mind in croydon
For better mental health

THE FIRST STEP:

An exploration of how Croydon's Black and Minority Ethnic communities access counselling services

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SUMMARY

Background: People from Black and Minority Ethnic (BME) groups are less likely to access counselling services and other preventative community services than White British people. However, local mental health charity, Mind in Croydon, found that people from BME communities were accessing their counselling service in numbers that represented their population's presence in the community, even though the service made no particular effort to target such communities.

Aims: To research and understand the levels of uptake of Mind in Croydon's counselling service by BME communities. To inform effective commissioning and reduce inequalities in access to non-pharmacological sources of support to BME communities in the London Borough of Croydon.

Method: Clients, both BME and White British, who had attended the service were surveyed by postal questionnaire. A number attended one-to-one interviews. Referrers (G.P.s) were surveyed by postal questionnaire. One was interviewed face-to-face. There were also one-to-one in depth interviews with other key stakeholders including other counselling service providers, the local mental health service user group, staff from statutory mental health services and a BME community development officer.

Results: 104 clients and 24 G.P.s completed questionnaires. 12 people took part in one-to-one in depth interviews. We found that, assuming that language was not a barrier, BME clients were just as likely as White British clients to access the counselling service and this was based on the service having certain characteristics. These characteristics were; good reputation (including being referred/signposted by a friend or trusted professional), reasonable waiting lists, ease of access (the ability to self-refer) and reasonable costs. Such services did not need to be BME specific (having a counsellor of the same ethnicity was not considered important for most people), nor did they need to be based in BME community organisations, nor be near to where people lived (within reason). However, BME clients were more likely than White British clients to cite services being in the voluntary rather than statutory sector as being an important factor in choice. They also gave a higher rating than White British clients to confidentiality/anonymity. There was some evidence that referrers (e.g. G.P.s) could do more to recommend and endorse counselling as a suitable treatment option for people from BME communities. Referrers also cited less restrictive eligibility criteria, a broader range of interventions

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than Cognitive Behavioural Therapy (CBT) being on offer and a greater number of counselling sessions (i.e. up to 20) as being an important reason for referral.

Conclusions: Commissioners should continue to invest in a range of non-statutory providers of talking therapies as a way of providing choice and equality of access. Talking therapies on offer should not be restricted to CBT and referral criteria for some agencies should be wider than a diagnosis of depression or anxiety. It is important that people can self-refer and for many people the fact that attendance for counselling does not appear on their health record is crucial. Commissioners should aim to have services that can offer these choices as part of the range of services available to people.

BACKGROUND

There is concern that people from Black and Minority Ethnic (BME) communities are overrepresented in the mental health system and experience that system negatively. Research to illustrate this point has been summarised by the Sainsbury Centre for Mental Health (2002), and Sewell (2009). A major piece of research by the Sainsbury Centre for Mental Health found, inter alia, that for African and Caribbean communities:

> "Mainstream (mental health) services are experienced as inhumane, unhelpful and inappropriate. Black service users are not treated with respect and their voices are not heard. Services are not accessible, welcoming, relevant or well integrated with the community. The care pathways of Black people are problematic and influence the nature and outcome of treatment and the willingness of these communities to engage with mainstream services. Black people come to services too late, when they are already in crisis, reinforcing the circles of fear." (Sainsbury Centre for Mental Health, 2002, p.9)

The above quote suggests that lack of access to preventative services such as talking therapies in the community may be a factor in people being overrepresented in secondary and acute services. Irrespective of whether this is the case, from an equality of access perspective, studies have shown that people from BME communities are less likely to access talking therapies than White British communities (Sainsbury Centre for Mental Health, 2002; Raleigh et al, 2007). Authors have recommended that:

> "All health and social care communities with significant populations of Black people should identify practical steps to encourage early access in non-stigmatising or generic community settings . . . Each health and social community must ensure equal access to appropriate counselling and psychotherapy services" (Sainsbury Centre for Mental Health, 2002 , pp 78-79).

and;

> ". . . improvements are needed in mental health services provided to minority ethnic groups, including better access to talking therapies." (Raleigh et al, 2007, p. 310)

In terms of the strategic development of psychological therapies, the Department of Health has launched the £173 million Improving Access to Psychological Therapies (IAPT) programme which aims to:

> " . . . help primary care trusts (PCTs) implement National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. " (DOH, 2008 p. 1)

In terms of improved access to psychological services for BME communities, the Department of Health states:

> "Local third-sector organisations and faith groups will often have a good level of knowledge about the range of BME communities within a local area. Such organisations are often the first point of contact for individuals from BME and hard-to-reach groups." (DOH, 2009a, p. 2)

It is, of course, true that BME communities are a heterogeneous group. The Department of Health highlights that:

> "What works for one community will not

necessarily work for another – the needs of an African Caribbean man who is afraid to engage with services are different from the needs of an Asian woman who may think that having a mental health problem is shameful. Our research has shown that different ethnic groups have varied perceptions about mental health services and want to access and use them in different ways."(DOH, 2009b p. 6)

At Mind in Croydon we found that people from BME communities were accessing our counselling services in numbers that were proportionate to their presence in the community. We had made no particular effort to target people from BME communities, are not a community BME organisation and are located in a part of the borough that is a significant distance away from where the majority of people from BME communities live. We decided to attempt to discover what it was about our service that made it appropriate and accessible to people from BME communities.

