue that this finding is robust because it used standardised diagnostic criteria and ethnically-blind assessments. However they acknowledge that the influence of clinical bias and cultural relativity on diagnosis cannot be ruled out. The authors conclude that isolation and social exclusion are significant factors in the higher incidence of schizophrenia among black Caribbeans in the UK.[35] The disparity in schizophrenia rates between ethnic groups could also be due to differences in groups' exposure to discrimination and also the positive, buffering effects of family and other networks.[36]

Suicide

Research has found that there are differences in the rates of suicide between some BME communities and majority populations.[37] McKenzie, Serfty and Crawford describe high comparative rates for some groups (e.g. Aboriginal people of Australia and New Zealand, native Americans in the US) and low rates for others (e.g. Asian men of Bangladeshi, Sri Lankan or Pakistani origin in the UK).[38] A UK study found lower rates of suicidal ideation overall for people from BME communities but higher rates among those who were born in the UK. Importantly, this study found that people of White British or Irish ethnicity were more likely to receive treatment following a suicide attempt than those from other ethnic

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[31] Fazel, M., Wheeler, J., and Danesh, J. (2005) 'Prevalence of Serious Mental Disorder in 7,000 Refugees Resettled in Western Countries: A Systematic Review', *The Lancet*, 365:9467:1309-1314, p.1309.

[32] Ibid.

[33] Cantor-Graae, E. Ph.D. and Selten, J.P., Ph.D. (January 2005) 'Schizophrenia and Migration: A Meta-Analysis and Review' *American Journal of Psychiatry*, 162:1:12-24, p.12.

[34] Fearon, P., Kirkbride, J.B., Morgan, C., Dazzan, P., Morgan, K., Lloyd, T., Hutchinson, G., Tarrant, J., Fung, W.L., Holloway, J., Mallett, R., Harrison, G., Leff, J. and Murray, R.M. (2006) 'Incidence of Schizophrenia and Other Psychoses in BME communities: Results From the MRC AESOP Study', *Psychological Medicine* 36:1541-50.

[35] Pinto, R., Ashworth, M. and Jones, R. (2008) 'Schizophrenia in Black Caribbeans Living in the UK: An Exploration of Underlying Causes of the High Incidence Rate', *British Journal of General Practice*, 58:551:429-434.

[36] Morgan (2011), op. cit., p.89.

[37] McKenzie, K., Serfty, M. and Crawford, M. (2003) 'Suicide in BME communities', *The British Journal of Psychiatry* 183:100-101.

[38] Ibid., p.100.

groups.[39] One study found that suicide rates are higher where the ethnic minority group is smaller in density.[40] In relation to self-harm, a study in England found that the highest incidence of self-harm was in young Black females aged between 16-34 years and that despite this risk, fewer of them receive psychiatric care.[41]

B. Mental health needs of people from BME communities in Ireland

There is very limited evidence about the prevalence of mental health difficulties among people from BME communities in Ireland. A small-scale study in one mental health service in Dublin aimed to identify the psychological and psychiatric needs of the help-seeking migrant population of Ireland in comparison to the native population.[42] Migrants came from a variety of countries including China, Poland, Nigeria, Russia, Romania and Afghanistan.[43] The authors found that 28% of the migrant service users reported instances of torture compared to 3% of the indigenous group.[44] Migrant participants were more likely to fulfil the criteria for post-traumatic stress disorder (27.1%) however there was no difference between the two groups in rates of schizophrenia and bipolar diagnoses and no significant differences for rates of depression or anxiety.[45] The authors speculate that the low rate of schizophrenia diagnoses compared to international studies may indicate that migrants in need are not accessing mental health services.[46]

A case study utilising a community development approach to health needs assessment was conducted among people from BME communities in Dublin. Operating from a 'social determinants of health' model the authors found that immigration, accommodation, racism, discrimination, employment and education impact at a community level upon the health of ethnic minorities.[47] As part of this study participants also reported how satisfied they were with their health; 38% of participants stated that stress, anxiety or depression were the main reason they were dissatisfied with their overall health.[48]

There is some research in Ireland on the mental health needs of members of the Irish Traveller community which is congruent with international research on higher risk of suicide. The All-Ireland Traveller Health Study – Our Geels 2010 found that instances of suicide are seven times higher among Traveller men than in the general population.[49] This study also gave an indication of the self-reported psychological needs of Irish Travellers: 62.7 % of Irish Traveller women said that their mental health was not good for one or more of the last 30 days compared to 19.9% of female medical card holders.[50]

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[39] Crawford, M.J., Nur, U., McKenzie, K. and Tyrer, P. (2005) 'Suicidal Ideation and Suicide Attempts Among BME communities in England: Results of a national household survey', *Psychological Medicine* 35:9:1369-1377.

[40] Neeleman, J., Wilson-Jones, C. and Wessely, S. (2001) 'Ethnic Density and Deliberate Self Harm; A Small Area Study in South East London' *Journal of Epidemiology and Community Health*, 55: 85-90.

[41] Cooper, C., Murphy, E., Webb, Webb, R., Hawton, K., Bergen, H., Waters, K., Navneet, K. (2010) 'Ethnic Differences in Self-Harm, Rates, Characteristics and Service Provision: Three-cohort study', *British Journal of Psychiatry* 197:212-218.

[42] Kelly, F., Kelly, B. and Ryan, D. (2008) *Assessment of Psychiatric and Psychological Needs Among Help-Seeking Migrants in Dublin Final Report,* unpublished report for the National Disability Authority.

[43] Ibid., p.21-22.

[44] Ibid., p.20.

[45] Ibid., p.21.

[46] Ibid., p.26.

[47] Sanders, T. and Whyte S. (2006) *Assessing the Health and Related Needs of Minority Ethnic Groups in Dublin's North Inner City. A case study of a Community Development Approach to Health Needs Assessment,* Dublin: Cairde.

[48] Ibid., p.44.

[49] Quirke, B. (2010) *Selected Findings and Recommendations from the All-Ireland Traveller Health Study - Our Geels*, Dublin: Pavee Point.

[50] Ibid., p.18.

Among Irish Traveller men 59.4% said that their mental health was not good for one or more of the last 30 days.[51]

C. Summary

International research comparing the mental health of people from BME communities with majority populations must be viewed with caution and is inconsistent regarding the relative risk of having a mental health difficulty among people from an ethnic minority group. However, for certain conditions such as post-traumatic stress disorder and psychosis the evidence is stronger for a higher risk. It has been suggested that comparing rates of mental health diagnoses does not validly assess mental health needs and that specific analysis is needed for each ethnic minority group in order to develop appropriate services.[52] It is also important to address other sources of variation within BME communities such as age and gender.[53]

Methodological issues could be the cause of mixed results. Important methodological issues raised by Morgan are the use of crude ethnic categories and the validity of applying Western assessment tools which are formulated from a Westernised health perspective. He also highlights how assessment tools may not be able to adequately capture the mental health difficulties of people from BME communities and therefore it is possible that people from ethnic minorities are being either over- or under-diagnosed.[54]

Nevertheless, the lack of evidence on the mental health needs of people from BME communities in Ireland is a significant hindrance to policy development and service planning. The All-Ireland Health Study has provided a valuable initial picture of the health status of the Traveller community. More research is needed to more fully understand Travellers' mental health. Similar research is needed to fill the knowledge gaps in relation to the many other BME communities living in Ireland. Such research must itself reflect a culturally sensitive understanding of mental health needs.

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[51] Ibid., p.18.
[52] McKenzie, et al., op. cit., p.285.
[53] Morgan (2011), op. cit., p.89.
[54] Ibid., p.89.

CHAPTER 4: UTILISATION AND ACCESS ISSUES

A. Utilisation of mental health services by people from BME communities

A Vision for Change states that mental health services must be accessible to all who require them, including being delivered in a manner that means that the individual can readily access the services they require.[55] This section explores international and Irish evidence on how and to what extent people from an ethnic minority background utilise mental health services.

Disparities exist between people from BME communities and majority populations in the utilisation of mental health services even when accounting for the type of condition experienced, health insurance cover and income.[56] International research from both the US and the UK indicates that people from BME communities have more problems getting access to and problems interacting with services.[57]

i. Utilisation of mental health services and help-seeking behaviour in the US and the Americas

In the US it has been reported that people from BME communities have less access to mental health services and that when they do access services these are of poor quality.[58] Low access figures and crisis access are indications that the needs of BME communities are not being met. African Americans are less likely to receive treatment for their mental health needs.[59] Furthermore, African Americans receiving specialised care usually leave their treatment early.[60] In terms of help-seeking behaviour it has also been found that they may be more likely than White Americans to seek out alternative therapies.[61]

Health services research on the Hispanic community consistently shows that those with mental health difficulties are receiving insufficient mental health care.[62] Studies suggest that fewer than 1 in 11 Hispanic Americans contact specialists in mental health care and fewer than 1 in 5 contact general health care providers.[63] Less than 1 in 10 Hispanic American immigrants with mental health difficulties utilise general health care providers while less than 1 in 20 use specialised mental health services.[64] The National Comorbidity study found that Latin Americans did not use many mental health services even though participants had fluent English and in general most seek help for mental health difficulties through primary care.[65]

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[55] Department of Health and Children (2006), op. cit.,, p.15.
[56] Institute of Medicine (2003) cited in Dougherty, R.H. (2004) 'Reducing Disparity in Behavioural Health Services: A Report from the American College of Mental Health Administration', *Administration and Policy in Mental Health*, 31:253-263.
[57] Morgan (2011), op. cit., p.91.
[58] US Department of Health and Human Services (2001) *Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General*, Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Centre for Mental Health Services. p.3.
[59] Ibid., p.68.
[60] Ibid., p.68.
[61] Ibid., p.68.
[62] Ibid., p.142.
[63] Ibid., p.142
[64] Ibid., p.142
[65] Ibid., p.142.

ii.   Utilisation of mental health services and help-seeking behaviour: Victoria, Australia

