Department of Health

Analysis of the Impact on Equality of

TALKING THERAPIES: a four year plan of action

February 2011

Contents

1. Introduction

The *Talking Therapies: Four Year Plan of Action* sets out how the Improving Access to Psychological Therapies (IAPT) programme will meet the Government's commitment to expand access to psychological therapies. This Analysis of the Impact on Equality (AIE) has been co-produced with community members to model a roll-out of talking therapies which demonstrably meets individual and community needs.

The plan of action aims to deliver the Government's commitment to expand access to psychological therapies, which to date has focused on adults of working age, to include
  - people with co-morbid physical health long-term and mental health issues
  - people with medically unexplained symptoms, which can be physical health symptoms caused by psychological distress
  - people with severe and enduring mental health problems

This analysis of the impact on equality will evaluate whether the four-year plan is able to advance equality and eliminate discrimination as access to talking therapies is extended. Within this document, the term 'Talking Therapies' and 'Improving Access to Psychological Therapies (IAPT)' will be used interchangeably.

Taking into account the protected characteristics under the Equality Act 2010, the analysis of the impact on equality will:

  - Evidence the likely effect of advancing equality and the elimination of discrimination.
  - Show how the four-year plan will meet the needs of different communities and groups
  - Provide details of consultation that has been undertaken on the Plan
  - Identify challenges, risks and opportunities

From these findings, recommendations will be translated into an action plan that demonstrates improved opportunities to access therapies.

2. Legislation

The Equality Act 2010 introduced new provisions and brought together a number of previous equality Acts. The 2010 Act has the following general duties, to:

  - Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Act;
  - Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
  - Foster good relations between persons who share a relevant protected characteristic and those who do not share it.

Specific duties are legal obligations, which help public agencies meet the general duty. These include:

- Public Sector Equality Duty which comes into effect in April 2011
- Prohibition on age discrimination in services and public functions (being considered by the coalition government)

The Public Sector Equality Duty will bring together the existing race, disability and gender duties, and extends coverage to age, sexual orientation, religion or belief, pregnancy and maternity and gender reassignment.

In order to integrate and extend the Act, certain communities and groups have been ascribed 'protected characteristics'. This means that public bodies need to be particularly mindful of how the inclusion and equitable treatment of protected groups as public agencies produce, monitor and report on how they have met their equality objectives.

The relevant protected characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and Civil Partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex
- Sexual orientation

This analysis of the impact on equality considers the evidence that the Talking Therapies four-year plan of action will:

1. Affect the promotion of equality and the elimination of discrimination **in each of the groups**
2. Meet the needs of **different communities** and groups
3. Give examples of existing **good practice** in this area, such as measures to make it easier for people in particular groups to influence policy.

The protected characteristic 'marriage and civil partnership' has not been analysed within this AIE because there is no evidence available about the impact of marriage and civil partnership on the provision of talking therapy services. At a local level, marital and civil partnership status can be collected and analysed to ensure that service take-up is line with the local community. and meets legislative requirements to eliminate discrimination on this basis. In line with the expanding provision of talking therapy services, a request has been made to include marital and civil partnership as a data item that can be collected and analysed.

Following the analysis, an equality action plan will show how Talking Therapies aims to address issues that perpetuate or maintain mental health inequalities and show how it will promote activities, which positively benefit individuals using psychological therapies.

3. Human Rights

Human Rights and equalities principles are derived from the same principles of equity, inclusivity, mutual respect and dignity for every person. A Human Rights approach treats the individual as a whole person and seeks to address their holistic requirements. The Equality and Human Rights Commission identifies 15 rights protected by the Human Rights Act 1998. These can be summarised as follows:

- being treated fairly and with dignity;
- taking part in the community;
- living the life you choose
- being safe and protected from harm

Human rights and equality principles underpin the provision of talking therapy services, in its aim to make therapy easier to access across England and improve recovery rates among groups that historically have experienced reduced access to psychological therapy, or who are disproportionately represented among those needing high intensity treatments, or who are at higher risk of being subject to compulsory admission to secure units.

4. Integrated mental health care

The Talking Therapy four-year plan of action emphasises the need for services to provide equal access and equity of outcome across the life course and circumstances of the population. The plan of action is coherent with indicators in the proposed Public Health outcomes framework to reduce the mortality rate of people with mental health problems and the NHS Outcomes Framework indicator to enhance the quality of life for people with a mental illness. These indicators are achieved through early intervention service provision. Additionally, this involves enhanced access to psychological therapies for groups and communities that die prematurely or are at greater risk of mental health problems.

5. Service User Involvement

The main source of quantitative data is the **Data Review** of Improving Access to Psychological Therapy services or Talking Therapies in their first year of local service provision. This covers the period 2008-2009. This was supplemented with quantitative and some qualitative reporting from an **Electronic Survey** with the National Involvement Partnership (NIP) which was available for completion during the December 2010. The National

Involvement Partnership is a coalition of mental health organisations, supporting the involvement of service users and carers.

Questions were rated to gauge whether people thought that the four-year plan of action would meet individual and community needs.

a. First wave sites

35 IAPT services were set up in September 2008. 32 sites responded to a Data Review to evaluate services and six Primary Care Trusts (PCT's) provided an adequate quality of equalities data. Equalities data was collated by the following characteristics:

- Age
- Disability
- Ethnicity
- Gender

From this review, we have the following findings:

<u>Age</u>

65 and under	96%
65 plus	4%

<u>Disability</u>

Patients' records from first wave sites asked patients if they considered themselves disabled and the nature of their impairment. A large proportion of service users opted not to disclose this information. Additionally, patient data recording issues meant that some sites were more likely to collate data on 'visible' impairments such as mobility and visual impairment and less so on for other forms of impairment.