METHOD

The Setting

Croydon is one of the largest London boroughs and the most populace. The 2001 census gives the population of Croydon as 330,587, at that time 36% of the population were from BME communities. At the time of this study, Psychological Therapy services commissioned by Croydon Primary Care Trust (PCT) and Croydon Council included a range of talking therapies from a range of local providers. It was estimated that 42,000 in the borough were experiencing depression and anxiety disorders and that:

"In order to meet the nationally recommended benchmark referral rate to psychological therapy services, the current number of referrals in Croydon would have to increase by 180% (from 2,884 to 8,143 referrals in a year)."(NHS Croydon, et al, 2008)

Counselling Services in the Borough of Croydon

NHS primary care counselling in the borough was provided by a private health care provider who won the service when it was put out to tender. The service they provided was based on the stepped care model as recommended in NICE guidelines (National Collaborating Centre for Mental Health, 2009, p. 28). They provided step 2 interventions (guided self-help, computerised CBT, brief psychological interventions) for people diagnosed with mild to moderate depression and step 3 interventions for people for moderate to severe difficulties.

The local Mental Health NHS Trust provided the Croydon Integrated Psychological Therapies Service (CIPTS) which provided "psychological assessment and, when appropriate, psychological treatment for individuals referred to the service with moderate to severe levels of psychological distress, associated with a mental health problem and of a degree that causes a significant disruption to the individual's level of occupational or interpersonal functioning." (South London and Maudsley NHS Foundation Trust, 2010)

Croydon PCT and Croydon Council also commissioned talking therapies from a range of voluntary sector providers (NHS Croydon, et al, 2008 p 46) which could be accessed by self-referral and signposting. Monitoring data for referrals to Mind in Croydon's Counselling Service showed high levels of referrals from G.P.s and other statutory agencies. This data came from clients' initial contact with the service. Statutory agencies would usually have referred to this as "signposting" rather than referral, because they were not required to write a formal referral letter, they could just provide the patient with contact details or a leaflet about the service. As far as the client was concerned he/she had been referred (or even recommended) by their G.P. or other statutory agency to the service.

Approximately 5,000 sessions of counselling a year were provided by the three largest voluntary sector providers in the borough.

Mind in Croydon's Counselling Service

Mind in Croydon's Counselling Service opened in 1980. It had grown since then and at the time of this study had a Counselling Services Manager, who is a UKCP Registered Psychotherapist, two salaried Counsellors/Psychotherapists, an Administrator and up to 24 Volunteers/Trainee counsellors. Around

24% of its counsellors were from BME communities (snapshot survey summer 2009), although this fact was not publicised to prospective clients or referrers. In 2008/9 the service provided 176 people with 2,065 hours of counselling sessions. It worked with clients presenting with a wide range of issues (see Table 4) and offered a wide range of therapies, including CBT, on an individual basis. It offered a greater than normal number of sessions per client; up to 20 sessions. (NICE guidelines recommend 6 to 8 sessions of CBT for those who are mildly or moderately depressed and 16 to 20 sessions for those who are severely depressed). (National Collaborating Centre for Mental Health, 2009). The service had a high profile and was generally held in very high regard; it was consistently the first choice of GPs and other health professionals as an alternative to the statutory services. In 2008/09, 53% of referrals were from G.Ps, 21% were self-referrals, 9% came from the NHS primary care counselling service, 9% came from Community Mental Health Teams, 6% were recommended by family or friends, with the remaining 2% coming from other voluntary organisations or other sources. The service was based in Purley, in the south of the borough, where relatively few of the borough's BME residents live, although it was easily accessible by public transport from across the borough. Unlike statutory services, the Mind in Croydon service made a charge to the service user according to their ability to pay. This was a donation of a minimum of £3 for those on low or no income and a minimum of £10 for others.

The service did not target its services towards the BME communities. Nor did it have a deliberate policy to use volunteer counsellors from BME groups or try to match the ethnicity of its service users with that of the counsellors. Mind in Croydon generally and the Counselling Service specifically employed no Community Development Workers aimed at the BME communities. The Counselling Service did not restrict the therapies on offer to Cognitive Behavioural Therapy.

Ethnicity of those accessing counselling services in Croydon

In 2008/9, 36%, of those accessing Mind in Croydon's Counselling Services were from BME communities. In the same period, the other major provider of primary care counselling services in Croydon recorded that 23.3% of people from BME communities accessed their service. (Priory, 2009) However, 40.2% of ethnicity data was classified as "missing".

