Ethnic Minorities and Mental Health:

Guidelines for mental health services and staff on working with people from ethnic minority communities

Mental Health Reform
Promoting Improved Mental Health Services

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Coimisiún Meabhair-Shláinte | Mental Health Commission

The Community Foundation for Ireland

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Introduction

The following guidance has been developed by Mental Health Reform (MHR) in partnership with the Mental Health Commission (MHC). It is rooted in MHR's policy position on ethnic minorities and mental health, which was developed on the basis of an international literature review and wide consultation with representatives from a number of ethnic minority groups, in addition to MHR's Multi-Disciplinary and Ethnic Minorities Advisory Groups. MHR's position paper *Ethnic Minorities and Mental Health* is available in full at www.mentalhealthreform.ie/resources.

In December 2014, Mental Health Reform and the Mental Health Commission hosted a roundtable discussion with key stakeholders and experts working in the field of ethnic minorities and mental health. This event prompted the decision to develop dedicated guidelines for mental health services and staff on how to provide culturally appropriate care and supports. The guidelines were considered by MHR's aforementioned advisory groups and have been approved by both Mental Health Reform and the Mental Health Commission.

The guidelines have been structured around a set of themes. Under each of the themes the relevant standards drawn from the Mental Health Commission's Quality Framework for Mental Health Services are included, followed by specific guidance appropriate to developing culturally competent mental health services.

The guidance is consistent with national policy, including *A Vision for Change*, the suicide prevention strategy Connecting for Life and the National Intercultural Health Strategy 2007-2012.

A Vision for Change states 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 ethnic minority groups, including the provision of interpretation services.[1]

The National Intercultural Health Strategy 2007-2012 acknowledged that the health of people from ethnic minority groups is important and stated that enhancing access to mental health services should be a priority.

Connecting for Life recognises that people from ethnic minority groups are at increased risk of suicide and self-harm and includes a specific goal to target approaches to reduce suicidal behaviour and improve mental health among this group of individuals. The strategy also aims to reduce stigmatising attitudes to mental health and suicidal behaviour within priority groups.

Finally, this guidance takes account of progress that has been achieved internationally in promoting culturally competent mental health services, including the US National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (US CLAS Standards), as well as initiatives undertaken in Australia and the UK. These frameworks provide resources for the development of policy and good practice within the Irish context and are outlined in greater detail under each of the relevant themes.

1 Department of Health and Children (2006) A Vision for Change. Report of the Expert Group on Mental Health Policy. Stationery Office, Dublin. P. 41.

Prevalence of mental health difficulties among people from ethnic minority groups

While there is very limited evidence on the prevalence of mental health difficulties among people from ethnic minority groups in Ireland, international research can provide an indication of the mental health needs among this group. Such research suggests that the rate of diagnosis of severe mental health difficulties is higher in migrant and ethnic minority groups while the rate of more common mental health difficulties is similar to the majority population.[2] International authors have also concluded that refugees who have resettled in Western countries are ten times more likely to experience post-traumatic stress than the general population.[3] Furthermore, research has found that there are differences in the rates of suicide between some ethnic minority communities and majority populations and that suicide rates are higher where the ethnic minority group is smaller in density.[4] In terms of care and/or treatment, a UK 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 groups.[5]

There is some research in Ireland on the mental health needs of members of the Irish Traveller community which is consistent 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.[6] 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[7]. Among Irish Traveller men 59.4% said that their mental health was not good for one or more of the last 30 days. [8]

In a small scale study in one mental health service in Dublin, there was no difference in rates of schizophrenia and bipolar diagnoses between individuals from ethnic minority groups and the general population. Furthermore there was no significant difference in rates of depression or anxiety.[9] However, the authors concluded that the low rate of schizophrenia diagnoses compared to international studies may indicate that migrants in need are not accessing mental health services.[10]

International research shows that in Western countries people from ethnic minority communities access mental health services less than the majority population. In Ireland, adults from ethnic minority 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 ethnic minority communities appear to access mental health services less than would be expected by their presence in the population. 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 and many 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.[11]

It must be acknowledged that Ireland's population is diverse in terms of both ethnicity and country of origin and the number of people from other countries living in Ireland continues to grow.

2 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.

3 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.

4 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.

5 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.

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

7 Ibid, p.50.

8 Ibid, p.18.

9 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, p.21.

10 Ibid, p.26.

11 Quirke, B. (2010), op. cit., p.18.

Mental Health Reform has previously recommended that mental health services should serve the whole community, including individuals from ethnic minority groups.[12] In keeping with international human rights treaties Ireland is obligated to protect the health of minority groups through targeted programmes.

Barriers experienced by people from ethnic minority groups in getting mental health services and supports

A number of barriers have been identified for individuals from ethnic minority groups in accessing mental health services in Ireland. Mental health services and staff should be aware of such barriers and the following should be considered in the development of culturally appropriate service delivery:

- A lack of understanding among mental health professionals of the social and cultural context for people from ethnic minority groups, including experiences of poverty, racism, discrimination and other types of social exclusion
- A lack of understanding among people from ethnic minority communities about mental health services and how to access them
- Patterns of help-seeking behaviour and attitudes to mental health among ethnic minority groups
- Services are designed and developed in a way that reflects the majority culture
- Issues of stigma and discrimination which deter people from ethnic minority groups from both accessing services and continuing with care
- Issues of mistrust of mental health services among people from ethnic minority groups
- 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
- Potential costs associated with mental health care, including transport costs associated with getting to and from appointments

What is cultural competence?

Culture influences how we view our health. It influences help-seeking behaviour both in terms of access and care/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. Therefore it is important that service providers are culturally competent.

Under the National Intercultural Strategy 2007 – 2012, cultural competence was described as: "having the right policies, knowledge and skills to meet the needs and practices of people from different cultural backgrounds." [13] The Strategy recognised that culture includes lifestyle, dress, diet, language and spiritual needs, though religion can cross cultural boundaries.

These guidelines use the term 'cultural competence' to refer to the attitudes, behaviours, knowledge and skills that mental health professionals need to have in order to deliver culturally responsive mental health services, while recognising that such competency must incorporate addressing power imbalances and institutional discrimination.