Research by the Victorian Transcultural Psychiatry Unit also indicates that people from BME communities access mental health services at a lower rate than people from the general population.[66] People born in non-English speaking countries had a lower level of treatment when compared with the Australian-born population in community based and acute inpatient-services. Furthermore, inpatients who were born in a non-English speaking country were more likely to be diagnosed with psychosis and more likely to be admitted to an acute care unit. Non-Australian-born service users were also more likely to be admitted as involuntary compared to Australian-born service users, and while they had fewer readmissions they were more likely to be admitted for longer.[67]

iii.   Utilisation of mental health services and help seeking behaviour: the UK

There are similar findings of low access, crisis access and low utilisation of mental health services by BME communities in the UK. In England it was found that people from the Black Caribbean community were more likely to be involuntarily admitted to hospital.[68] This means that unlike white service users they were admitted through emergency and sometimes coercive routes.[69] A meta-analysis found that black Caribbeans were four times more likely to be compulsorily admitted than white service users.[70] It is possible to see a different pattern between Black and Asian groups in the UK from what limited data exists.[71] Compared to Black groups, research has found that South Asians appear to be less likely to be either compulsorily or voluntarily admitted to hospital and that their admissions were likely to be of shorter duration.[72] They are also less likely to be diagnosed in primary care compared to white people and less likely to be referred on to specialist care.[73]

iv.   Utilisation of mental health services by people from BME communities in Ireland

There is little evidence about the levels of access to mental health services in Ireland by people from an ethnic minority group apart from inpatient statistics. It has been noted that there is a paucity of research in Ireland on migrants' access to mental health services.[74] The most recent annual data from the Health Research Board reports that 82% of admissions were returned as White Irish and 5.5% were recorded as 'any other white' background in 2011.[75] 10% of admissions were unknown/unspecified ethnicity and 2.5% belonged to various ethnic groups.[76] This compares with 85.8% of the population in Ireland identifying themselves as White Irish in the Census 2011. Information on usage of Child and

[66] Stolk, Y., Minas, I.H., and Klimidis, S. (2008) *Access to Mental Health Services in Victoria: A focus on ethnic minority communities*, Victoria, Australia: Victoria Transcultural Psychiatry Unit, available at www.vtpu.org.au

[67] Ibid., p.1.

[68] Morgan, et al. (2004) cited in Morgan (2011), op. cit., p.91.

[69] Ibid., p.91.

[70] Bhui, K., Stanfeld, S., Hull, S., Priebe, S., Mole, F., and Feder, G. (2003) 'Ethnic Variations in Pathways to and Use of Specialist Mental Health Services in the UK: Systematic review', *British Journal of Psychiatry* 182:105-116.

[71] Morgan (2011), op. cit., p.91.

[72] Bhui, et al., op. cit., p.113.

[73] Ibid., p.112.

[74] Kelly, et al. (2008) op. cit., p.19.

[75] Daly, A. and Walsh, D. (2012) *Health Research Board, HRB Series 18, Activities of Irish Psychiatric Units and Hospitals 2011*, Dublin: Health Research Board, p.39.

[76] Ibid.

Adolescent Mental Health Services shows relatively low access of services compared to BME communities' presence in the population.[77]

Table C: Ethnic background of children and adolescents using mental health services

Percentage of children attending mental health service	Ethnicity	Proportion in the population
90.1%	White Irish	84.4%
3.5%	White any other white background	6.8%
3%	White Irish Traveller	1.2%
1.7%	Black ethnic background	2.5%
0.7%	Asian Ethnic background	2.1%

Adapted from HSE Fourth Annual CAMHS Report 2011-12

In interview-based research with 101 participants in Dublin's North Inner City it was reported that 70% of the participants had accessed their GP within the last year; however, only two had accessed community mental health services.[78] The All Ireland Traveller Health Study reported on access and use of services by the Traveller community. It found that 90% of Travellers said they had not used mental health services in the previous twelve months.[79] It was also reported that Travellers perceived mental health services to be inadequate. In particular the study found that Travellers tended not to use available counselling services due to a lack of culturally appropriate provision and social stigma.[80]

> **v.   Summary**

Research shows that in Western countries people from BME communities access mental health services less than the majority population. In the UK, Black people are more likely to be admitted to inpatient units involuntarily and have longer stays. In Australia, people born outside the country are more likely to be admitted involuntarily than those who are born in Australia. In Ireland, adults from BME communities appear to be admitted to mental health inpatient units more than would be expected by their presence in the population. On the other hand, children and adolescents from BME communities appear to access mental health services less than would be expected by their presence in the population. Much more research is needed to provide a detailed picture of the way that people from BME communities in Ireland access mental health services, particularly on adult usage of primary mental health care and specialist mental health services.

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[77] Health Service Executive *Fourth Annual Child & Adolescent Mental Health Service Report 2011-2012*, Kildare: HSE, p.32.
[78] Cairde (2006), op. cit., p.44.
[79] Quirke, B. (2010), op. cit., p.14.
[80] Ibid., p.18.

B. **Barriers to accessing mental health care for minorities**

This section outlines the barriers that may prevent people from BME communities from accessing mental health care. Culture can be seen as a factor that influences help-seeking behaviour. It can influence the value that society places on mental health.[81] It can influence how distress may be expressed and the presentation of symptoms.[82] Culture can influence how people access services and how families and communities respond to mental or emotional distress.[83] These will then influence how likely health professionals are to correctly diagnose mental health conditions as well as the interventions that are offered.[84]

The way that people conceptualise their mental/emotional distress also influences how they believe they should be treated.[85] This means that cultural concepts should be incorporated into treatment.[86] The Intercultural Health Strategy states that cultural and religious beliefs play an important role in both access to and the receiving of culturally appropriate care and support.[87]

i. **Stigma/prejudice as a barrier to accessing mental health care**

Stigma/prejudice has been found to be a barrier for people from ethnic minorities accessing mental health services. In the US it has been argued that people from BME communities who already face prejudice from being part of an ethnic minority faced additional stigma due to having a mental health difficulty.[88] The authors refer to this as a 'double stigma'.[89] Research in the US has also found that African Americans attach greater stigma to mental illness than white people.[90] Stigma has been found to not only impede people from taking action but to stop them from continuing treatment once commenced.[91] Stigma can emerge from the public, the individual or the mental health system/provider.[92] American research found that stigma and shame stop people, including people from BME communities, from accessing mental health services or even acknowledging that they have a mental health issue.[93] A cross-cultural study found that only 12% of Asian Americans living in Los Angeles would tell a friend or family member that they have a mental health difficulty compared to 25% of white people.[94] The same study found that only 4% of Asian people would seek help from a specialist compared to 26% of white people. And finally the study found that only 3% of Asian people would turn

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[81]Jenkins, R. (2007) 'Health Services Research and Policy', in *Culture and Mental Health: A Comprehensive Textbook,* Bhui, K. and Bhugra, D. (eds), New York: Hodder Arnold, pp.70-87, p.75.

[82] Ibid., p.75.

[83] Ibid., p.75.

[84] Ibid., p.75.

[85] Leong, F.T.L. and Kalibatseva, Z. (2011) 'Cross Cultural Barriers to Mental Health Services in the United States', *Cerebrum*, available at http://dana.org/news/cerebrum/detail.aspx?id=31364

[86] Ibid.

[87] Health Service Executive (2008) *The National Intercultural Health Strategy 2007-2012*, Dublin: HSE, p.10.

[88] Gary, F.A. (2005) 'Stigma: Barrier to Mental Health Care Among Ethnic Minorities', *Issues in Mental Health Nursing* 26:10:979-999.

[89] Ibid., p.981.

[90]Kohn, R. (2007) 'Mental Health and Cultural Psychiatry in the USA and Canada' in Bhui, K. and Bhugra, D. (eds) *Culture and Mental Health: A Comprehensive Textbook*, New York: Hodder Arnold, pp.225-244, p.238.

[91] Gary, F. (2005), op. cit., p.980.

[92] Ibid., p.983.

[93] US Department of Health and Human Services (2001), op. cit., p. iv.

[94] Zhang, et al. (1998) cited in US Department of Health and Human Services (2001), op cit., p.29.

to a physician compared to 13% of white people. The authors concluded that stigma was pervasive for Asian Americans living in Los Angeles.[95]

Stigma has also been identified as a barrier to accessing treatment in the UK. In a study among 87 members of the Pakistani, Indian and Chinese communities, the authors found that people from these communities with a mental health difficulty experience high levels of stigma. They concluded that despite a move to community based care in the treatment of mental illness, stigma and discrimination still exist and undermine help-seeking and recovery for people from BME communities.[96]

ii. Stigma/prejudice and mental health in Ireland

To date, national research on mental health stigma/prejudice in Ireland has not distinguished the experience of people from BME communities. In a report from a national conference conducted by the HSE Western region entitled Addressing the Mental Health Needs of Minority Ethnic Groups and Asylum Seekers in Ireland it was suggested that receiving poor quality care compounds the issue of stigmatisation and that services should not stigmatise. In a round table discussion with asylum seekers at the conference, the asylum seekers reported that they did not want to feel stigmatised.[97] Separately, Irish Travellers have reported that using counselling services would be difficult due to stigma.[98]

iii. Mistrust as a barrier to accessing mental healthcare

Mistrust has also been cited as a barrier to accessing mental health services; however, little research has been conducted about this issue. Research in the US conducted in the 1980s found that African Americans with depression were more likely to fear hospitalisation and treatment than white people.[99] The US Department of Health and Human Services has suggested that possible reasons for such mistrust are experiences of discrimination and historical persecution.[100] A more recent study among Filipino Americans conducted in Los Angeles, California, found that having a high cultural mistrust is related to a low help-seeking attitude.[101]

Research in Ireland has also picked up on mistrust as an issue among Irish Travellers. In qualitative research conducted among members of the Traveller community, it was reported that they were less likely to trust service providers.[102]

iv. Lack of knowledge about services as a barrier to accessing mental health care

Lack of knowledge about services can be a barrier to accessing mental health services. Some research has even suggested that this is one of the main reasons for under-utilisation of services by people from BME communities.[103] In Victoria, Australia, lack of knowledge about how and where to receive help and

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[95] Ibid., p.29.

[96] Knifton, L. (2012) 'Understanding and Addressing the Stigma of Mental Illness with Ethnic Minority Communities', *Health Sociology Review* 21:3:287-298, p.287.

[97] HSE (2006) *Report from the National Conference HSE West Addressing the Mental Health needs of Minority Ethnic Groups and Asylum Seekers*.

[98] Quirke, B. (2010), op. cit., p.19.