> "'40.2% of ethnicity details are missing, which makes it difficult to make comparisons between the ethnicity of the referrals and the ethnicity of the Croydon population. For every ethnic group, apart from Chinese or other ethnic group, referrals to the service had lower proportions than the proportions found in the Croydon population. Taking into account that 40.2% of ethnicity information is missing, referrals of any Asian or Asian British background is particularly low (4.5% compared to the 11.31% in the Croydon population)." (Priory, 2009)

At the time of writing this report the Croydon Integrated Psychological Therapies Service was not able to provide any ethnicity data.

The Sample and Intervention

A postal questionnaire was sent to all 237 clients, both BME and White British, who had completed their counselling with Mind in Croydon between January 2007 and March 2009. The questionnaire was designed in collaboration with Mind in Croydon's honorary medical advisor, Dr. Deji Ayonrinde, Consultant Psychiatrist. 117 replies were received, which is a return rate of 49%. 104 people declared their ethnicity. Of the 104, 62 people (60%) were White British and 42 (40%) were from a range of BME communities (see Table 1). Of the clients who replied from BME communities, 10 (24%) were men and 32 (76%) were women. Of the clients that replied from the White British community, 14 (23%) were men and 48 (77%) were women.

The postal questionnaire data was analysed to identify reasons why people chose to access the Mind in Croydon Counselling Service. The responses of BME and White British clients were compared to see if the different groups cited different reasons for their attendance (Table 2). To supplement the questionnaire data, one-to-one interviews were held with four BME service users.

The two main referral routes to the service were referral from General Practitioners (G.P.s) (53%) and self-referral (21%). In order to determine why GPs chose to refer patients to Mind in Croydon, a questionnaire was sent to 60 G.P.s based in 20 surgeries in the CRO postcode area. Replies were received from 24 which is a 40% return rate. To supplement this information, a face-to-face interview was held with one G.P. from the north of the borough who was a regular referrer/signposter to Mind in Croydon.

Further one-to-one interviews were held with a range of local key stakeholders including other counselling service providers, the local service user group, staff from statutory mental health services and BME community development officers.

Table 1

Male	Female	
		White
14	48	British
	2	Irish
2	5	Any other white background
		Mixed
1	1	White and black Caribbean
		White and black African
		White and Asian
		Any other mixed background
		Asian or Asian British
2	5	Indian
1	1	Pakistani
1	2	Bangladeshi
	2	Sri Lankan
	2	Any other Asian background
		Black or Black British
2	5	Caribbean
	3	African
1	2	British
		Any other black background
		Other ethnic groups
	1	Chinese
	1	Any other ethnic group