12 Mental Health Reform (2012) Manifesto – Guiding A Vision for Change, Dublin: Mental Health Reform, p.18.

13 HSE (2008) National Intercultural Health Strategy 2007-2012, Dublin: HSE, p.126.

Theme 1: Respect for diverse beliefs and values

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Mental health services and staff should respect the diverse beliefs and values of people from ethnic minority communities and deliver care and treatment in a manner that takes account of such beliefs. Respectful, empathetic relationships are required between people using the mental health services and those providing them.

Standard 2.1 of the Mental Health Commission's Quality Framework states that "service users receive services in a manner that respects and acknowledges their specific values, beliefs and experiences".[14] More specifically, the Quality Framework holds mental health services responsible for:

- Ensuring that service users are consulted regarding their individual values and beliefs
- Responding sensitively to the beliefs, value systems and experiences of the service user during service delivery, and providing appropriate privacy for service users to practice their cultural, religious and spiritual beliefs
- Ensuring all individuals receive mental health care that is in compliance with equality legislation and prohibits discrimination on the grounds of ethnicity, including membership of the Traveller community
- Ensuring that there is a policy in place regarding the implementation of this standard
- Monitoring the policy's performance in relation to this standard as part of a quality improvement process

In consultation with MHR's Ethnic Minorities Advisory Group it was identified that relationships between the individual and mental health services should also be built on trust. Professionals may need to allocate additional time to developing such a rapport, sharing information about their background, their current role, their reasons for working with the individual and establishing some mutual understanding.

Under the HSE's Health Services Intercultural Guide, the HSE advises staff to be aware that culture is a dynamic process and that individuals have specific needs irrespective of their cultural, societal or religious obligations. The overall purpose of the HSE's Guide is to provide information to staff so that they can provide a sensitive, appropriate and quality service across cultural lines.[15]

The issue of cultural competency is particularly relevant to fulfilling the Mental Health Commission's Standard 2.1. It is important to recognise that mental health services have been designed and developed in a way that reflects a majority culture. For example, standard assessment tools may reflect the dominant culture and mental health professionals may be unaware of this cultural bias. Mental health professionals may also be unaware of how their cultural background influences their interpretation of service users' situation and condition.

People from ethnic minority communities may have a different perception of mental health

14 Mental Health Commission (2007) Quality Framework [for] Mental Health Services in Ireland, Dublin:MHC.

15 HSE (2009) Health Services Intercultural Guide: Responding to the needs of diverse religious communities and cultures in healthcare settings, Dublin: HSE.

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 individuals from different cultures may understand their "illness" in ways other than the pervading biomedical conception in Western Countries.[16] In a small-scale study in East Anglia, participants described 'mental health' as a construct which created problems in recognising 'mental health'.[17] This was described by participants as a 'lack of awareness', 'lack of knowledge' and 'different understanding of the problem'. 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."

Another qualitative study conducted in the UK identified participants' beliefs relating to mental health and "mental illness" as an important theme.[18] Here mental health was described as a 'set of can-dos' such as 'communicating well' and subjective experiences such as 'being free from stress' and 'being confident'. Participants differentiated between 'normal' reactive emotional problems and mental health difficulties which they referred to as 'madness'. Some participants felt that depression has a supernatural cause.

16 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.

17 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.

18 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.

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.[19] One participant is quoted as saying:

"I do not feel I was depressed. I was not feeling well because I was worrying about my family."

It is also important for mental health services to recognise that in some cultures the language does not exist to describe mental health issues and the impact that this has on individuals. In many instances, people from ethnic minority groups will attempt to express mental health difficulties using physical attributes.

Specific ways that staff can provide a culturally sensitive service include:

Recommendation 1

Mental health staff should understand and be knowledgeable of the role that cultural health beliefs and practices play in their own lives as well as the lives of individuals seeking services.[20,21] This should be facilitated through training opportunities and self-reflective practice on personal and organisational culture. Such training and self-reflective practice are necessary in order to understand the difficulties often experienced by people from ethnic minority

19 Kelly, F., Kelly, B. and Ryan, D.(2008).

20 The UN Committee on Economic, Social and Cultural Rights has made specific comments on the right to health for people from marginalised groups. General Comment14 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….".

21 The Intercultural Health Strategy recognized that cultural and religious beliefs play an important role in both access to and the receiving of culturally appropriate care and support.

communities in accessing and engaging in mental health services. As mentioned above it is important to recognise that mental health services have been designed and developed in a way that reflects the majority culture.

The way that people define their mental and emotional distress influences their help seeking behaviour and how they believe they should be cared for/treated.[22]

Mental health staff should also be aware of specific social and cultural issues that are experienced by people from ethnic minority communities. 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, which according to *A Vision for Change* can be a factor in causing and exacerbating mental health difficulties. The Strategy also recognised that discrimination and racism are important issues which may impact on the mental health of people from ethnic minority groups. [23,24] A recent review showed that there are strong and consistent relationships between racial discrimination and a range of detrimental health outcomes such as depression, anxiety, low self-esteem, reduced resilience, increased behaviour problems and lower levels of well-being in minority adolescents.[25]

It is of fundamental importance that mental health professionals are cognisant of these challenges.

Recommendation 2

Mental health services and staff should ensure that cultural concepts and beliefs are reflected in the development and delivery of individual care/recovery planning.[26] This will help to ensure that people from ethnic minority communities understand and engage in their care/treatment options and plan. The language used by mental health professionals in describing individual care/recovery planning must also be carefully considered and individualised in order to meet the person's specific communication needs.

Services should develop policies and procedures to facilitate the specific culture-based needs such as family roles and obligations, dietary and religious needs.[27]

The US CLAS Standards recommend that staff should inquire about and understand any relevant cultural practices that the individual may want to avail of to support their recovery from a mental health difficulty, e.g. spiritual or other practices, and should support the individual to avail of these cultural practices where appropriate. Through this awareness, the provider will be able to negotiate

22 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.

23 In a UK study, it was concluded that isolation and social exclusion are significant factors in the higher incidence of schizophrenia among black Caribbeans in the UK. A case study operating from a 'social determinants of health' model and was carried out among people from ethnic minority communities in Dublin found that immigration, accommodation, racism, discrimination, employment and education impacted at a community level upon the health of ethnic minorities.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.The College of Psychiatrists' position paper on the mental health needs of asylum seekers and refugees highlights how mental health difficulties can be aggravated by the social isolation which asylum seekers may experience.