[99] Sussman, L.K., Robins, L. and Earls, F. (1987) 'Treatment Seeking for Depression by Black and White Americans', *Social Science and Medicine* 24:187-196, cited in U.S. Department of Health and Human Services (2001), op cit., p.29.

[100] US Department of Health and Human Services (2001), op. cit., p.29.

[101] David, E.J.R. (2010) 'Cultural Mistrust and Mental Health Help-Seeking Attitudes among Filipino Americans', *Asian American Journal of Psychology*, 1:1:57-66.

[102] Quirke, B. (2010), op. cit., p. 13.

[103] Leong and Kalibatseva (2011), op. cit., p.6.

how mental health services work has been identified as one of the barriers to BME communities' access of services.[104]

A report from inner city Dublin found that many of the migrants in its study did not know how to access psychiatric care.[105] They reported a lack of understanding of services available and also a fear of repatriation upon going to a clinic.[106] In the All Ireland Traveller Health Study lack of information was reported as being a barrier for 37.3% of participants.[107] A report by Cairde also cited lack of information about services as a barrier in trying to access general health services.[108]

v.   Perception of mental health difficulties as a barrier to help-seeking behaviour

People from BME communities may have a different perception of mental health and therefore may not recognise when they are experiencing mental health difficulties. This difference in understanding may create a barrier to help-seeking. Mollica, et al. argue that patients from different cultures may understand their illness in ways other than the pervading biomedical conception in Western countries.[109] In a small-scale study in East Anglia, participants described 'mental health' as a construct which created problems in recognising 'mental health'.[110] This was described by participants as a 'lack of awareness', 'lack of knowledge' and 'different understanding of the problem'.[111] One participant was quoted as saying:

> *"They don't realise that they've got mental health problems. They just see it as "Well . . . I've just gotta put up with this, although I don't like it and I know I'm unhappy.'" [112]*

Another qualitative study conducted in the UK identified participants' beliefs relating to mental health and mental illness as an important theme.[113] Here mental health was described as a 'set of can do's' such as 'communicating well' and subjective experiences such as 'being free from stress' and 'being confident'.[114] Participants differentiated between 'normal' reactive emotional problems and mental health difficulties which they referred to as 'madness'.[115] Some participants felt that depression has a supernatural cause.[116]

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[104] Government of Victoria, Australia (2006) *Cultural Diversity: A Plan for Victoria's Specialist Mental Health Services: 2006-2010*, Melbourne, Australia: Metropolitan Health and Aged Care Services Division, Victorian Government Department of Human Services, p.4-5.

[105] Kelly, et al. (2008), op. cit., p.11.

[106] Ibid., p.11.

[107] Quirke, B. (2010), op. cit., p.14.

[108] Cairde (2006), op. cit., p. 50.

[109] Mollica, R., Kirschner, E. and Ngo-Metzger. 'The Mental Health Challenges of Immigration' in Thornicroft, G. Szmukler, G., Mueser, K. and Drake, R. (eds), *Oxford Textbook of Community Mental* Health (2011), New York: Oxford Community Press, p.98.

[110] Franks, W., Gawn, N. and Bowden, G. '*Barriers to Access to Mental Health Services for Migrant Workers, refugees and asylum seekers', Journal of Public Mental Health* 6:1:133-41.

[111] Ibid.

[112] Ibid.

[113] Papadopoulos, I., Lees, S., Lay, M. and Gebrehiwot, A. (2004) 'Ethiopian Refugees in the UK: Migration, adaptation and settlement experience and their relevance to health', *Ethnicity and Health* 9:1:55-73.

[114] Ibid., p.66.

[115] Ibid., p.66.

[116] Ibid., p.66.

Similar differences in understanding have been identified in a small-scale study conducted in North Dublin. The authors of this pilot study reported that many participants did not agree with the diagnosis given to them.[117] One participant is quoted as saying:

> "*I do not feel about depression. I do not feel I was depressed. I was not feeling well because I was worrying about my family.*"[118]

vi.   Cost of care as a barrier to mental healthcare

Cost of care was shown to be an issue for the Irish Traveller community with 31% citing cost as a barrier in relation to health services generally.[119] A study among people from BME communities in Dublin also found that participants cited financial cost as a barrier to accessing services.[120]

vii.   Communication barriers

Lack of effective means of communication has been identified as a barrier for immigrant and refugee populations.[121] Language has been found to be a barrier in accessing services in the US, with a lack of culturally appropriate services and suitably qualified bi-lingual mental health staff. [122]

In Ireland communication difficulties were reported in a chart review study at St. James's Hospital Dublin.[123] Elsewhere, Kelly, et al. suggested that communication difficulties as well as a fear of being misunderstood were barriers to accessing services in Dublin's north inner city.[124] In terms of access to GP services, a study among Serbo-Croat and Russian refugees in the West of Ireland found that the use of informal interpreters such as family members in the context of GP care can be problematic for the individuals concerned and is a serious hindrance to healthcare. The refugees expressed that they were not confident they were being understood by their GPs. They preferred the use of professional, trained interpreters.[125]

viii.   Other barriers to accessing mental health care

The National Intercultural Health Strategy suggested three other major barriers that can hinder access to healthcare for people from BME communities:

1) understanding the pathways of negotiating the health system
2) accessing a range of services (usually GP), and
3) the service user's experience of racism and discrimination.[126]

In the All Ireland Traveller Health Study a number of barriers to accessing general health services were reported including waiting lists (62.7%), embarrassment (47.8%), difficulty in getting to services (25%),

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[117] Ibid., p.28.

[118] Kelly, et al. (2008), op. cit., p.28.

[119] Quirke, B. (2010), op. cit., p.16.

[120] Cairde (2006), op. cit., p.50.

[121] Mollica, et al. (2011), op. cit., p.98.

[122] Leong and Kalibatseva (2011), op.cit., p.7.

[123] Kennedy, N., Jerrard-Dunne, P., Gill, M. and Webb, W. (2002) 'Characteristics and Treatment of Asylum Seekers Reviewed by Psychiatrists in an Irish Inner City Area', *Irish Journal of Psychological Medicine* 19:2:4-7.

[124] Kelly et al. (2008), op. cit., p.18.

[125] MacFarlane, A., Dzebisova, C., Karapish, D., Kovacevic, B., Ogbebor, F. and Okonkwo, E. (2009) 'Arranging and Negotiating the use of Informal Interpreters in General Practice Consultations: Experiences of refugees and asylum seekers in the West of Ireland', *Social Science & Medicine* 69:2:210-214.

[126] Health Service Executive (2008), op. cit., p.11.

health settings (22%) and being refused service (15%).[127] The Cairde needs assessment in North Dublin found that among the 17% of participants who did not access any health services, insecure employment and trying to keep below the radar due to their undocumented status were the main reasons cited for not accessing services.[128]

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[127] Quirke, B. (2010), op. cit., p.14.
[128] Cairde (2006), op. cit., p.48.

CHAPTER 5: POLICY IN IRELAND ON MENTAL HEALTH AND BME COMMUNITIES

A. *A Vision for Change*

The Government's mental health policy *A Vision for Change*, published in 2006, states that responding to the needs of minority groups in Ireland is important. It acknowledges that culture shapes the experience of emotion and the concept of self, the process of assessment and modes of interventions.[129] It suggests that training should be provided for a wide range of service providers which would enable them to be culturally sensitive and stresses that these services, including interpreters, are an important part of services for people from a minority group.[130] It suggests that community development programmes are a good way of reaching people from minority groups. The policy recognises that immigrant communities have different ways of dealing with distress and that community development programmes can learn from immigrants. The key recommendation in *A Vision for Change* relating to ethnic minorities is:

> **Recommendation 4.8:** Mental health services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard, and mental health services should be resourced to provide services to other ethnic groups, including provision for interpreters.[131]

B. The National Intercultural Health Strategy 2007-2012

The *National Intercultural Health Strategy 2007-2012* was developed on foot of the National Action Plan against Racism launched in 2005 in collaboration with service users, NGOs, the community and voluntary sector, key statutory agencies and HSE workers.[132] The strategy maintained that the health of people from an ethnic minority group is important and stated that enhancing access to mental health services is a priority.[133] It acknowledged the effects which direct provision and unemployment have upon mental health.[134] It also discussed the health needs of people from the Traveller community and noted that social determinants affect their mental health.[135] The strategy identified migrants, asylum seekers and members of the Traveller community as being at particular risk of poverty and social exclusion,[136] and recognised that discrimination and racism are important issues which may impact on the mental health of people from an ethnic minority group.[137]

The *National Intercultural Health Strategy* affirmed that staff training in areas of anti-discrimination and cultural competence was a priority, stating that: "appropriate intercultural training and support for staff is a fundamental principle of the Strategy..."[138] A key point of the strategy is that it is important to support minority ethnic communities in order to help them to identify and address their own care

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[129] Department of Health and Children (2006), op. cit., p.40.
[130] Ibid., p.42.
[131] Ibid., p.41.
[132] HSE (2008), p.2.
[133] Ibid., p.59.
[134] Ibid., p.42.
[135] Ibid., p.49.
[136] Ibid., p.35.
[137] Ibid., p.9.
[138] Ibid., p.9.

needs.[139] The strategy recommended that research be conducted around the number of referrals to secondary and tertiary care.[140]

The strategy contains three specific recommendations concerning the mental health of people from BME communities.

> **2.2.9** commits the HSE to providing support to implement recommendation 4.8 of *A Vision for Change* on culturally sensitive mental health services.

> **2.2.10** states that "specific issues that have an impact on the mental health of members of this cohort, resulting from the implementation of various policies, will be explored with other sectors in an effort to ameliorate these effects. The HSE is committed to use of all available resources to advocate on and highlight the detrimental effects to health of such policies. Discussions with structures in the Department of Justice, Equality and Law Reform around the effects of the direct provision system and with the Department of the Environment in relation to Traveller accommodation, in particular, will be key priority areas in this regard."

> **2.2.11** states that "community initiatives aimed at providing care and support around the mental health needs of people from diverse cultures and ethnic backgrounds will be supported and promoted within the context of the model of community mental health endorsed in *A Vision for Change*."[141]

The timeframe for the *National Intercultural Health Strategy* has now passed. Disappointingly few of its recommendations were realised, although there have been some developments.