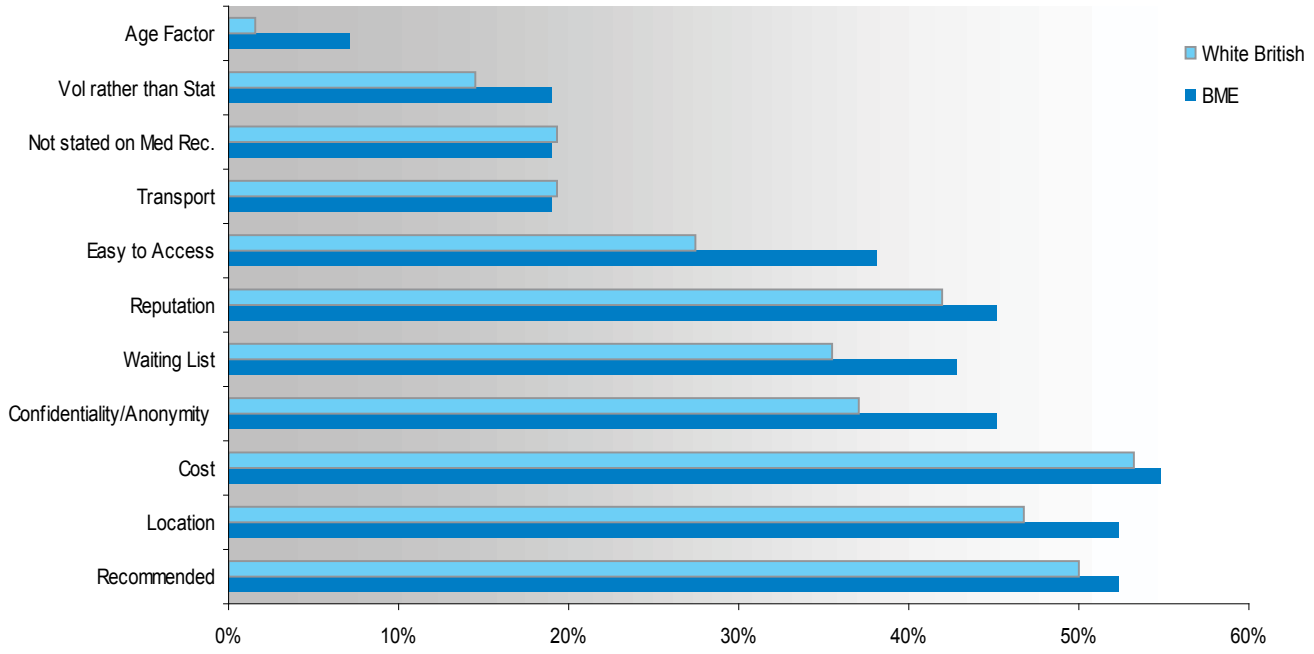
RESULTS

Service Users

The questionnaire asked clients to give the reasons for choosing counselling with Mind in Croydon (Table 2). Respondents were able to give multiple reasons. Many of the reasons given for choosing Mind in Croydon's Counselling Service were common to both BME and White British clients and were the factors that people might be expected to require from any good quality service. Cost was rated highly as a positive factor, even though in comparison, NHS services were free. However, the charges at Mind were considerably less than for private counselling. It seems that clients were willing to pay a reasonable sum for a good quality service.

Table 2

Service User's Reasons for using Mind in Croydon's Counselling Service



Recommendation was also extremely important. Such a recommendation was usually from GPs, friends or other health professionals. Location was rated highly, even though for many people from BME communities, this involved a journey from one end of the borough to another (a round journey of approximately 10 miles). BME clients were more likely than White British clients to travel from the north of the borough (BME 36%: White British 22%) and less likely to live close to the Mind in Croydon premises (BME 29%: White British 38%). However, the counselling service was well served by public transport and it was relatively easy to park near the service. It seems that such a journey was considered reasonable compared with perhaps having to travel very long distances to inaccessible services.
However, BME clients were more likely than White British clients to cite confidentiality/anonymity, ease of access (the ability to self-refer), location, shorter waiting list than the NHS, reputation and that fact that the service was in the voluntary rather than statutory sector. This preference reflects previous findings (e.g. Sainsbury Centre for Mental Health, 2002) that people from BME communities may be wary of services in the statutory sector.

Confidentiality and anonymity were rated very highly, and there was anecdotal evidence from BME clients that the fact that the services was located a long way from where they lived was a positive factor as it meant they were less likely to encounter a family member or someone who knew them. Some people reported that they would not use a service very close to where they lived for this reason. This issue has been highlighted elsewhere and the Department of Health recommends that from BME service users:

> "Commissioners will want to ensure that the location of the IAPT service encourages engagement. A location that offers some form of anonymity would help to engage people who fear the perceived stigma of having mental health problems, or who feel isolated from – or anxious about using – statutory services." (DOH, 2009a, p. 9).

Participants were asked whether it was important to them that their counsellor was of the same ethnicity as them. 71% of BME clients disagreed with this, 14% were neutral and only 14% felt that this was important. Of White British clients, 69% disagreed with this, 24% were neutral and only 13% felt this was important. In summary, having a counsellor of the same ethnicity was not an important issue for most clients, both BME and White British. For the small numbers who felt it was important, this was as much an issue for White British clients as it was for BME clients.

Once they encountered the service most people from the White British group (90%) agreed with the statement that "Mind were able to provide a service that was responsive and considerate to my needs (including cultural/ethnic/disability)". In comparison 74% of people from the BME group agreed with this statement, with 19% being neutral and 7% disagreeing.

One-to-one interviews

One-to-one interviews were held with four BME service users, two of whom had used the Mind in Croydon Counselling service and two of who were from the local mental health service user group and were able to speak more generally about the issues. Participants reported that they had been recommended to the service by a trusted healthcare professional, for example, a G.P. or Health Visitor.

> "I had never considered counselling until my GP suggested Mind in Croydon."

Another factor that featured very highly was the ability to self-refer. This meant that people could come directly to the service without having to go via a G.P. or other health professional. This reflected the importance that people gave to the service being anonymous and confidential. People were concerned that if they accessed counselling in the NHS via their G.P. this would appear on their health record and might impact on their employment. Respondents all highlighted the fact that the waiting time for an assessment and/or an appointment at Mind in Croydon was significantly shorter than for NHS services. People mentioned that although counselling was free of charge in NHS services, the waiting list was so long that they would rather pay to receive a service within a reasonable time. People felt the costs involved were reasonable. When they came to the service, people reported finding the atmosphere and environment there "welcoming

and comforting". It was felt very important that the environment was non clinical.

In answer to general questions about their willingness to access counselling services, respondents reported examples of visiting the doctor with spurious reasons before finally seeking help with their poor mental health. In particular, men described a reluctance to ask for help as they felt that they were expected to cope and seeking help was a sign of weakness.

> "I thought it was a sign of weakness to have counselling but I realised that after having my counselling my opinion changed."