24 HSE (2008) p.8.

25 Priest et al., "A systematic review of studies examining the relationship between reported racism and health and well-being for children and young people". *Journal of Social Science and Medicine* 95.100 (2013): 115-127. Print.

26 Leong, F.T.L. and Kalibatseva, Z. (2011).

27 Multicultural Mental Health Australia (2010) National Cultural Competency Tool (NCCT) For Mental Health Services Parramatta, NSW, Australia: Multicultural Mental Health Australia.

treatment options in a culturally and linguistically appropriate manner. However, as providers and staff learn about the cultural health beliefs and practices of different communities, it is important that this knowledge is not used to stereotype or over generalise.

In the state of Victoria, Australia's Cultural Responsiveness Framework for health services advises, inclusive practice in care planning which includes dietary, spiritual, family attitudinal and other cultural practices.[28]

In care and recovery planning, mental health professionals should be cognisant of the potential social and economic challenges that may face people from ethnic minority communities, including, for example, unmet housing need, unemployment, lack of education, poverty and social isolation. A wider knowledge among mental health professionals of community supports, including culturally specific services and programmes should be promoted and utilised in individual care/recovery planning.

Recommendation 3

Mental health professionals should determine the communication and language assistance needs of individuals from ethnic minority communities. This recommendation is elaborated on in theme 2 but it is important to recognise that effective communication must be facilitated in order for mental health professionals to identify the particular values and beliefs of individuals.

28 Department of Health (2009) Cultural Responsiveness Framework: Guidelines for Victorian Health Services, Victoria: Department of Health.

Recommendation 4

Services should provide individuals with assurances that disrespect or discrimination of any kind by staff will not be tolerated. [29] Specific measures for reducing discrimination in mental health services should be implemented, for example, by employing individuals from ethnic minority communities and educating local communities to target stigma and discrimination.[30]

Stigma and prejudice has been found to be a barrier for people from ethnic minorities accessing mental health services, in continuing with their mental health treatment and/or in acknowledging that they have a mental health difficulty.[31] Stigma can emerge from the public, the individual or the mental health system/ provider.

29 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.

30 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 ethnic minorities 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 ethnic minority communities. Elsewhere, Mollica has suggested that increasing access through primary care can combat stigma.

31 Gary, F.A. (2005) 'Stigma: Barrier to Mental Health Care Among Ethnic Minorities', Issues in Mental Health Nursing 26:10:981.

Recommendation 5

Mental health staff working with people with mental health difficulties should be trained in the area of anti-discrimination and cultural competency. Specific measures for implementing this recommendation are set out in theme 5. Guiding principles of cultural competency include:

- Valuing the individual's cultural beliefs
- Recognising the complexity in language interpretation
- Continuous self-information and learning
- Involving the community in defining and addressing needs

The National Intercultural Health Strategy affirmed that staff training in areas of anti-discrimination and cultural competence was a priority, stating: "appropriate intercultural training and support for staff is a fundamental principle of the Strategy…". A comprehensive programme of action has been undertaken in the UK to eliminate discrimination against people from ethnic minority communities in mental health care.[32] 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.[33] As part of this programme, it has been recommended 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.[34] Respecting diversity has 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).
The remaining themes in this document will set out specific measures that are necessary to achieve the principal standard on cultural competency, as set out in the US CLAS Standards: "[Services should] provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs". Some of these practical measures include:

- Educating and training mental health staff in culturally and linguistically appropriate policies and practices on an ongoing basis
- Establishing a partnership with the community in the design and delivery of culturally appropriate services
- Ensuring the competence of individuals providing language assistance and recognising that the use of untrained individuals and/or minors as interpreters should be avoided
- Providing easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

The above measures will be set out in full in the themes below.

32 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.

33 Ibid., p.4.

34 Ibid., p.21.

Theme 2: Communication and language supports

Theme 2: Communication and language supports

Mental health services and staff should identify the communication and language assistance needs of people from ethnic minority communities, provide information in ways that are accessible and provide appropriate interpretation services, where necessary.

Standard 5.1.3 of the Mental Health Commission's Quality Framework states that "mental health services should provide information in ways that are accessible to people from ethnic minority groups".[35]

More specifically, the Quality Framework holds mental health services responsible for the following:

- Information should be communicated in a way that is easily understood by the service user, and repeated as required, being aware that explanations may be necessary on more than one occasion. Supportive written material should be made available in a variety of languages, formats and media and should meet communication needs at all levels in the mental health service
- Where necessary, service users should have access to interpretation services (including sign language translators)

A Vision for Change states that "good communication is at the heart of mental health work. Therefore the question of language is extremely important. Good interpreters are vital for effective cross-cultural working. Mental health work requires interpreters who are able to interpret the 'idiom' of the patient's distress as well as the actual words used".[36]

The HSE's National Intercultural Health Strategy also identifies the importance of accessible information, language and communication, in addition to professional interpretation and translation in health services, as a key priority. It recommends that services develop creative ways in which to provide information to people from ethnic minority communities; to involve individuals from such groups in the development of information materials; to adapt existing materials to meet their language needs and ensure that information is provided in clear and simple language, using universally accepted symbols wherever possible.[37]

The US CLAS Standards explain that language supports facilitate effective and accurate exchange of information between an individual and their mental health professional. By facilitating conversations regarding prevention, symptoms, diagnosis, treatment, and other issues, language assistance improves the quality of services and patient safety. Culturally and linguistically appropriate services are recognised as increasing patient safety (e.g., through preventing miscommunication, facilitating accurate assessment and diagnosis and reducing medical error).[38, 39] Services can include

35 Mental Health Commission (2007).

36 AVFC (2006), p.41.

37 HSE (2008) National Intercultural Health Strategy p. 98.

38 The HSE's National Intercultural Strategy has identified that cultural differences and language barriers may increase potential for misdiagnosis.