A number of guidelines and aids have been developed in the area of translating and interpreting. Achievements to date include the development of the HSE *Emergency Multilingual Aid Box* which comprises a Language Identification Card, a set of twenty translated phrasebooks and a user manual entitled *On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services*.[142] The *Multilingual Aid Box* was such a success that it was requested by colleagues in other health care settings.

The *Health Services Intercultural Guide* was developed for healthcare staff and profiles the religious and cultural needs of 25 diverse groups.[143] It is primarily for staff in in-patient settings.[144] *Lost in Translation? Good Practice Guidelines for HSE Staff in Planning, Managing and Assuring Quality Translations of Health Related Material into Other Languages* was published in February 2012.[145] It is a resource which will help support staff in the translation of leaflets, forms and other health related information.[146]

In 2008 the report *Developing Quality Cost Effective Interpreting and Translation services for Government Service Providers in Ireland* was published.[147] The HSE also commissioned a pilot interpreting scheme. The resulting report, *An Evaluation of Uptake and Experience of a Pilot Interpreting*

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[139] Ibid., p.10.
[140] Ibid., p.16.
[141] Ibid., p.18.
[142] HSE (2009) *National Intercultural Health Strategy 2007-2012: Update March 2009*, Kildare: HSE.
[143] Ibid.
[144] Ibid.
[145] HSE (2012) *National Intercultural Health Strategy 2007-2012: Update March 2012*, Kildare: HSE.
[146] Ibid.
[147] HSE (2009) *National Intercultural Health Strategy 2007-2012: Update March 2009*.

Service in General Practice in the HSE Eastern Region, provided an insight into the issues in this area.[148] It found:

> "… that even when interpreters are available at no cost to general practices, their use of interpreters in day to day practice is very low. A range of complex issues have been identified to explain this and these relate mainly to the limited capacity of general practices, as small organisations, to incorporate interpreted consultations into their existing ways of working and, also, a lack of training among the professionals involved (general practitioners and interpreters) which would ensure that the interpreted consultation is a meaningful and productive encounter for all concerned." [149]

The Department of General Practice at NUI Galway in partnership with the HSE was funded to develop guidelines to improve cross-cultural communication in general practice consultations.[150] The Rotunda Hospital and the Children's University Hospital were asked to pilot a joint project with regard to an ethnic identifier in 2008.[151] This had been implemented in the 1990s in the Rotunda but had been unsuccessful mainly due to a lack of staff training.[152] As part of the pilot, training was provided for staff, and leaflets/letters informing GPs and patients that a question about an ethnic identifier would be asked were distributed.[153]

Collaborative work linked to the recommendations of the *National Intercultural Health Strategy* has also included:

- Access Ireland Intercultural Mediation Project and the Galway Refugee Support Group. The Galway Refugee Support Group trained 10 refugees and 14 asylum seekers who now volunteer as Peer Health Workers and Intercultural Mediators.[154]

- HSE Social Inclusion supported a MAP project-Mental Health for Asylum Seekers.[155] Residents of a Direct Provision Centre in Portlaoise were supported in identifying their concerns regarding health and welfare.[156] They were also supported in suggesting strategies to cope with these.[157]

- The HSE also supported the appointment of a Roma Outreach Worker.[158] The Roma Outreach Worker facilitates Roma links to health services and helps to support them in accessing these services.[159]

- The All Ireland Traveller Health Study[160] and Roma Health Issues: Decade of Roma Inclusion.[161]

More recently, the HSE's National Service Plan for 2012 planned for the implementation of three recommendations from the *National Intercultural Health Strategy*:

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[148] HSE (2009) *National Intercultural Health Strategy 2007-2012: Update September 2009,* Kildare: HSE.
[149] Ibid.
[150] HSE (2010) *National Intercultural Health Strategy 2007-2012: Update September 2010,* Kildare: HSE.
[151] HSE (2009) *National Intercultural Health Strategy 2007-2012: Update September 2009,* Kildare: HSE.
[152] Ibid.
[153] Ibid .
[154] HSE (2010) *National Intercultural Health Strategy 2007-2012: Update September 2010,* Kildare: HSE.
[155] Ibid.
[156] Ibid.
[157] Ibid.
[158] HSE (2011) *National Intercultural Health Strategy 2007-2012: Update September 2011,* Kildare: HSE.
[159] Ibid.
[160] HSE (2010) *National Intercultural Health Strategy 2007-2012: Update September 2010,* Kildare: HSE.
[161] HSE (2011) *National Intercultural Health Strategy 2007-2012: Update September 2011,* Kildare: HSE.

- Enhance accessibility, improve data and support staff in ensuring culturally competent service delivery [ongoing]
- Extend the roll-out of the ethnic identifier to capture key health information of minority ethnic groups in each HSE regions [quarter 2]
- Develop a national database to support staff in accessing and developing appropriate translated health related material [quarter 4][162]

Regarding Traveller health, the HSE committed to progressing delivery of recommendations in the All Ireland Traveller Health Study with particular reference to those priority areas identified such as mental health, suicide, men's health, addictions/alcohol, domestic violence, diabetes and cardiovascular health."[163] Recently two information leaflets have been published for Travellers by Pavee Point and the Traveller Health Unit: one on bullying guidelines and one on the deliberate self-harm service at Temple Street Children's University Hospital.

However, to date no specific action has been reported to implement Recommendation 4.8 from *A Vision for Change*. Of the six reports of the Independent Monitoring Group on *A Vision for Change*, only one mentions Recommendation 4.8 and this is simply to acknowledge the launch of the *National Intercultural Health Strategy*.

C. Regional Health Strategy for Ethnic Minorities of the Eastern Regional Health Authority

During the period before the establishment of the HSE, the *Regional Health Strategy for Ethnic Minorities* by the Eastern Regional Health Authority (ERHA) covered general health issues but also recognised the mental health needs of people from an ethnic minority group. It stated that their mental health needs arose as an issue during the development of the Strategy.[164] The ERHA recommended three priority areas of action for all health services:

1. The development of an interpretation service
2. Resourcing of NGOs, and
3. Provision of cultural awareness and anti-discrimination training for staff.[165]

The ERHA further stated that the active involvement of the service user and agencies is necessary to ensure the success of the strategy and recommended the establishment of a Regional Implementation Forum.[166] The ERHA stressed that it is important to address the language and communication needs of people from an ethnic minority group.

In relation to mental health specifically, the ERHA acknowledged that cultural factors can influence the motivation and ability to access mental health services and that a holistic, multi-agency approach to care should be taken.[167] They affirmed the effectiveness of psychosocial support offered as part of peer-led programmes by a range of NGOs, but stressed that a number of other interventions should be designed and implemented.[168] The strategy included suggestions for interventions such as the training of local community members in listening and counselling skills and provision of parent education

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[162] HSE (2012) *HSE National Service Plan 2012*, p.69.
[163] Ibid., p.69.
[164] Eastern Regional Authority (undated) *Regional Health Strategy for Ethnic Minorities*.
[165] Ibid., p.9.
[166] Ibid., p.9.
[167] Ibid., p.25.
[168] Ibid., p.25.

groups.[169] NGOs were considered crucial to the plan. For example, many torture survivors prefer to avail of services offered by an NGO dedicated to them rather than generic services. The ERHA suggested that the psychological service which is available for asylum seekers should be extended to include access for other people from an ethnic minority group.[170] They suggested that a range of culturally appropriate services for people from an ethnic minority group is needed, including psychiatric input.[171]

D. Report from the National Conference HSE West 2006

A conference entitled 'Addressing the Mental Health Needs of Minority Ethnic Groups and Asylum Seekers in Ireland' was held in HSE West in 2006. This conference examined the mental health needs of asylum seekers, refugees, Travellers and other minority groups.[172] The aim of the conference was to provide a platform in which concerned stakeholders could not only make recommendations but also share their ideas.[173] The resulting report highlighted how key issues such as discrimination, racism and stigma can undermine the mental health of people from BME communities.[174] Conference participants suggested that language barriers and cultural differences may increase mental distress.[175] The conference identified cultural concepts of illness and health and also acknowledged culture as a critical factor in diagnosis and outcomes.[176] The conference highlighted the gaps in knowledge and the experience of cultural differences within the health service.[177] As a consequence of this, the conference concluded that for services to be culturally competent it is important to utilise service user involvement in both planning their own care and also in the planning of services.[178] The conference report recommended training to promote cultural awareness with on-going mandatory in-service equality training programmes for staff. The report also recommended that 'Targeted Service Initiatives' should be undertaken to address the mental health needs of people from BME communities.[179] These would be based upon the needs of the service user and would be identified with their direct consultation.[180] It also stressed that combating stigma and discrimination is a priority.[181]

Included in the conference report are findings from a survey of members of the Traveller community in Donegal, which was undertaken as part of the Donegal Travellers' Project. The recommendations from the project were:

- that the mental health of people from ethnic minorities should be made a priority
- that culturally appropriate services should be provided at local, regional and national level
- that ways to eliminate racism and discrimination from the mental health services should be found

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[169] Ibid., p.25.
[170] Ibid., p.26.
[171] Ibid., p.26.
[172] HSE (2006) *Report from the National Conference HSE West Addressing the Mental Health needs of Minority Ethnic Groups and Asylum Seekers*, p.4.
[173] Ibid., p.4.
[174] Ibid., p.4.
[175] Ibid., p.5.
[176] Ibid., p.13.
[177] Ibid., p.13.
[178] Ibid., p.8.
[179] Ibid., p.9.
[180] Ibid., p. 8.
[181] Ibid., p.11.