Respondents also described stigma around poor mental health within their community and a resulting reluctance to seek help. Others reported negative experiences of the statutory mental health system by BME friends and family. People were concerned that statutory agencies had statutory powers to make life changing decisions (e.g. to detain people under the Mental Health Act, to take their children into care). Also, doctors and other mental health service professionals were often perceived as being in the majority from a white ethnic background. Having said this, respondents did not particularly want or feel the need for a counsellor of a particular ethnic background. Respondents reported that after receiving counselling at Mind in Croydon they felt more comfortable to share experiences with others and many had recommended others to visit Mind in Croydon.

Referrers (G.Ps)

GPs were the biggest referrer to the Mind in Croydon Counselling Service, making up 53% of referrals. 24 G.P.s, from 20 surgeries, responded to a questionnaire (Table 3) . GPs were asked "Why do you choose to refer specifically to Mind as opposed to any other service (e.g. NHS/Private)".

For G.P.s, cost and reputation were cited as being the most important factors, closely followed by the agency being from the voluntary rather than statutory sector.

> "Private counselling can be costly and out of the reach of many clients."

> "I am concerned at the variability of NHS counselling, sometimes good, sometimes bad and sometimes lack of consistency. "

The fact that the Mind in Croydon Counselling Service offered less restrictive eligibility criteria, a broad range of counselling interventions, not just CBT, and was not as restricted in number of sessions offered as NHS counselling was felt to be important.

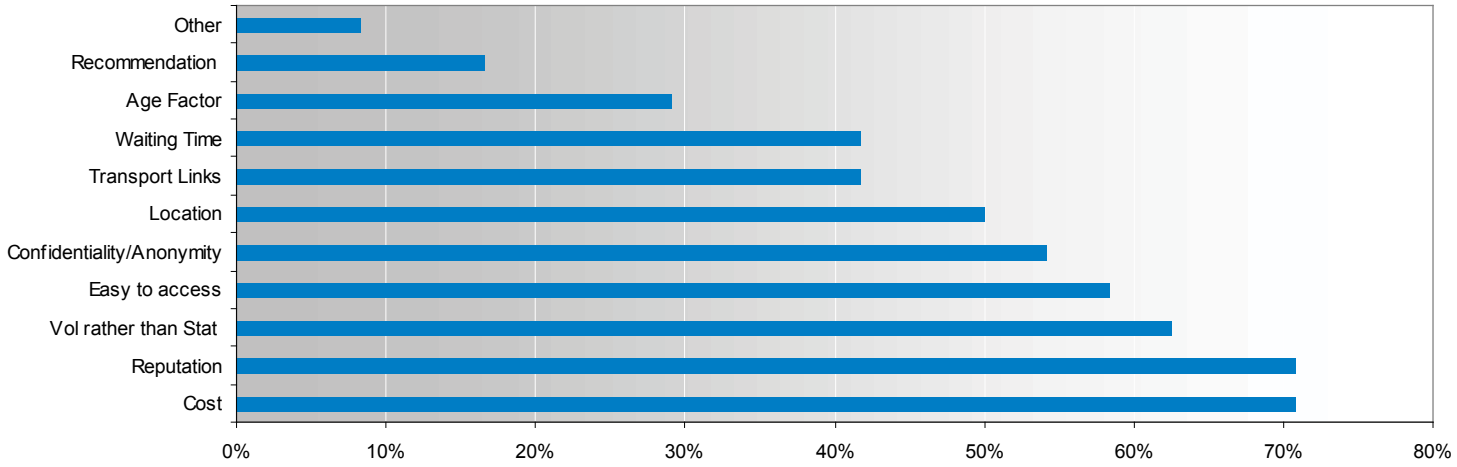
> "Length of counselling available is very helpful i.e. up to 20 weeks."

The reputation of the service was enhanced not just by personal experience of G.P.s but also because the service and the agency generally were held in high esteem by statutory mental health services.

Other factors that G.P.s rated very highly included

Table 3

GP's reasons for signposting to Mind in Croydon's Counselling Service



ease of access, and confidentiality/anonymity.

In order to supplement the G.P. questionnaire data a face-to-face interview was conducted with a G.P. who headed up a health centre in the north of the borough.

The G.P. reported trends from his experience. He reported that, in general, men only ask for help when issues have become serious. In contrast, BME women were more likely to ask for help as women were generally more pragmatic and recognise there is an issue. He also felt that there was reluctance within some parts of some cultures e.g. Asian older men, to seek help as there is a stigma attached to mental health issues. More generally, it was felt that BME patients often only seek counselling when directed by a GP.

> "BME patients may present with some anxiety and depression symptoms but the suggestion of counselling often comes from me as a GP."