39 Research within Australia demonstrates the link between culture, language and patient safety outcomes. The delivery of safe high quality care is premised on effective communication between the individual and the service/professional. Limited English language proficiency can adversely effect the communication process and the health outcome as well as infringe the rights of the individual. In their pilot study of Language Proficiency and Adverse Events in US Hospitals, Divi et al (2007) firmly contend that an increasing evidence base is emerging to suggest that patient–provider communication is a serious patient safety concern and a common root cause of adverse events in healthcare delivery. They describe the effects of language barriers as follows: 1)Undermining trust in the quality of the medical care received and the patient-health professional relationship 2) Compromising

interpreters, bilingual staff, or remote interpreting systems via phone or video, as well as the translation of written materials and signage. [40]

Communication has been identified as a significant barrier for people from ethnic minority communities in both accessing and remaining in mental health services. In Ireland, communication difficulties were reported in a chart review study at St. James's Hospital in Dublin.[41] 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.[42]

At a national consultation held by Mental Health Reform, specific difficulties were identified for people from the Traveller community with respect to communication. Some Travellers find it difficult to communicate with their GP, to understand the language used by doctors, the diagnosis they are given and the purpose of medication prescribed.

Specific ways that mental health services can ensure that they address the language and communication needs of individuals from ethnic minority communities include:

Recommendation 1

Mental health services and staff should identify the communication and language needs of people from ethnic minority communities.

- Mental health services should ensure that staff are aware that it is the responsibility of each staff member providing care to people to assess their level of understanding and ability to communicate [43]

- Mental health services should ensure that staff are fully aware of, and trained in, the use of language assistance services, policies, and procedures [44,45]

- Mental health services should develop processes for identifying the language(s) of individuals from ethnic minority communities (e.g., language identification flash cards or "I speak" cards) [46,47]

appropriate follow-up and care which may result in a 'trajectory of accident opportunity' for the patient 3) Misunderstandings and inadequate comprehension of diagnoses and treatment 4) Problems with informed consent 5)Dissatisfaction with care 6)Preventable morbidity and mortality 7)Disparities in prescriptions, test ordering and diagnostic evaluations 8)Inhibiting a clinician's ability to elicit patient symptoms which can result in an increased use of diagnostic resources or invasive procedures, inappropriate treatment and diagnostic errors 9)Increased cost through unnecessary procedures or increased interventions to rectify errors.

40 The Joint Commission (2010) Advancing Effective Communication, Cultural Competence, and Patient and Family Centered Care: A Roadmap for Hospitals. Oakbrook Terrace, IL: The Joint Commission.

41 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.

42 Kelly et al. (2008), op. cit., p.18.

43 HSE (2009) On Speaking Terms*: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services*, p. 10.

44 See Standard 4, US CLAS Standards.

45 In Amsterdam, a project was undertaken to develop the components of competency training. The resulting framework was built around five cultural competencies that include "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".

46 See US CLAS Standards.

47 The HSE's Emergency Multilingual Aid (EMA) box aims to assist frontline staff in communicating with individuals with limited English proficiency who attend hospitals in acute or emergency situations. The toolkit contains some of the most common questions and terms that staff may need to ask patients to make an initial assessment in acute/emergency situations. The resource includes 20 multilingual phrasebooks in those languages identified

- Mental health services should be aware of the possibility of low health literacy among people from ethnic minority communities [48]
- Mental health staff should have the knowledge and skills to make an appropriate assessment of an individual's communication needs
- Mental health professionals should also be aware that other people, such as family members or caregivers, may be involved in the provision of support or care to an individual. If family members or caregivers also have limited English and/or other communication needs, their linguistic needs should also be met to ensure the best outcomes for the individual receiving care
- Mental health staff should be aware that the requirement of interpreter services should be included in the individual's care /recovery plan. Once a staff member has confirmed that an interpreter is required it is important to record this in the individuals' case notes [49]

as being most widely spoken in Irish hospitals. There is significant scope for the EMA to be adapted and used throughout the entire health care system. The EMA box could also be used with individuals presenting in crisis to emergency departments with mental health difficulties.

48 The HHS Agency for Healthcare Research and Quality has developed a toolkit that outlines health literacy universal precautions, defined as "actions that minimize risk for everyone when it is unclear which patients may be affected" by low health literacy. The US CLAS andards recognise that universal precautions are necessary because health professionals cannot always identify individuals with low health literacy.

49 HSE (2009) p. 10.

Recommendation 2

Mental health services and staff should offer and provide appropriate interpretation services, where necessary

- Staff should let service users know that they have the right to an interpreter to assist in communication. It should be made clear that there is no cost to the individual and that staff will arrange for the interpreter (the individual does not have to do this). The individual can use or refuse the assigned interpreter [50]
- Staff should be aware that a consultation involving the use of an interpreter will take longer than a routine appointment. Additional time should be allocated for this when appointments are made [51]
- Mental health staff should be appropriately trained in working with interpreters
- Mental health services should put in place processes to access accredited or suitably competent interpreters who have been trained in mental health interpreting [52]
- Interpreters should be trained in cultural competency [53]
- Mental health services should establish contracts with interpreter services for in-person, over-the-phone, and video interpreting [54]

50 Ibid.

51 Ibid.

52 Multicultural Mental Health Australia (2010).

53 See US CLAS Standards.

54 In Australia, the Mental Health Branch of the Department of Human Services has issued guidance on interpretation within mental health services, including that all adult mental health services should provide 24-hour access to interpreting services in all available community languages.

- Mental health services should ensure the quality of the language skills of self-reported bilingual staff who use their non-English language skills to communicate with service users [55,56]

- Mental health services should ensure that family members (including children and/or carers) are not permitted to interpret for their loved one. [57] Children may not have the cognitive or emotional maturity to function in the role of interpreter. In addition, the use of children as interpreters has been found not only to place unnecessary tension on the parent-child relationship but also to place stress and emotional strain on the child

55 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. 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.

56 The use of clinical and nonclinical staff who speak a non-English language but who are untrained in medical interpretation can pose potential safety risks. Research has shown that when clinicians speak a non-English language, or when untrained bilingual staff is available, an important set of potential barriers can arise and hinder the effective and appropriate use of trained interpreters.

57 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.