- that planning, development and implementation of the mental health services should be carried out in collaboration with Travellers
- that training should be provided for mental health care professionals, and
- that ways should be found of measuring the success of the above points[182]

E. Position paper on Asylum Seekers and Refugees by the College of Psychiatrists of Ireland

The College of Psychiatrists of Ireland has prepared a position paper on the mental health needs of asylum seekers and refugees. The paper notes that no national strategy exists to meet the mental health needs of asylum seekers and refugees and that these groups did not feature in *A Vision for Change*.[183] The paper highlights how mental health difficulties can be aggravated by the social isolation which the asylum seeker may face due to the current dispersal policy.[184] Previously the Irish Psychiatric Association had stated that the treatment of asylum seekers was a highly specialised area which required particular skills not normally found in mental health settings.[185] The Irish Psychiatric Association had stated that

> "Health services and mental health services should be systematically informed and trained for the reality that culturally sensitive mental health care is now a requirement of modern Ireland. The extra needs of non-national communities should be widely and properly provisioned for." [186]

The College of Psychiatrists made the following three recommendations:

- Consultant-led multidisciplinary teams should be established in major urban centres. These should have a special interest in the mental health of asylum seekers and refugees[187]
- Training in the transcultural aspects of psychiatry should be emphasised [on the College's curriculum][188]
- Training courses should be provided by the College of Psychiatrists in the preparation of psychiatric reports on asylum seekers[189]

F. Summary of mental health policy

Government policies on ethnic minorities and on mental health make commitments to ensuring that the mental health needs of people from BME communities are addressed. Both the *National Intercultural Health Strategy* and *A Vision for Change* contain broad recommendations to improve minorities' access to mental health support. A number of specific actions have been taken under the *National Intercultural Health Strategy* that apply to all health services. These include:

- The HSE's *Multilingual Aid Box*
- Good practice guidelines for HSE staff on working with interpreters
- A *Health Services Intercultural Guide*

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[182] Ibid., p.17.
[183] Nwachukwu, I., Browne, D. and Tobin, J. (2009) *The Mental Health Service Requirements for Asylum Seekers and Refugees in Ireland*, Dublin: Faculty of Adult Psychiatry Executive Committee, College of Psychiatry of Ireland, p.1.
[184] Ibid., p.3.
[185] Ibid., p.3.
[186] Irish Psychiatric Association (2002) 'Submission from the Irish Psychiatric Association to the National Action Plan against Racism Consultation' (27th August 2002), cited in Nwachukwu et al., op. cit., p.3.
[187] Ibid., p.4.
[188] Ibid., p.4.
[189] Ibid., p.4.

A range of other pilot initiatives and group-specific projects have also been put in place under the *National Intercultural Health Strategy*. However, there has been no report of a specific action to implement the recommendation in *A Vision for Change* on culturally sensitive mental health services.

The College of Psychiatrists of Ireland has published a position statement on asylum seekers and refugees. The College recommends dedicated multidisciplinary teams in urban centres for this group and that training in transcultural psychiatry be part of the College's curriculum.

CHAPTER 6: MEASURES TO IMPROVE MENTAL HEALTH SERVICE DELIVERY FOR PEOPLE FROM BME COMMUNITIES

A multi-level approach is required to reduce disparity and increase mental health service use by people from BME communities; one which includes tackling the levels of access, treatment and outcomes.[190] Any approach needs to address change at both national and local levels and incorporate service users, policy makers, organisations and researchers. A key component of any plan is the development of cultural competency among mental health staff.

A. Cultural competency

Culture has been seen to influence how we view our health. It influences help-seeking behaviour both in terms of access and treatment. All cultures have beliefs and practices which are unique and which they use to explain and manage ill health and mental or emotional distress. These in turn influence how mental health difficulties are experienced.[191] Therefore it is important that service providers are culturally competent.

Cultural competence has been identified as an important aspect in the treatment of people from an ethnic minority group and consequently as an important part of policy.[192] Minervino and Martin describe how cultural competence frameworks originated approximately twenty years ago in the US.[193] However there are differences in interpretation about cultural competency; each country will have its own conception of cultural competency that will be dependent upon the local context.[194] Morgan comments that the absence of a shared definition of 'cultural competence' hinders evaluation of service delivery and interventions.[195]

Defining cultural competence

Cultural competence has been widely defined as:

> "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations."[196]

This definition has been utilised and adapted by numerous organisations on an international level.[197] In a more recent paper, Davis defined cultural competency as the integration and transformation of knowledge, information and data about individuals and groups of people into specific clinical standards,

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[190] Dougherty, R. H. (2004), op. cit., p.254.

[191] Morgan (2011), op. cit., p.89.

[192] Bhui, K., Warfa, N. Edonya, P., McKenzie, K. and Bhugra, D. (2007) 'Cultural Competence in Mental Health Care: a Review of Model Evaluations', *BMC Health Services Research* 7:15.

[193] Minervino, S. and Martin, M.C. (2007) 'Cultural Competence and Cultural Mediation: Diversity strategies and practices in health care', *Translocations* 2:1.

[194] Bhui, et al. (2007), op. cit.

[195] Morgan (2011), op. cit., p.92.

[196] Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989) *Towards a Culturally Competent System of Care, Volume I.* Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center. Cited at http://www.nccccurricula.info/culturalcompetence.html

[197] See the National Centre for cultural Competence, Georgetown; US Department of Human Services Office of Minority Health (OMH) and the Cultural Responsiveness Framework Guidelines for Victorian Health Services (2009).

skills, service approaches, techniques and marketing programs that match the individual's culture and competency.[198]

In Victoria, Australia, the term 'cultural responsiveness' was chosen recently for use in its guidance document for health services. Here the term cultural responsiveness was described as:

> "the capacity to respond to the healthcare issues for diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organisational, professional and individual."[199]

In the *National Intercultural Health Strategy* 'cultural competence' is described as "having the right policies, knowledge and skills to meet the needs and practices of people from different cultural backgrounds."[200] It is seen to include lifestyle, dress, diet, language and spiritual needs, though religion can cross cultural boundaries.[201]

Cross, et al. argue that cultural competence requires organisations and their personnel to have the capacity to:

- value diversity
- conduct self-assessment
- manage the dynamics of difference
- acquire and institutionalize cultural knowledge
- adapt to the diversity and cultural contexts of the individuals and communities served[202]

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[198] Davis, K. (1997) *Exploring the Intersection between Cultural Competency and Managed Behavioral Health Care Policy: Implications for state and county mental health agencies,* Alexandria, VA: National Technical Assistance Center for State Mental Health Planning, cited at
http://www.nasponline.org/resources/culturalcompetence/definingcultcomp.aspx
[199] Government of Victoria (2009) *Cultural Responsiveness Framework: Guidelines for Victorian Health Services,* Melbourne: Rural and Regional Health and Aged Care Services, Department of Health, p.12.
[200] HSE (2008), op. cit., p.126.
[201] Ibid., p.126.
[202] Cross, et al. (1989), op. cit.

Goode argues that there are a set of key values and principles that should guide cultural competence development.[203] These are shown in Table D below:

Table D: Key values and principles of cultural competence:

Key area	Guiding principle
Organisational	Systems and organisations must sanction and in some cases mandate the inclusion of cultural knowledge into policy making, infrastructure and practice
	Cultural competence embraces the principles of equal access and non-discriminatory practices in service delivery
Community engagement	Cultural competence extends the concept of self-determination to the community
	Cultural competence involves working in conjunction with natural, informal and self-help networks within diverse communities (e.g. neighbourhood groups, self-help groups, religious organisations and spiritual leaders, etc.)
	Communities determine their own needs
	Community members are full partners in their decision-making
	Communities should economically benefit from collaboration

Source: Goode (2002)

In terms of implementing cultural competence, Bhui, et al. undertook a systematic review which identified nine models in North America that sought to improve cultural competency in practice and service delivery.[204] The study showed that cultural competence training is important, though there is limited evidence of its effectiveness, and that the 'cultural consultation model' demonstrated satisfaction by clinicians using it. This model involved making a 'cultural consultant' available to services who could assist with assessment and provide advice on treatment.[205]

B. Plans and programmes to increase access to services

This section describes examples of national or state-wide plans or programmes to increase access to mental health services by people from BME communities.

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[203] Goode, T. (2002) *Promoting Cultural Diversity and Cultural Competency – Self Assessment Checklist for Personnel Providing Services and Supports to Children with Disabilities & Special Health Care Need*, National Centre for Cultural Competence, Georgetown University, USA, cited in Carrie Hayter (2009) *Cultural and Linguistic Inclusion? Literature review on social inclusion, cohesion and culture,* National Ethnic Disability Alliance, Harris Park, New South Wales.
[204] Bhui, et al. (2007), op. cit., p.1.
[205] Ibid., p.1.

i.   BME communities in the UK

A comprehensive programme of action has been undertaken in the UK to eliminate discrimination against people from BME communities in mental health care.[206] The UK Department of Health recognised that it would not be possible to address improvements concerning access, experience and outcomes for BME service users without taking a mainstream approach.[207] The Delivering Race Equality in Mental Health Care action plan is one component of a wider programme of action to bring about equality in health and social care.[208] It is based on three key publications *(Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*; *Delivering Race Equality: A Framework for Action*; and the independent inquiry into the death of David Bennett).[209,210] The perspective in the UK is that the approach should not be focussed on creating separate mental health services for those from BME communities but rather on improving services for everyone.[211]

Public consultations showed that among other issues, BME communities were dissatisfied with the quality of mental health care they received and felt that mental health professionals needed training in cultural competence.[212] A plan of action to reduce disparity was developed based on three building blocks:

- developing a more appropriate and responsive service
- increasing community engagement with service providers
- better quality information on the ethnic profile of local populations and service users which would be more intelligently used.[213]

Also, a number of recommendations were made in response to the death of David Bennett, one of which was that all those working in mental health services should be trained in cultural awareness and sensitivity and that all managers and staff should receive compulsory training in cultural competency.[214] Respecting diversity had also been included in a set of 10 'essential shared capabilities' for mental health service staff developed by the National Institute for Mental Health in England (NIMHE) and the Sainsbury Centre for Mental Health (SCMH).[215]

In order to oversee the action plan, a BME Mental Health Programme Board has been set up at the Department of Health. This board is directly accountable to Ministers for implementation of the plan.[216]

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[206] Department of Health (UK) (2005) *Delivering Race Equality in Mental Health Care: An action plan for reform inside and outside Services*, London: Department of Health, p.8.
[207] Ibid., p.10.
[208] Ibid., p.4.
[209] Ibid., p.3.
[210] David Bennett was a 38-year-old African-Caribbean patient in the UK who died on 30 October 1998 in a medium secure psychiatric unit after being restrained by staff.
[211] Ibid., p.8
[212] Ibid., p.13.
[213] Ibid., p.8.
[214] Ibid., p.21.
[215] Ibid., p.21.
[216] Ibid., p.5.

ii. Programmes in the US to reduce disparities

US: CLAS Standards

The Office of Minority Health of the Department of Health and Human Services in the US (OMH) has published national standards for Culturally and Linguistically Appropriate Services in healthcare (CLAS). These CLAS standards are a blueprint to assist service providers and individuals in implementing culturally appropriate services.[217] The principal standard is to:

> "provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practises, preferred languages, health literacy and other communication needs."[218]

Other standards cover:

- Governance, Leadership and Workforce
- Communication and Language Assistance
- Engagement, Continuous Improvement and Accountability

To date, six states in the US have or are in the process of mandating some form of cultural and linguistic competency.[219] Two state-wide initiatives have occurred in the states of California and Connecticut.[220]

In California, cultural competency plans are a required part of each county's managed care plan.[221] The state-wide Cultural Competence Advisory Committee has three goals/principles to implement: eliminate disparities in access to services, improve the care for the consumers and families of California, and ensure cultural competence is embedded at all levels (policy to practice) of the mental health services.[222] According to Dougherty, the state-wide 10-year effort has transformed California's mental health system.[223] In the State of Connecticut a different approach to cultural competence has been taken. Instead of measuring cultural competence through a list of identifiable features of practice, it is measured through criteria of effectiveness and outcomes.[224] While state-wide programmes can have far reaching goals and impact on a large volume of people, policymakers in Connecticut also recognise that some barriers can only be tackled at a local level.[225]

iii. The National Cultural Competency Tool for Mental Health Services in Australia

In Australia, the Mental Health Commission funded the development of a National Cultural Competency Tool (NCCT) for the mental health sector which is designed to be implemented at an organisational level.[226] The NCCT is a self-assessment tool which assists services in meeting Standard 4 of the National Standards for Mental Health Services (NSMHS). The NCCT itself incorporates a set of National Cultural

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[217] US Department of Health and Human Services, Office of Minority Health 'What are the National CLAS Standards?' <https://www.thinkculturalhealth.hhs.gov/Content/clas.asp> [date accessed: 4 July 2013]
[218] US Department of Health and Human Services, Office of Minority Health 'The National CLAS Standards' (5/3/2013) http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 [date accessed 4 July 2013]
[219] Ibid.
[220] Dougherty, op. cit., p.256.
[221] Ibid., p.256.
[222] Ibid., p.256.
[223] Ibid., p.256.
[224] Ibid., p.256.
[225] Ibid., p.256.
[226] Multicultural Mental Health Australia (2010) *National Cultural Competency Tool (NCCT) for Mental Health Services*, p.9.

Competency Standards. The National Cultural Competency Standards cover areas such as service planning, collaboration with stakeholders, research and evaluation, access, interpretation services and training. Each cultural competency standard consists of a statement of the standard, the principle underpinning that standard and relevant performance measures. The accompanying checklist requires the service to review and record the status of each performance measure. Evidence of the implementation of a performance measure must be provided and where a performance measure has not been achieved by the service, the organisation should indicate the strategies it will put in place in order to achieve it.

iv.   Guidelines for Health Services in Victoria, Australia 2009

The state of Victoria, Australia, has a diverse population. It recognises that culturally and linguistically diverse (CALD) groups have poorer mental health outcomes as they typically present for treatment later and are more likely to be treated involuntarily [227] Access to culturally competent mental health care is recognised as a key issue for CALD communities.[228] The state of Victoria has also seen an increase in the number of refugees and these are younger than in previous years. In order to address these issues a *Cultural Responsiveness Framework* for health services was developed in 2009 following a state-wide review.[229] The review revealed six main problems in relation to which six standards for cultural responsiveness were developed:

- a whole-of-organisation approach to cultural responsiveness

- leadership for cultural responsiveness is demonstrated by the health service

- the provision for accredited interpreters to be provided if they are needed

- inclusive practise in care planning which includes dietary, spiritual, family attitudinal and other cultural practices

- the CALD consumer, carer and community member should be involved in the planning, improvement and review of programmes on an on-going basis

- staff should be provided with opportunities to develop their cultural responsiveness[230]

According to the framework:

> "Cultural responsiveness thus may be viewed as a viable strategy to improve the links between access, equity, quality and safety, better health outcomes for culturally and linguistically diverse populations and a strategy to enhance the cost effectiveness of health service delivery."[231]

Also in Victoria, a number of training programmes are offered by the Victorian Transcultural Psychiatry Unit that assist with the development of core skills and knowledge necessary for culturally competent

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[227] Department of Health [Australia] (2009) *Because Mental Health Matters - Victorian Mental Health Reform Strategy 2009-2019*, Mental Health and Drugs Division, Department of Human Services, available at http://www.health.vic.gov.au/mentalhealth/reform/documents/mhs_web_summary.pdf, p.50.

[228] Ibid., p.50.

[229] Government of Victoria (2009) *Cultural Responsiveness Framework: Guidelines for Victorian Health Services,* Melbourne: Rural and Regional Health and Aged Care Services, Department of Health, p.5.

[230] Ibid., p.6.

[231] Ibid., p.13.

mental health services.[232] During 2006-7 the Unit offered a telephone support service for mental health professionals and a clinical support programme that offered advice and information. Furthermore the Unit contained linkages to other professionals/organisations and was linked to online resource directories.[233]

Elsewhere, the *Victorian Aboriginal Suicide Prevention and Response Action Plan 2010-2015* is a strategy developed to prevent and reduce the incidence and impact of Aboriginal suicide and self-harm. This action plan is overseen by a working group of Aboriginal people, health organisations and Victorian mental health bodies. Four areas were identified as being a priority: prevention by building resilience, improving access to care and support for those people who are at risk, improving the response to crisis and to the community after suicide, and improving the evidence base, data collection and analysis.[234]

C. Training for service providers

Training of healthcare professionals is an important part of cultural competency. However, it has been argued that cultural competency training has showed limited effectiveness.[235] Research in Australia found limited effectiveness for indigenous cultural training programmes for health workers in Australia.[236] The authors are critical of 'cultural awareness' programmes as these do not examine the culture of the health system.[237] The research also suggested that the 'safety model' had the most potential for training as it involves exploring issues of power and social inequality. The 'safety model' involves helping health workers to understand their own identity and cultural beliefs.[238]

In Amsterdam, a project was undertaken to develop the components of competency training. The study firstly identified and analysed difficulties experienced by doctors and patients that arose in providing healthcare.[239] This was followed by defining competencies which could solve or manage these difficulties.[240] The resulting framework was built around five cultural competencies that include learning knowledge and awareness:

> Competency 1: Knowledge of epidemiology and the differential effect of treatment in various ethnic groups

> Competency 2: An awareness of how culture shapes individual behaviour and thinking

> Competency 3: An awareness of the social context in which specific ethnic groups live

> Competency 4: An awareness of one's own prejudices and tendency to stereotype

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[232] Government of Australia (2006) *Cultural Diversity Plan for Victoria's Specialist Mental Health Services 2006-2010*, Melbourne: Metropolitan Health and Aged Care Services Division, Victorian Government of Human Services, p.16.

[233] Ibid., p.16.

[234] Department of Health [Victoria, Australia] (2011) *The Victorian Aboriginal Suicide Prevention and Response Action Plan 2010-2015*, Melbourne, Australia: Aboriginal Health, Wellbeing, Integrated Care and Ageing, Department of Health, p.6.

[235] Ibid., p.1.

[236] Downing, R., Kowal, E. and Paradies, Y. (2011) 'Indigenous Cultural Training for Health Workers in Australia', *International Journal for Quality in Health Care* 23:3:247-257, p.247.

[237] Ibid., p.254.

[238] Ibid., p.254.

[239] Seeleman, C., Suurmond, J. and Stronks, K. (2009) 'Cultural Competence: A conceptual framework for teaching and learning', *Medical Education* 43: 229-237, p.230.

[240] Ibid., p.230.

> Competency 5: An ability to transfer information in a way the patient can understand and to use external help e.g. interpreters and an ability to adapt to new situations flexibly[241]

Ireland's *National Intercultural Health Strategy* also raises the issue of the organisational culture of the health system and how it embraces diversity, recruitment and the training of staff around the delivery of culturally competent, anti-racist and non-discriminatory services.[242] The strategy notes that 54.7% of service providers stated that they had not received cultural awareness training.[243]

D. Language Policy: US, Australia and Ireland

i. US CLAS Standard

The CLAS standards include a standard on communication and language assistance that contains the following components:

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services

- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing

- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area[244]

The Office for Minority Health has also developed a Health Care Language Services Implementation Guide. Its purpose is to help healthcare organisations implement effective Language Access Services for patients with limited English proficiency.[245] The guide outlines four steps:

- Step 1: Assessing patient language needs
- Step 2: Assessing organisational capabilities
- Step 3: Examining LAS components: interpretation services, written materials, signage and way-finding, notice of LAS to LEP patients, community involvement, and written language assistance plans
- Step 4: LAS evaluation[246]

ii. Australian standards on interpretation services

Australia's National Cultural Competency Tool includes a standard stating that the service must adhere to a Language Services Policy.[247] It contains five performance measures:

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[241] Ibid., p.231.
[242] HSE (2008), op. cit., p.11.
[243] Ibid.
[244] USDepartment of Health and Human Services, Office of Minority Health 'The National CLAS Standards' (5/3/2013) http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 [date accessed 4 July 2013]
[245] US Department of Health & Human Services, Office of Minority Health (undated) *Health Care Language Services Implementation Guide* available at https://hclsig.thinkculturalhealth.hhs.gov/
[246] Ibid.
[247] Multicultural Mental Health Australia (2010) *National Cultural Competency Tool (NCCT) for Mental Health Services*, p.5.