This notion seems to be supported by previous research (Raleigh, et al, 2007) showing that BME service users had not sought talking therapies. Interviews with BME service users supported this notion also. In terms of issues around the provision of counselling services, the G.P. felt that it was very important that third sector providers allow the opportunity for self referral and this vastly cuts down on the administration for the GP. Generally, it was felt that third sector providers had shorter waiting lists and were affordable, especially to those on a low income. The length of counselling i.e. up to 20 weeks or sometimes longer was felt to be very helpful and there was a general concern that the quality of the NHS provision was "unpredictable".

This G.P. stated that he now only referred to Mind in Croydon. He did not refer to the NHS primary care counselling service as it was administratively difficult and time consuming with many letters having to be written by the GP and the waiting list generated more administrative issues for the GP. In contrast, with a referral to Mind in Croydon the patient did all the correspondence and this also tested the patients' commitment to taking counselling. The G.P. felt that people were happy to travel the relatively long distance, in order to access a good quality service.

> "Mind in Croydon is about 40 minutes by bus, but the service from Mind in Croydon is worth the journey."

There were some issue around being recognised locally when visiting a GPs surgery and this supports the view expressed by some service users that they would rather travel away from the immediate area where they lived in order to receive their counselling. The G.P. knew from experience that Mind in Croydon provided "an excellent service" which gave him confidence to refer people. The issue of cost was important. He believed that Mind in Croydon was the most reasonable, especially for those on low incomes.

Other Stakeholders

One-to-one interviews were held with a range of other key local stakeholders. These were other counselling service providers, the local mental health service user group, staff from statutory mental health services and a BME community development officer.

Feedback from these stakeholder interviews can be summarised as follows:

- Mental Health service users generally have a fear of statutory services because of the power they have to make life changing decisions. There can sometimes be a lack of empathy with the service user as the staff have a "strict agenda to follow".
- BME people do not enter Mental Health services until their needs are acute and often first contact with the services is traumatic and leads to hospitalisation.
- BME service users are seen as more difficult and there is greater use of outreach services by professionals.
- While on medication service users are less likely to engage and cannot therefore benefit from talking therapies. This creates a future reluctance to engage.
- Generally medical services see some BME service users as more aggressive and there is an element of institutionalised racism and stereotyping.

- Talking therapies on offer from the statutory services are too Eurocentric.
- BME service users of the mental health services are less fearful of the third sector service providers.
- There are social issues for the BME population which inhibit their ability to be equipped to ask for and undertake talking therapies. These can be poverty, poor education, housing, low income etc.
- In an ideal world there would be counselling work undertaken while in hospital but often the pressure on freeing up beds leads to a service user being discharged back into the community with minimal support. E.g. medication.
- There is family pressure not to engage with services for a variety of reasons
- There is pressure to use the family support system as an alternative to statutory care.
- In order to engage with the statutory services potential users often have to disengage from their family.
- There is often a reliance on medication for BME clients and the depressive part of the illness remains undiagnosed and untreated.
- Statutory counselling is only available if you do not have a diagnosis of psychosis. The anxiety and depression which could be aided by counselling is regularly combined with the diagnosed illness and remains untreated by counselling.
- Older BME adults have trouble accessing mainstream services so have a tendency to approach specialist groups such as charities run for their particular ethnic group. This choice of whom to approach may also be because of language difficulties and often interpreters are not available through other service providers.

These issues seem generally to reflect those found in previous studies (see, for example, Littlewood & Lipsedge, 1997; Fernando, 2002; Sainsbury Centre for Mental Health, 2002; Sewell, 2009).

Discussion

In terms of why people chose Mind in Croydon for their counselling, generally, the responses of BME and White British clients were similar. The service had the attributes that would make it attractive and accessible to anyone. These can be summarised as:

- Proven quality of service
- Ease of process
- Anonymity through self referral
- Recommendations from the statutory health service
- Confidentiality of third sector provider (including the fact that attendance did not appear on the person's health record)
- Shorter waiting lists than elsewhere
- Cost (even though NHS services are free)
- Convenient location (even if this involved a 40 minute, 10 mile journey)
- A safe environment; welcoming and comforting, non clinical

However, BME respondents were more likely than White British respondents to cite services being in the voluntary rather than statutory sector as being an important factor in choice. They also gave a higher rating than White British clients to confidentiality/anonymity. One-to-one interviews re-enforced the view that BME clients are more likely than White British clients to be wary of statutory services, in particular statutory mental health services. These findings re-enforce the findings of previous research (e.g. Sainsbury Centre for Mental Health, 2002) and are supported by Department of Health recommendations (DOH, 2009a). This information may be useful for commissioners when thinking about the services that people from BME communities are likely to engage with.

BME respondents did value highly the ability to self-refer and this information may be useful to commissioners. There is evidence elsewhere (DOH, 2009c, p 76) that self-referral can increase the uptake of counselling in BME communities. However, the ability to self-refer to statutory services may be of limited value given the previous points about BME communities' wariness of statutory services. It should also be remembered that part of the value of self-referral is around confidentiality, anonymity and matters not appearing on the

person's health record. Again, it seems that any service that cannot offer this, even if it can offer self-referral, may not be so acceptable to people from BME communities (nor, for that matter, to some White British people).