Recommendation 3

Mental health services should provide easy to understand materials and deliver information in a manner that is accessible

- When staff are communicating, they should use simple language and minimise jargon [58]

- Mental health services and professionals should adhere to existing HSE guidance documents on meeting the communication and language needs of people from ethnic minority communities [59]

- Issue plain language guidance and create documents that demonstrate best practices in clear communication and information design

- Create forms that are easy to fill out, and offer assistance in completing forms

- Easy-to-understand materials should be developed and processes for periodically re-evaluating and updating such materials should be put in place

- Mental health services should formalise processes for translating materials into languages other than English and for evaluating the quality of these translations

- Mental health services should develop materials in alternative formats for individuals with communication needs, including those with sensory, developmental, and/or cognitive impairments

58 HSE (2009), p. 10.

59 Ibid.

- Services should test materials with target audiences. For example, focus group discussions with members of ethnic minority groups can identify content in the material that might be embarrassing or offensive, suggest cultural practices that provide more appropriate examples, and assess whether graphics reflect the diversity of the target community

- Services should consider providing financial compensation or in-kind services to community members who help translate and review materials

Once all measures have been taken to overcome communication barriers, mental health professionals should make contact with individuals shortly after their engagement with the service to ensure that they understand what was discussed. Anecdotal evidence suggests that individuals from ethnic minority groups will often advise professionals that they understand when actually they do not, due to frustration, embarrassment and/or a lack of confidence.

Theme 3: Access to mental health services

Theme 3: Access to mental health services

Mental health services should improve accessibility to their services for people from ethnic minority communities.

Standard 2.1 of the Mental Health Commission's Quality Framework states that "mental health services should ensure equality for all individuals in accessing services regardless of the individual's ethnicity, including membership of the Traveller community".

The HSE's National Intercultural Health Strategy and the national mental health policy *A Vision for Change* contain broad recommendations to improve ethnic minorities' access to mental health supports.

The Intercultural Heaslth Strategy has recognised major barriers that can hinder access to mental health services for people from ethnic minority communities, including: "understanding the pathways of negotiating the health system", "accessing a range of services (usually GP)" and "the service user's experience of racism and discrimination".

Representatives of ethnic minority groups have reported that people from ethnic minority communities do not know about mental health services and how to access them. International research from both the US and the UK indicates that people from ethnic minority communities have more problems getting access to services and interacting with services than the general population.[60] Furthermore, research shows that in Western countries people from ethnic minority communities access mental health services less than the majority population. Some research has suggested that a lack of knowledge about mental health services is one of the main reasons for under-utilisation of services.[61] In Victoria, Australia, a lack of knowledge about how and where to receive help and how mental health services work has been identified as one of the barriers to ethnic minority communities' access of services.[62]

A report from inner city Dublin found that many of the migrants in its study did not know how to access psychiatric care. They reported a lack of understanding of services available and also a fear of repatriation upon going to a clinic.[63] In the All Ireland Traveller Health Study, lack of information was reported as being a barrier for 37.3% of participants.[64] A report by Cairde also cited lack of information about services as a barrier in trying to access general health services.[65] Cairde is a community development organisation working to tackle health inequalities among people from ethnic minority communities by improving access to health services, and participation in health planning and delivery.

Reports from some NGOs working within ethnic minority communities in Ireland point to a tendency for clinicians to refer people from ethnic minority communities less often to multidisciplinary supports and specialist mental health services.

60 Morgan (2011), op. cit., p.91.

61 Leong, F.T.L. and Kalibatseva, Z. (2011).

62 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.

63 Kelly, et al. (2008), op. cit., p.11.

64 Quirke, B. (2010), op. cit., p.14.

65 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.

Stigma and prejudice has also been found to be a barrier for people from ethnic minorities in both accessing mental health services and in continuing with their treatment. Stigma has been found to not only impede people from taking action but to also stop them from continuing treatment once commenced.[66] Irish Travellers have reported that using counselling services would be difficult due to stigma.[67]

Mistrust has been cited as a barrier to accessing mental health services. The US Department of Health and Human Services has suggested that possible reasons for such mistrust are experiences of discrimination and historical persecution.[68] 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.[69] 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 members were less likely to trust service providers.[70] Furthermore, Exchange House Ireland has identified that when someone has a negative experience with a mental health professional, it "depletes any trust" the person may have had with the services.

Given the number of professionals and agencies involved in mental health service delivery, people from ethnic minority communities may be deterred from accessing supports. There is anecdotal evidence that individuals may not be comfortable disclosing personal information, particularly where their status is unknown, to a number of different agencies. There is a need for clear procedures on confidentiality throughout the mental health services in order to address this issue.

Different perceptions of mental health difficulties among people from ethnic minority communities (as outlined in theme 1), a lack of effective means of communication (as outlined in theme 2), and the costs associated with mental health care are also barriers to accessing services for these groups.

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 has been developed to eliminate discrimination against people from ethnic minority communities.[71] It is based on three building blocks including: 1) developing a more appropriate and responsive service 2) increasing community engagement with service providers and 3) better quality information on the ethnic profile of local populations and service users which would be more intelligently used. The perspective in the UK is that the approach should not be focused on creating separate mental health services for those from ethnic minority communities but rather on improving services for everyone.

The US CLAS Standards recognise that despite health inequities being related to issues of discrimination and social injustice, one of the ways in which accessibility can be enhanced for people from ethnic minority communities is to

66 Gary, F. (2005), op. cit., p.980.

67 s. 98 Quirke, B. (2010), op. cit., p.19.

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

69 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.

70 Quirke, B. (2010), op. cit., p. 13.

71 Department of Health (UK) (2005), p.8.

ensure the provision of culturally and linguistically appropriate services. This is broadly defined as care and services that are respectful of, and responsive to, the cultural and linguistic needs of all individuals.

In Australia, the National Cultural Competency Tool (NCCT) for the mental health sector is a self-assessment tool to assist services in meeting the National Standards for Mental Health Services, including in the area of improved access. Standard 4 states that "services ensure equitable access for people from culturally and linguistically diverse backgrounds, and their carers and families".