1. A language service policy provides guidelines for booking and effective use of interpreters in accordance with the Language Services Policy for their state or territory
2. Negotiate with interpreter services agencies to ensure accredited or suitably competent interpreters trained in mental health interpreting are utilised
3. Where available, use accredited or suitably competent interpreters trained in mental health interpreting
4. Provide staff training on the effective use of interpreters and the principles outlined within the language Services Policy of the state/territory, and
5. Develop a staff profile which reflects the cultural diversity of the wider community[248]

Also in Australia, the Mental Health Branch of the Department of Human Services has issued guidance on interpretation within mental health services:

- All Adult Mental Health Services should provide 24-hour access to interpreting services in all available community languages
- Procedures should be established for using telephone interpreter services
- Adult Mental Health Services should utilise NAATI level 3 accredited interpreters
- Where accreditation is not possible [e.g. emerging language] level 2 interpreters may need to be engaged
- Assessment for the need of an interpreter should be assessed at entry level and reviewed at key stages in the service delivery process.
- Clients should be informed of their right of access to an interpreter by mental health service staff
- This area requires knowledge and skill development by both mental health staff and interpreters.[249]

In Australia interpreters and translators are accredited by the National Accreditation Authority for Translators and Interpreters (NAATI). Government policy dictates that if possible organisations should use interpreters and translators accredited at a professional level. There are three relevant accreditation levels: professional, paraprofessional and a recognised interpreter/translator.[250] A professional interpreter/translator is competent in a wide range of subjects. They have the ability to communicate specialist information. A paraprofessional interpreter is competent to communicate in general conversation but do not have sufficient training to communicate specialist information. A recognised interpreter/translator works in an emerging or rare language; this language cannot be tested by NAATI.[251]

In the state of Victoria, Australia, the Cultural Diversity Plan for Victoria's Specialist Mental Health Services 2006-2010 outlines access to high quality language services.[252]As part of their operational budgets area mental health services receive funding for language services.[253] In 2005-2006 the Victorian

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[248] Ibid., p.16.
[249] Miletic, T., Piu, M., Minas, H., Stankovska, M., Stolk, Y. and Klimidis, S. (2006) *Guidelines for Working Effectively with Interpreters in Mental Health Settings*, Fitzroy, Victoria: Victorian Transcultural Psychiatry Unit, p.4.
[250] Department of Human Services [Victoria, Australia] (2005) *Language Services Policy*, Melbourne, Australia: Policy and Strategic Projects Division, Department of Human Services, p.3.
[251] Ibid, p.3.
[252] Ibid., p.30.
[253] Ibid., p.29.

Government introduced specific funding of $55,000 for language services in the psychiatric disability and rehabilitation and support services sector.[254]

The need for interpreters in Ireland

There is a need for qualified interpreters in Ireland. Inability to communicate in the language of the host country was identified as a major barrier to accessing and participating in health service delivery.[255] Consultations with service users revealed that they feel much distress in attempting to engage with GPs. The use of family and friends as interpreters was reported as an issue. Consultations also highlighted that when distressed a service user who is able to communicate in English may develop difficulties.[256] In a survey conducted by the Irish College of General Practitioners in 2003, GPs identified a lack of interpreters as the greatest barrier in providing medical assistance to asylum seekers and refugees.[257] The results of a pilot interpreting scheme in Dublin mid-Leinster suggest that availability of interpreters does not necessarily result in their use. The pilot study found that GPs did not take maximum advantage of an advertised interpretation service but instead relied on informal strategies for communication.[258]

The *National Intercultural Health Strategy* identified a number of issues which need to be addressed in relation to interpreting:

- Training and accreditation
- Appropriate codes of practice
- Provision of training for service providers using interpretation services
- Evaluation of the effectiveness of these services
- Provision of support to interpreters[259]

It advised that appropriate training should be given to service providers in their use of interpreters, which should be given as part of cultural competence training.[260] Information about interpreter services should be communicated to people from BME communities. It made the following recommendation:

> "A thorough audit and evaluation of existing systems of facilitating interpretation should be undertaken to inform the nature and design of a national interpretation service. This will include consideration of current models and practices in this area and some evaluation of their effectiveness. Consideration will be accorded to the situation of remote areas where need is not sufficient to warrant internal provision of services and yet interpreters may be required suddenly and urgently. For practical purposes, collaboration around this should be effected with due regard to the outcomes of the advisory group on this issue, chaired by the NRCCRI and the RIA. Recommendations regarding appropriate models for this service should take place within the context of a consultation forum with all key stakeholders, including service users, health professionals, interpreters and relevant academic groups."[261]

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[254] Ibid., p.29.
[255] HSE (2008), op. cit., p.100.
[256] Ibid., p.100.
[257] Ibid., p.101.
[258] Ibid., p.101.
[259] Ibid., p.101.
[260] Ibid., p.101.
[261] Ibid., p.102.

The HSE is bound by legislation to ensure that information and services are accessible to everyone.[262] As mentioned earlier, the HSE developed guidelines to support good practice in the provision of interpreting services for health care providers.[263] The resulting document *On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services* offers guidance on:

- assessing the language needs of patients
- informing patients that they may have access to an interpreter
- arranging interpreter services by telephone or face to face
- working effectively with interpreters
- good practice in interpreting[264]

However, there are no regulations or legislation governing the interpreting industry in Ireland.[265] Due to a lack of accreditation or standards the range and quality of services in the interpreting industry can vary.[266]

SPIRASI has developed a self-directed training package entitled *Working with an Interpreter is Easy*. It consists of a handbook and a DVD which should be accompanied by a 3 hour experiential workshop.[267] Each of the four chapters within the package contains informal explanations of how to work with interpreters.[268] Service providers may check their knowledge through the self-evaluation tests provided at the end of each section.[269]

E. Other measures to increase cultural competence of mental health services

i. A tool to measure cultural competence

In the UK, a review by the National CAMHS Support Service (NCSS) found that levels of cultural competence varied significantly throughout CAMHS regions.[270] As a result, a programme of cultural competence training and assessment was undertaken in CAMHS services. A tool was developed to measure the cultural competence of individuals working within CAMHS in England. Cultural competence was defined as "the process one goes through in order to continuously develop and refine one's capacity to provide effective health care, taking into consideration people's cultural beliefs, behaviours and needs". This process involves incorporating cultural awareness, cultural knowledge and cultural sensitivity and their application. The project developed the CAMHS Cultural Competence in Action Tool (CAMHS CCATool) alongside a two-day training programme. One of the authors converted the assessment tool into a user-friendly software programme that was then licensed to each CAMHS region in England.

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[262] Health Service Executive Social Inclusion Unit (Office of the CEO) (2009) *On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services*, Kildare: HSE, p.5.
[263] Ibid., p.5.
[264] Ibid., p.5.
[265] Ibid., p.13.
[266] Ibid., p.13.
[267] SPIRASI (undated) *Working with an Interpreter is Easy*, Dublin: SPIRASI, p.3.
[268] Ibid., p.6.
[269] Ibid., p.6
[270] Papadopoulos, I., Tilki, M. and Ayling, S. 'Cultural Competence in Action for CAMHS: Development of a Cultural Competence Assessment Tool and Training Programme', *Contemporary Nurse, 2*8:1-2:129-140.

ii.   Developing culturally competent recovery tools

The Mental Health Recovery Star is a tool that assists services users in working towards recovery within the adult mental health services.[271] A project was undertaken under the national Delivering Race Equality in Mental Health programme in the UK to develop a culturally sensitive version of the Recovery Star. A pilot study was conducted in order to assess its cultural relevance and modifications were made to the structure and within the 'ladder of change'. The highest step of the ladder was amended to include family and friends (not just self-reliance) in order to take account of collectivist cultures.[272] In response to the criticism that the Recovery Star did not contain sufficient religious or spiritual references some of the steps were amended to include 'higher being', etc.[273] In the study, 75% of participants who used the modified Recovery Star felt that it was relevant to them.[274] A key point made was that training on cultural competency was considered necessary in enabling staff to use the culturally sensitive Recovery Star.[275]

iii.   An example of a Mental Health Advocacy Project

The Roma Mental Health Advocacy Project was a three year project financed by the King's Fund in the UK and delivered by the Roma Support Group (RSG) from August 2008 to July 2011.[276] It employed a part-time project coordinator and two part-time bilingual mental health advocates who supported Roma community members in accessing mental health services.   100 community members were supported by project advocates and another 50 Roma individuals were informed about the project. Many Roma services users were afraid of the established medical system and were unable to access an independent mental health advocate to guide them. [277]

An evaluation of the project identified a number of positive findings. They found the ability of Roma service users to access general and mental health services improved. Service users also reported increased satisfaction with mental health services. Indications by Roma service users also suggested that they had improved wellbeing and empowerment. [278] The evaluation found that mental health professionals' increased knowledge and awareness of Roma culture led to improved communication. This better enabled health professionals to tailor interventions to meet the needs of Roma clients.[279]

In relation to general Roma health in Ireland, the HSE has funded a Roma Outreach Worker to facilitate access for Roma people to the health services and also to develop an information base.[280] The HSE is also co-hosting a series of seminars where Roma health issues such as barriers to access will be discussed.[281]

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[271] Mental Health Providers Forum (2009) *Report of the Recovery Star Model and Cultural Competency - Report of the Recovery Star BAME Pilot Study*, available at http://www.nmhdu.org.uk/silo/files/the-recovery-star-model-and-cultural-competency.pdf

[272] Ibid., p.19.

[273] Ibid., p.19.

[274] Ibid., p.33.

[275] Ibid., p.35.

[276] Roma Support Group (2012) *Roma Mental Health Advocacy Project Evaluation Report,* London: Roma Support Group,, p.5.

[277] Ibid., op.cit*.,* p.15.

[278] Ibid., op.cit., p.6.

[279] Ibid., op.cit., p.7.

[280] Department of Justice and Equality, Traveller Policy Division (2011) *Ireland's National Traveller/Roma Integration Strategy*, Dublin: Department of Justice and Equality, p.16.

[281] Ibid., p.17.

F. Specialist services

i. Community health workers

It has been found that the use of community health workers can increase the use of mental health services particularly by people who are traumatised immigrants or refugees.[282] Community health workers are usually members of the immigrant communities who are trained in providing support, counselling and information. Interventions can have different goals such as increasing access to services or increasing health-related knowledge.[283] Use of community health workers has been established in Ireland. For example health workers for the Traveller community are available in a number of areas.

ii. Transcultural psychiatric clinics

A model of care known as a Cultural Psychiatric Clinic was piloted at the Mater Hospital in Dublin.[284] Its aim was to assess the needs of migrants and to ascertain the necessity for such a service. The clinic employed interpreters to aid in effective communication in situations where individuals did not have the use of English and set up a cultural advisory panel. Research found the pilot clinic to be effective.[285]

In the US a specialist service was set up in Chinatown. The Bridge Programme was created by the Charles B. Wang Community Health Centre.[286] The programme provided a link between primary care and mental health services. Its services were fourfold: to provide training for doctors, to provide early detection, to provide treatment in a primary healthcare setting and to help with access to specialist mental health services when they are needed. The programme was created to address issues such as cultural stigma, cultural recognition and interpretation of psychiatric symptoms and late presentation of symptoms to mental health services by Asian Americans. It was found to be effective and was replicated in Boston and Oakland.

iii. Involving families and local communities

Community Connections for Families (CCF) is a system of care which helps families and their children who have emotional disturbances in Allegheny County, Pennsylvania.[287] Here the local government works through strong neighbourhood and family partnership to provide integrated, family-directed support and services that aim to be culturally competent. The author stresses that cultural competence and family involvement cannot exist without each other. CCF has a number of key features such as training, neighbourhood interventions and social and recreational activities. Families can provide support to other families. Furthermore, the neighbourhood is allowed to hire people who have a positive history in their neighbourhood. This facilitates trust among those in the neighbourhood. Food is also an important part of meetings and trainings. Families are able to be involved in decision making, leadership and planning. Dougherty emphasises that the inclusive procedures of each programme activity need to be enforced. This can be achieved through programme evaluation that includes family and neighbourhood representatives and through a bi-annual progress report.