For BME respondents, good reputation and being recommended to the service by a friend or trusted professional was seen as being very important. There was evidence from one-to-one interviews with clients and G.P.s that people from BME communities may be less likely to consider counselling as an intervention than White British people and that a recommendation and endorsement by G.P.s of counselling as a suitable treatment option can be extremely important. We found that referrers tended to only refer to services that they held in high esteem. This study found that G.P.s would not refer to services that they did not consider being of the highest standard, including those which they felt provided "inconsistent services" or those with very long waiting lists.

Referrers also valued highly services with less restrictive eligibility criteria and a broader range of interventions than CBT being on offer. The also cited the greater number of counselling sessions (i.e. up to 20) as being an important reason for referral. G.P.s valued the fact that referral to the Mind in Croydon service was very easy and did not involve having to write letters or fill in forms.

Most statutory counselling services work to the NICE guidelines, using the stepped approach based on CBT (Cognitive Behavioural Therapy) for people with a diagnosis of Depression and Anxiety. There has been some debate about whether limiting counselling services in this way is entirely appropriate (see for example Roth & Fonagy, 2005; Baldwin et al, 2007; Mollon, 2009), particularly for people from BME communities (Fernando, 2010).

The Mind in Croydon Counselling Service did not limit the method of counselling to CBT, although it was expected that CBT would be the most widely used therapy in the IAPT (Improved Access to Psychological Therapies) initiative (Layard, 2006). The Mind in Croydon service had counsellors and trainees from a variety of orientations with a variety of integrative training from different colleges and universities, including psychodynamic, existential, person centred, psychosynthesis, gestalt and CBT. There is evidence that counsellors can integrate CBT with other counselling approaches (Buckley, 2007). Therefore, Mind in Croydon were able to offer access to counselling services to people with a wider range of presenting issues and could provide a broader range of counselling treatments. Presenting issues did not need to be restricted to diagnosed anxiety and depression. Clients were able to attend counselling for up to 20 weeks which is beyond what is normally offered in statutory primary care counselling services.

Data was also collected routinely throughout the year (2008/9) to record the presenting issues given by service users choosing to attend counselling with Mind in Croydon (Table 4).

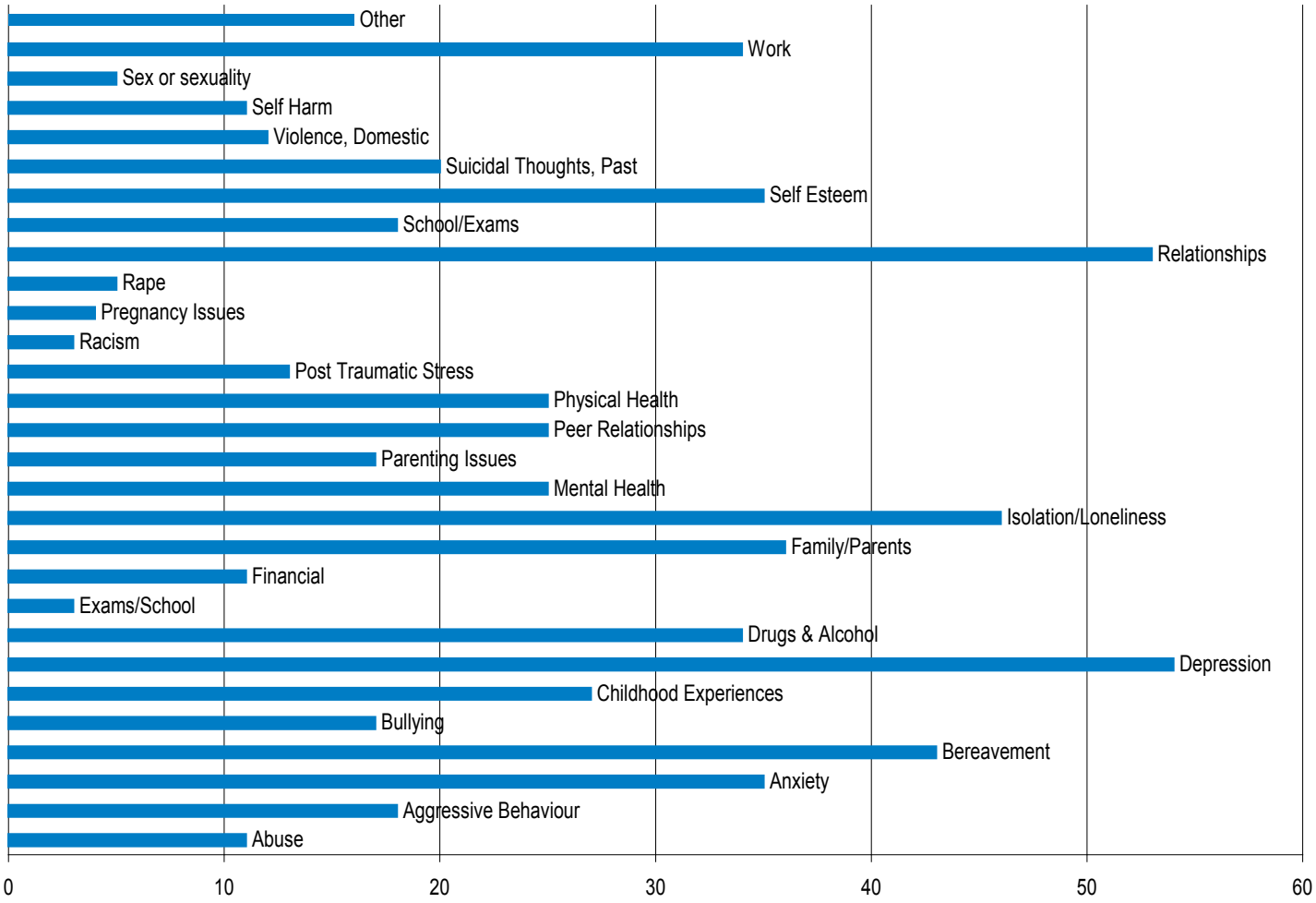
This data showed that the presenting issues were wide ranging (some of which would have excluded people from NHS primary care counselling services) and only the smallest percentage was based on cultural or ethnicity issues. The vast majority were not based on any diversity factor. By applying broader eligibility criteria and a wider range of therapies Mind in Croydon was able to attract a greater diversity of service users than one with more limited therapies and limited entry criteria. This study was not able to show that this was a factor that was a particular issue for BME clients and this is perhaps an area for further research.