In Ireland actions have been taken to improve accessibility for people from ethnic minority communities. These include: the development of the HSE's Intercultural Health Strategy that applies to all health services, the publication of the HSE's Multilingual Aid Box, good practice guidelines for HSE staff on working with interpreters and a Health Services Intercultural Guide. The following recommendations should also be considered:

Recommendations

- Mental health services and staff should ensure that individuals from ethnic minority communities understand how to access mental health services, their options for care/treatment, how to maintain their mental health and how to follow their individual care/recovery plan

- Mental health services should promote awareness of their services by disseminating information in English and other relevant languages, through a number of channels including print, audio-visual and community events, to different cultural groups in places including, local doctors' surgeries; hospitals; community centres; places of worship; schools; libraries; and other meeting places deemed to be specific to ethnic minority groups (cultural clubs, etc).[72] Specific recommendations on providing accessible information is outlined in theme 2

- Mental health services and staff should communicate with individuals from ethnic minority communities in their preferred language when accessing and using the service. This should be facilitated through the provision of appropriately qualified interpreters, where necessary. [73] This recommendation is outlined in detail in theme 2

72 Multicultural Mental Health Australia (2010).

73 Ibid.

- Mental health services should facilitate consultations with community groups in order to identify the mental health needs of people from ethnic minority groups. Consultations/focus groups should be peer-led or co-facilitated, where possible

- Mental health services should ensure that all mental health care is provided by appropriately qualified and culturally competent staff; taking into account the specific values and beliefs of people from ethnic minority communities. Research has shown that where the specific views of people from ethnic minority communities are not taken into account, individuals are less likely to access and/or remain engaged in mental health services. This recommendation is outlined in detail in theme 5 [74]

- Mental health services should ensure that individuals from ethnic minority communities experience improved access to mental health care by establishing links with other service providers. For example, there should be clear protocols for communication between primary (including GP practices) and secondary mental health service providers

- Mental health services should ensure that they recognise the importance of advocacy supports in improving accessibility to mental health services for people from ethnic minority communities. In this context, mental health services should establish clear protocols of communication and engagement with existing advocacy supports in the community and encourage staff to engage with these supports. This recommendation is outlined in detail in theme 4

74 Ibid.

Theme 4: Family/advocate involvement and support

Theme 4: Family/advocate involvement and support

Mental health services should provide opportunities for family/advocate involvement and support for individuals from ethnic minority communities.

A Vision for Change recognises the role of the family in mental health care. It states that "immigrant communities often have many different ways of dealing with distress, including mechanisms of conflict negotiation, through the extended family, and service providers can learn from these approaches".[75]

Representatives from ethnic minority communities have identified that "culture can influence how families and communities respond to mental or emotional distress".[76] Cultural competency needs to take account of common practices of people from ethnic minority groups, including the role of family members. For example, representatives have advised that the word 'family' can have different interpretations; some families from ethnic minority communities can be large and their wish to visit family members engaged in services needs to be considered.

Mental health services need to understand the relationship between individuals from ethnic minority groups and their families, their community, wider services and society. Such dynamics may have a significant impact on the individual's willingness to access services, engage in and/or remain in care. This may be attributed to the family's or community's understanding of mental health, to the individual's concerns of a lack of support or understanding from family members and/or a fear of discrimination or isolation. It is of fundamental importance for services to recognise the level of mental health education in families and communities and how this may influence the individual in their decision making.

Furthermore, as with all populations and families, a person from an ethnic minority community may or may not want to involve their family in their mental health care and/or recovery. However, it is important for mental health services to understand how culture may influence that decision and the effect it will have on the individual.

Mental health services need to reflect the values and support the cultural importance of family in mental health care delivery for people from ethnic minority groups. This can be supported by educating family members on mental health, including information on the benefits of addressing existing mental health difficulties.

The HSE Intercultural Health Strategy identified that emerging ethnic minority forums aimed at developing the capacity and advocacy of ethnic minority communities to explore health related concerns, are relevant models. Similarly, national and regional Traveller Health Networks have been shown to be positive models through which partnership and capacity building may be effected.

Internationally, the Community Connections for Families (CCF) in Pennslyvania in the US is a system of mental health care that works through strong neighbourhood and family partnership to provide integrated, family-directed support and services that aim to be culturally competent.[77] This project identified that cultural competence

75 A Vision for Change, p.40.

76 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, p.75.

77 Dougherty, et al. op. cit., pp.257.

and family involvement cannot exist without each other. Families should be involved in decision making, leadership and planning in their loved ones' mental health care.

Specific ways that mental health services can ensure that individuals from ethnic minority communities have appropriate advocacy supports include:

Recommendation 1

Mental health services and staff should ensure that individuals from ethnic minority groups, as well as carers, family members and communities are involved in the design, development, delivery and evaluation of mental health programmes and services on an ongoing basis.[78] Specific ways in which this can be achieved include:

- The development of service structures to plan for the facilitation of family involvement in the care of people from ethnic minority communities [79]
- The involvement of individuals (and their families) should be monitored in performance review and quality improvement processes [80]
- Policies should be put in place to facilitate the participation and involvement of individuals (their carers and family members)[81]
- Organisational guidelines and protocols should be developed to guide and support staff in working with individuals from ethnic minority communities, their carers and their family members [82]
- Individual, carer and family involvement should be represented in existing service structures to progress involvement of ethnic minority communities [83]

Recommendation 2

Mental health services should develop policies and procedures to facilitate the cultural needs of people from ethnic minority communities, their carers and families, including family roles and obligations. [84] This should be reflected in individual care/recovery planning. [85,86]

Information provided by individuals from ethnic minority communities about their care and treatment (including the role of family members/ carers) should be used by mental health services to inform planning, development and review of services and supports.

78 See Standard 5, Australian Cultural Responsiveness Framework.

79 Ibid.

80 Ibid.

81 Ibid.

82 Ibid.

83 Ibid.

84 Multicultural Mental Health Australia (2010).

85 See Standard 4 Australian Cultural Responsiveness Framework.

86 The Mental Health Recovery Star is a tool that assists services users in working towards recovery within the adult mental health services. 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.

Recommendation 3

Mental health services and professionals should engage with mental health advocates and ethnic minority groups in the community to improve advocacy supports for people from ethnic minority communities.[87]

A project in the UK, illustrated the enhanced ability of Roma service users to access mental health care with the support of an appointed advocate. The study also found that service users reported increased satisfaction with mental health services as a result. [88]

In Ireland, the Donegal Travellers Project collaborates with the local mental health teams with the aim of building capacity in terms of cultural competency. Traveller men and women accessing the mental health services can also avail of supports from the Donegal Travellers project, including appointment reminders and transport facilities.

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.[89] 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.[90] 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. Mental health services and staff should engage with existing community health workers to promote the recovery of people from ethnic minority communities.