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[282] Mollica, et al. (2011), op. cit. p.101.
[283] Ibid.
[284] Kelly, et al. (2008), op. cit., p.8.
[285] Ibid., p.32.
[286] Dougherty, et al. op. cit., pp.257-8.
[287] Ibid., p.257.

iv.   Reducing stigma

Stigma and discrimination have been highlighted as a barrier to mental health care among ethnic minorities; research has shown that many people from an ethnic minority group face the burden of a double stigma related to their ethnic minority and their mental health statuses.[288] The Report of the Surgeon General in the US has suggested that further research into stigma is needed. The Surgeon General suggested that when people from the ethnic minority in question join the ranks of mental health professionals this helps to reduce stigma. The Surgeon General also suggested that educating the public to target stigma and discrimination would be more effective if tailored to the languages and needs of people from BME communities.[289] Elsewhere, Mollica has suggested that increasing access through primary care can combat stigma.[290]

v.   Improving access through primary care

Mollica argues that increasing the knowledge and skills of GPs is important for increasing minorities' access to mental health care.[291] In the US it is known that many people from BME communities would prefer to access mental health services through primary care.[292] These services can prove invaluable in the detection and treatment of mental health issues.[293]

In Ireland, the National Intercultural Health Strategy commits to involving ethnic minority communities in the roll-out of the Primary Care Strategy.[294] It states that:

> "The structure of health services in Ireland directs that, in most instances, the General Practitioner is the first point of entry to the health services for the majority of service users. Enhanced access at this gateway is thus a key element to promoting appropriate uptake and usage of health services by people from diverse cultural and ethnic backgrounds." [295]

However, most GPs do not receive formal training in community-based mental health care, though they may have a mental health clinical placement as part of their training. A survey published in 2004 found that 68% of GPs had no specific training in mental health, while a further 32% had training that consisted of a clinical placement or on-the-job training. The same study found that 71% of GPs would be interested in further training in mental health.[296] There are a number of initiatives that have been seeking to increase the skill base of primary care professionals more widely, which have been supported by appointing a Director of the Mental Health Project at the Irish College of General Practitioners (ICG) funded by the HSE. In 2009, the ICGP and the College of Psychiatrists of Ireland (CPI) set up a joint

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[288] Gary, op. cit.

[289] US Department of Health and Human Services (2001) *Mental Health: Culture, Race, and Ethnicity –A Supplement to Mental Health: A Report of the Surgeon General*, Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Centre for Mental Health Services, p.165.

[290] Mollica, op. cit., p.101.

[291] Mollica, op. cit., p.101.

[292] US Department of Health and Human Services (2001) op. cit., p.163.

[293] Ibid., p.163.

[294] HSE (2008), op. cit., p.19.

[295] Ibid., p.76.

[296] Copty, M. (2004) *Mental Health in Primary Care,* Dublin: Health Service Executive/Irish College of General Practitioners, p.19.

forum.[297] The ICGP and the CPI (and the training bodies within them) are in a position jointly to devise training programmes and materials for GPs.

In 2004 the HSE launched a Mental Health in Primary Care Resource Pack for GPs. In addition, there are e-learning modules on mental health through the ICGP.[298]

G. Summary of measures to improve cultural competence of mental health services

The development of cultural competence among health professionals is central to measures to improve ethnic minorities' access to and experience of mental health services. The most widely-cited definition of cultural competence is:

> "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations."[299]

National programmes to develop cultural competence and remove barriers to access have been undertaken in the US, the UK and Australia. In the UK the Delivering Race Equality in Mental Health Care action plan emphasises:

- developing a more appropriate and responsive service
- increasing community engagement with service providers
- better quality information on the ethnic profile of local populations and service users which would be more intelligently used.[300]

The Office of Minority Health of the Department of Health and Human Services in the US (OMH) has published national standards for Culturally and Linguistically Appropriate Services in healthcare (CLAS). These are a blueprint to assist service providers and individuals in implementing culturally appropriate services.[301] The principal standard is to:

> "provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practises, preferred languages, health literacy and other communication needs."[302]

In Australia, the Mental Health Commission funded the development of a National Cultural Competency Tool (NCCT) for the mental health sector which is a self-assessment tool to assist services in meeting the National Standards for Mental Health Services (NSMHS).The standards cover areas such as service planning, collaboration with stakeholders, research and evaluation, access, interpretation services and training. The NCCT includes a standard stating that the service must adhere to a Language Services

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[297] Rogan, M. (2010) *HSE Progress Report on the 2009 Key Deliverables in the HSE Implementation Plan 2009-2013*, 19 Feb 2010, available at
http://www.dohc.ie/publications/vision_for_change_4th/hse_nat_reg/HSE_Key%20Deliverables%202009%20_Report.pdf?direct=1
[298] *Independent Monitoring Group for A Vision for Change First Annual Report for 2006-2007*.
[299] Cross, et al. (1989), op. cit.
[300] Department of Health (UK) (2005) *Delivering race equality in mental health care: An Action Plan for Reform Inside and Outside Services*, London: Department of Health, p.8.
[301] US Department of Health and Human Services, Office of Minority Health 'What are the National CLAS Standards?' <https://www.thinkculturalhealth.hhs.gov/Content/clas.asp> [date accessed: 4 July 2013]
[302] US Department of Health and Human Services, Office of Minority Health 'The National CLAS Standards' (5/3/2013) http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 [date accessed 4 July 2013]

Policy.[303] Government policy dictates that if possible organisations should use interpreters and translators accredited at a professional level.

Other measures that have been undertaken in different countries include tools to measure cultural competency (UK), developing a culturally-sensitive Recovery Star assessment tool (UK), running specialist transcultural psychiatry clinics (Ireland) and hiring specialist community health workers (Ireland).

In Ireland, mental health professionals desire to provide a culturally competent service and to be trained in the skills and attitudes that would support culturally sensitive provision. The potential exists to draw upon international good practice examples to strengthen mental health professionals' cultural competency and provide professionals with a more developed basis from which to support the mental health of people from BME communities.

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[303] Multicultural Mental Health Australia (2010) *National Cultural Competency Tool (NCCT) for Mental Health Services*, p.5.

RECOMMENDATIONS

The following recommendations have been developed with MHR's Ethnic Minorities and Mental Health group. The recommendations are organised according to the themes raised in the group's discussion.

Barrier/issue	Recommendations
Lack of cultural competence within mental health and primary care services	1. The HSE should develop a programme and implementation plan to develop cultural competence in primary care and specialist mental health services that includes guidance and a training programme for staff and should clarify lead responsibility for this programme within the Mental Health Division's Senior Management Team. 2. The Mental Health Commission should develop standards for cultural competency in mental health service delivery in partnership with BME communities and should develop a system for monitoring these standards. 3. Professional bodies responsible for training of mental health professionals, and the ICGP, should ensure that cultural competence is incorporated into the curriculum for trainees and in continuing professional development programmes. 4. People from BME groups should be involved in planning and delivering cultural competency training.
Need for mental health capacity among key community leaders, e.g. pastors	5. The NOSP should fund a dedicated strand of mental health capacity-building for ethnic community leaders. 6. The DOJ should include a specification in their Service Level Agreements with direct provision service providers to provide mental health awareness training for their staff. This should form part of any revised Reception conditions for asylum seekers 7. The NOSP should fund mental health workers for BME communities.
Lack of information on ethnic minorities' mental health needs, service provision and experiences of mental health services and supports	8. The HSE should include an ethnic identifier in data collected on mental health service utilisation in inpatient, day and residential services. 9. Research should be commissioned to assess the prevalence of mental health difficulties among ethnic minorities in Ireland. 10. Research should be commissioned to explore the experience of mental health services and supports by people from BME communities.

Stigma and cultural barriers to help-seeking from within the ethnic community	11. The SeeChange anti-stigma/discrimination campaign should develop a strand of action targeted at reducing the stigma around accessing mental health support among people from BME communities.
Cross-cutting gender issues and issues for other marginalised groups (e.g. LGBT, people with disabilities, etc.) are not recognised	12. Plans and initiatives to address ethnic minority mental health should take account of the interface with gender issues and issues for other marginalised groups (e.g. the LGBT community, people with disabilities, etc.). 13. Cultural competency training should incorporate understandings of cross-cutting marginalisation and multiple marginalised identities.
Language and communication barriers	14. Government should ensure that skilled interpreters who understand how to interpret in a mental health setting are available for free to individuals accessing primary care and mental health services, including within the Counselling in Primary Care service. 15. The HSE should ensure that primary care and mental health service staff use accessible language about mental health treatment when providing information to patients/service users, drawing on existing HSE guidance 16. Mental health service staff should receive intercultural communication skills training including training in how to work with interpreters. 17. The HSE should establish 'cultural liaison officers' similar to the Disability Liaison Officers that can provide guidance to staff on how to ensure cultural sensitivity in service delivery.
Addressing the social determinants of mental health for people from BME communities	18. Cross-sectoral actions to address the social determinants of mental health for people from BME communities should be progressed as part of the *Healthy Ireland* framework for improved health and wellbeing and any follow-on from the *National Intercultural Health Strategy 2007-2012*.

About Mental Health Reform

Mental Health Reform is the national coalition of organisations working to promote improved mental health services and social inclusion of people with mental health conditions in Ireland. We work with our members to help bring about structural and cultural changes in mental health services.