Some results were perhaps surprising. The fact that the Mind in Croydon counselling service was not targeted at BME people and was not a BME community agency did not seem to be a factor in terms of people from BME communities being willing to engage. Very few people from BME communities (14%) felt it was important that their counsellor was of the same ethnic group. This figure was almost identical to the number of White British people (13%) who felt this was important. In fact, because a quarter of the counsellors at Mind were from BME groups, for those people who felt it important that their counsellor was of the same ethnicity, this could be accommodated within the service.

Similarly, the fact that service involved quite a long

Table 4

Counselling - Presenting Issues



journey did not seem to be a factor that concerned BME respondents. In fact, location featured very highly in terms of one of the things that people valued about the Mind in Croydon service. It seems that people are very willing to travel a reasonable distance in order to access a good quality service. In fact, the one-to-one interviews with both service users and G.P.s gave evidence that the fact that the service was away from the immediate neighbourhood where people lived was seen as a positive factor. This meant that people felt they were less likely to come into contact with friends or neighbours and this helped to preserve anonymity and confidentiality. Again, this finding may be of interest to commissioners.

It is also perhaps surprising that very high numbers of people cited cost as being an important reason for accessing services at Mind in Croydon. The costs at Mind were modest compared with the private sector, but services in the NHS are free. It seems that people are willing to pay a reasonable amount in order to get access to a high quality service with a reasonable waiting list.

It was beyond the scope of this project to compare the relative costs of different providers and such comparisons could be problematic. However, the fact that many thousands of counselling sessions a year were provided by volunteers in voluntary agencies in Croydon increased significantly the amount of talking therapies that were on offer and did so in a very cost-effective way.

CONCLUSIONS & RECOMMENDATIONS

Croydon's Joint Strategic Needs Assessment (JSNA) (NHS Croydon et al, 2008) has recommended that:

"The Croydon psychological therapy strategy should aim to increase resources available in order

to increase capacity of psychological therapy services", and

"It is important to ensure equality of access to psychological therapies for all groups."

Our study has highlighted some issues that are relevant to these recommendations. We found these issues to be of particular relevance to people from BME communities, but we also found that they were very important issues for White British clients too.

Commissioners should continue to invest in a range of non-statutory providers of talking therapies as a way of providing choice and equality of access.

Talking therapies on offer should not be restricted to CBT and referral criteria for some agencies should be wider than a diagnosis of depression or anxiety.

It is important that people can self-refer and for many people the fact that attendance for counselling does not appear on their health record is crucial. Commissioners should aim to have services that can offer these choices as part of the range of services on offer to people.

By expanding the funding to the third sector while addressing issues in the statutory services, commissioners could also meet Department of Health recommendations in terms of improved access to psychological therapies for BME communities (DOH,2009a; DOH 2009b) and meet many of the aims of "New Horizons" (DOH, 2009c) including earlier intervention, multi-agency collaboration, value for money and equality.

Although this study was undertaken in the London Borough of Croydon, we feel it would be relevant to any area where people from BME communities live and the points which refer to White British clients would be of interest to a wide audience.

Limitations

Issues explored discount problems around language difficulties as this was outside the scope of the project.

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