87 The US CLAS standards provides guidance to services in appointing patient advocates or ombudspersons.

88 The Roma Mental Health Advocacy Project in the UK, delivered by the Roma Support Group, supported members of the Roma community in accessing mental health services. This project employed a part-time coordinator and two part–time bilingual mental health advocates who supported 100 individuals. Many Roma services users were afraid of the established medical system and were unable to access an independent mental health advocate to guide them. 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. 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.

89 Mollica, et al. (2011), op. cit. p.101.

90 Ibid.

Theme 5: Mental health staff training

Theme 5: Mental health staff training

Mental health staff should be appropriately aware, skilled, experienced and knowledgeable to meet the care needs of people from ethnic minority communities.

A Vision for Change states that "people from other countries and cultures, require specific knowledge and understanding on the part of those delivering mental health services, in terms of their culture and other characteristics".[91] It continues to recommend that "mental health professionals need to be able to negotiate around issues such as how assessments are performed, the way diagnoses are made, and the appropriateness or otherwise of different sorts of interventions. This will require professionals who are sensitive to the diversity of human experience and able to relate to people from different communities in an open and respectful manner".[92]

The policy also identifies that the "employment of professionals from a wide variety of backgrounds and cultures in mental health services is a positive step that should be taken to respond to the needs of the diverse population in Ireland".[93]

Standard 4.8 of the Mental Health Commission's Quality Framework states 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".

91 A Vision for Change, p. 40.

92 Ibid.

93 Ibid.

The Framework also places a responsibility on mental health services to ensure equality in recruitment and retention of staff regardless of their ethnicity, including membership of the Traveller community.

The National Intercultural Health Strategy recognises that staff training in areas of anti-discrimination and cultural competence is a priority, stating that "appropriate intercultural training and support for staff is a fundamental principle of the Strategy..."[94]

In the UK, consultations held while developing the action plan 'Delivering Race in Equality' showed that among other issues, ethnic minority communities were dissatisfied with the quality of the mental health care they received and felt that mental health professionals needed training in cultural competence.

Specific ways that mental health services can ensure that staff are appropriately skilled and qualified to meet the mental health care needs of individuals from ethnic minority communities include:

94 HSE (2008) National Intercultural Health Strategy, p.138.

Recommendation 1

Mental health services should embed the ethos of cultural competency in existing structures and systems. This can be developed by: [95]

- Fostering the principles of cultural competency through leadership and management structures. There should be clear communication between management and staff to facilitate this
- Ensuring that a commitment to cultural competency is reflected in the vision, goals and mission of the service and that this is supported by an actionable plan
- A commitment to cultural competency through system-wide approaches that are reflected in written policies, practices, procedures and programmes
- Developing strategies to enhance cultural competency skills and knowledge within the service and among staff
- Ensuring staff and management engage in Continuous Professional Development in order to enhance their skills and knowledge in working with people from ethnic minority groups

Recommendation 2

Mental health services should develop policies on the recruitment of staff from ethnic minority communities. Specific measures which should be taken by services include: [96]

- Implement strategies to recruit, retain and promote a diverse leadership and staff at all levels of the service that reflects the demographic characteristics of the populations in the service area
- Expand the services recruitment base, advertise job opportunities among ethnic minority groups and post information in multiple languages
- Collaborate with relevant stakeholders to build potential workforce capacities and recruit diverse staff. For example linkages between academic and service settings can help identify potential recruits
- Create a work environment that respects and accommodates cultural diversity and is responsive to the challenges a culturally and linguistically diverse staff may bring to the workplace

95 See US CLAS Standards.

96 See US CLAS Standards.

Recommendation 3

Mental health staff should be provided with the necessary resources and supports to deliver mental health care that is culturally competent. This includes the provision of training for staff to enhance their cultural responsiveness.[97] Specific ways in which staff should be supported include: [98]

- Providing space for staff to reflect on the cultural aspects of mental health care and facilitating internal multidisciplinary dialogue about language and culture issues. Staff should be encouraged to discuss issues on meeting the needs of people from ethnic minority communities
- Providing staff with regular ongoing supervision in order to support them in their performance in working with individuals from ethnic minority communities
- Providing opportunities for staff to engage in continuing education, including in the area of cultural competency
- Allocating resources to train staff in cultural competency.[99] On-going training for mental health staff on how to meet the needs of people from ethnic minority communities should be provided, including on how and when to access language supports for individuals with limited English. [100,101] Suggested training opportunities for staff (i.e. admission, reception, clinical staff, management and executive staff) should include the provision of language services and use of interpreters; culturally responsive service delivery strategies; conducting organisational cultural audits as well as cultural assessments to understand the individual's "explanatory model for health and illness" [102]
- Mental health services should use online publications/ education materials on cultural competency
- Materials should be developed for mental health staff, including new members of staff on how to deliver culturally competent services
- Mental health staff should be encouraged to engage with the local community in order to learn about people from ethnic minority communities
- Structures should be developed to support the aforementioned recommendations

97 See Standard 6 Australian Cultural Responsiveness Framework. The framework has identified the number of staff that have participated in cultural competency training as a measurement for this standard.

98 Ibid.

99 See Standard 6.1. Australian Cultural Responsiveness Framework.

100 The NCCT in Australia covers areas such as training. It includes a standard on providing staff training on the effective use of interpreters and the principles outlined within the Language Services Policy of the state/territory.

101 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 mental health services. 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.

102 See Standard 6.1. Australian Cultural Responsiveness Framework.

In Amsterdam, a project was undertaken to develop the elements of cultural competency training. The study firstly identified and analysed difficulties experienced by staff and service users in this area.[103] This was followed by defining competencies which could solve or manage these difficulties.[104] The resulting framework was built around five cultural competencies that included 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
Competency 5:	An ability to transfer information in a way that the individual can understand and to use external help e.g. interpreters and an ability to adapt to new situations

SPIRASI has developed a self-directed training package entitled 'Working with an Interpreter is Easy'. It consists of a handbook and DVD which should be accompanied by a 3 hour experiential workshop.[105] Each of the four chapters within the package contain informal explanations of how to work with interpreters. Service providers may check their knowledge through the self-evaluation tests provided at the end of each section.

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

104 Ibid., p.230.

105 SPIRASI (undated) Working with an Interpreter is Easy, Dublin: SPIRASI, p.3.

Recommendation 4

Mental health services should monitor and evaluate the training, skills and knowledge of staff in the area of cultural competency. Specifically services should:

- Evaluate the education and training delivered to their staff
- Develop post training staff evaluations on the effectiveness and application of the training in cultural competency
- Incorporate cultural competency into staff evaluations
- Human resources management policies and practices should include cultural responsiveness references in job descriptions, performance reviews and promotions etc [106]
- Internal communication systems for sharing cultural diversity information and data should be developed, maintained and periodically reviewed [107]

Additional recommendations which were made in MHR's ethnic minorities and mental health report include:

- Mental health professionals should adhere to guidance from their relevant professional association on cultural competency
- People from ethnic minority groups should be involved in planning and delivering cultural competency training
- Services should ensure that cultural competency training incorporates an understanding of cross-cutting marginalisation for ethnic minority groups

106 See Standard 6.1. Australian Cultural Responsiveness Framework.

107 Ibid.

Theme 6 – Evaluation and review

Theme 6: Evaluation and review

Mental health services should undergo systematic evaluation and review to ensure that the mental health needs of people from ethnic minority groups are being adequately met.

The HSE Intercultural Health Strategy recognises that "little information exists around the health status and needs of people from diverse cultures and ethnicities in Ireland. This deficit of data creates a significant barrier to identifying and addressing the health needs of individuals and monitoring progress around interventions".[108] The Strategy also states that the development of an ethnic equality monitoring system, in addition to an ethnic identifier is necessary for service delivery.[109] This will include the development of indicators on ethnic minority community health outcomes and the collection of data on service utilisation, equity of access and quality of service for people from ethnic minority groups.

Since 2012, SPIRASI has used ethnic identifiers in all initial multi-disciplinary assessments.

However, there remains very limited evidence about the prevalence of mental health difficulties among people from ethnic minority communities in Ireland.[110] It has been suggested that a specific analysis is needed for each ethnic minority group in order to develop appropriate services.[111] Morgan highlights how current assessment tools may not be able to adequately capture the mental health difficulties/needs of people from ethnic minority communities and therefore it is possible that this group is being either over-or under-diagnosed; and their mental health needs being inadequately met.[112]

The Australian cultural responsiveness framework recognises the importance of a systemic / whole-of-organisation approach to developing cultural competence, including in monitoring and evaluating cultural responsiveness performance and achievements. The Framework acknowledges the challenge of cultural responsiveness being "built in" as opposed to being "bolted on" to organisational structures.

Recommendation 1

Mental health services should ensure that cultural competency is incorporated throughout the service's planning and operations. Specific ways that this can be achieved include: [113]

- Identifying goals, objectives, and timelines to provide culturally and linguistically appropriate services
- Establishing accountability mechanisms throughout the service, including staff evaluations, individuals' satisfaction and quality improvement measures
- Involving local people (in the service area) in the design and implementation of culturally competent service provision
- Reviewing demographic data in the design and delivery of culturally competent mental health services

108 HSE (2008) p. 11.

109 Ibid, p. 102.

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 McKenzie,et al., op. cit., p.285.

112 Morgan (2011), op. cit., p.89.

113 See US CLAS Standard 9.

Recommendation 2

Mental health services should conduct organisational assessments to ensure that they deliver care in a culturally competent manner. Specific ways that this can be achieved include:[114]

- Conducting an organisational assessment or a cultural audit using existing cultural and linguistic competency assessment tools to assess existing structural policies, procedures, and practices. These tools can provide guidance to determine whether the core structures and processes (e.g., management, governance, delivery systems, and customer relation functions) necessary for providing culturally competent service delivery are in place

- Developing Key Performance I ndicators (KPIs) against the cultural responsiveness plan [115]

- Providing training opportunities for senior managers on culturally responsive service delivery strategies.[116] Training opportunities should be provided at a national and local level

- Using results from assessments to identify existing resources (e.g., bilingual staff members who could be trained as interpreters, existing relationships with community-based ethnic minority groups) in addition to weaknesses (e.g., the absence of translated signage or cultural competency training), and opportunities to improve the service's structural framework and capacity to address cultural and linguistic competence in care (e.g., revise mission statement, recruit people from diverse cultures into policy and management positions)

- Following assessment, prepare adequate plans for developing culturally competent services. Subsequent ongoing assessments should be established in order to monitor the service's progress in implementing cultural competency and refining strategic plans

Recommendation 3

Mental health services should collect and maintain demographic data to assess the mental health needs of people from ethnic minority communities in the service area. Specific ways that this can be achieved include:

- Collecting data early i.e. on admission. Types of information to collect could include: ethnicity, nationality, nativity, ability to speak English, language(s) other than English spoken, preferred spoken/written languages or other mode of communication, education, informed of right to interpreter services, request for, and/or use of, interpreter services

- Using standard collection instruments and storing data in a standard electronic format

- Providing ongoing data training and evaluation to staff

114 See US CLAS Standards.

115 See Standard 4.1,, Australian Cultural Responsiveness Framework Standard.

116 Ibid.

Concluding comments

As with all users of mental health services, the principles of recovery should underpin the care of individuals from ethnic minority communities throughout the mental health services. Individuals should be supported to learn to understand and cope with their mental health difficulties, build on their inherent strengths and resourcefulness, establish supportive networks, and pursue dreams and goals that are important to them and to which they are entitled to under human rights law. Ultimately recovery is a personal process and is unique to each individual.

This principle of recovery entails that services operate from a hopeful orientation that supports recovery; listens to and works in partnership with service users; offers choice and the opportunity for individuals to exercise their autonomy, and supports the social inclusion of people with a disability. The recovery ethos is further endorsed by the Mental Health Commission in its Quality Framework for Mental Health Services and in its report on a recovery approach within Irish mental health services. Mental Health Reform's full briefing paper on recovery can be found at this link: **mentalhealthreform.ie/resources**

These guidelines are relevant for all services providing mental health care to people from ethnic minority communities, from primary to specialist mental health services and supports.

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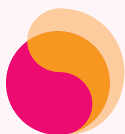
Most importantly, Mental Health Reform would like recognise the many individuals from ethnic minority groups with mental health difficulties living in Ireland. As the national coalition on mental health we will continue to promote improved mental health services and supports for all individuals across the country.



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