Disabled	2%
Non-disabled	98%

<u>Ethnicity</u>

White British	85.7%
Minority White groups	6.5%
Asian groups	2.5%
Black groups	2.3%
Mixed groups	1.6%
Other groups	1.4%

<u>Gender</u>

Female	64%
Male	36%

This gender proportion was in line with the Adult Psychiatric Morbidity Survey, which records prevalence of common mental ill health as 61% women and 39% men.

Economic position and benefit for members of study group

29.9% in receipt of benefits
64.1% no benefits
6.0% benefit status unknown

Religion or Beliefs and Sexual orientation

No data was collated with regard to religion or to sexual orientation.

b.   Who responded

There were 25 individual responses during a limited consultation period. The number of postal responses was impeded by adverse weather conditions and tight deadlines for comments due to internal governance processes. Consequently, variance by one or two responses affected demographic analysis.

Just under 80 percent of network members disclosed their ethnicity and 47 per cent disclosed their disability status.

Ethnicity
White British   (63%)
Any other ethnic group   (10%)
Did not wish to disclose   (27%)

Aged between
26-35   (5%)
36-45   (11%)
46-55   (42%)
56-65   (16%)
66-75   (16%)
Over 75   (5%)
Did not wish to disclose   (5%)

Sexual orientation

Bisexual   (5%)
Heterosexual   (68%)
Gay   (5%)
Lesbian   (5%)
Did not wish to disclose   (16%)

<u>Sex</u>

Male	(47%)
Female	(42%)
Transgender	(Not requested)
Did not wish to disclose	(11%)

<u>Religion or belief</u>

Buddhist	(5%)
Christian	(32%)
Jewish	(16%)
None	(26%)
Did not wish to disclose	(21%)

c. Findings

People considered that the most important aspects of Talking Therapy services were:

- More choice of the type of therapy received
- Provision of a person-centred service which meets individual needs
- Offering a service for people with severe and enduring illnesses
- To include support for people to stay in or return to work
- To help people cope with their lives
- Promote patient choice and measure their satisfaction
- Ease to access
- Information about the local IAPT service, showing therapies available.

Feedback about the aspects of IAPT that would help improve the service include

- Extending the IAPT assessment criteria to include people with severe and enduring illnesses including people with borderline personality disorders.
- Flexibility on the appointment time and the length and number of sessions to meet individual circumstances.
- Post treatment follow-up sessions to 'end' the therapeutic relationship.
- If interpreters are needed to reduce waiting times, then they are to be trained in cultural competence.
- Reduction in waiting times due to postcode variance.

These comments will inform the AIE equality action plan.

6. Analysis of the impact on equality

a. Age: Better Access for Older People

Improving access for older people is in response to reports that 40 per cent of older adults attending their GP, 50 per cent of older inpatients and 60 per cent of care home residents experience mental health problems[1]. Of this, depression is the most common mental health problem among older adults and is present in 80 per cent of people over the age of 74 who commit suicide. It is also in recognition of the need to provide talking therapies across the life course of the population.

In addition to the impact of depression, co-morbidity of physical and mental health occurs more often in older people than in younger adults. A combination of coronary heart disease (CHD) and depression means poorer outcomes for an older person. Patients with depression and CHD are also at increased risk of higher mortality and morbidity rates. Extending IAPT services to older people mitigates against these mental health inequalities and helps to promote better outcomes for people in their later life.

A review of IAPT services in the first year of commissioning found that on average older people represented four per cent of those accessing Improving Access to Psychological Therapies (IAPT) services. Based on the age profile of the general population and prevalence of depression and anxiety in the general population, the proportion of older people expected to use IAPT would be 12 per cent. Extension plans will address the unmet need of just under 10 per cent of older people that may wish to use talking therapies but have not done so.

The inclusion of age discrimination in the Equality Act 2010 is recognition that treatment needs to be age appropriate. Within IAPT, access to psychological therapies will involve challenging the under-representation of older adults and advancing age-related equality. This will involve tailoring services to meet age variances, tackling the stigma attached to depression or anxiety in later life and both identifying and dismantling discriminatory practices that act as a barrier to older people's referral or self-referral to IAPT. The IAPT programme also plans to work in partnership with organisations representing the interests of older adults.

b. Age: Children and Young People

Currently, IAPT services are predominantly designed for the adult population. However, the evidence is that 10% of 5-16 year olds are diagnosed with a mental health disorder[2]. Expanding the provision of National Institute for

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[1] (2009), Equality in Later Life – A National Study of older people's mental health services, Healthcare Commission

[2] (2007) Office of National Statistics

Health and Clinical Excellence (NICE) approved therapies for children and young people will begin to take effect from financial year 2011/12. NICE recommends that children and young people with moderate to severe depression should be offered specific psychological therapy as a first-line treatment.

One of the eleven IAPT pathfinder sites (2007/08) identified children and young people as an interest group for which it would seek to address barriers and highlight the positive benefits of improving access to psychological therapies. This involved offering advice and support to PCTs through a special interest group, which focussed on the needs of the children and young people. Findings from this pathfinder site in Bury, Lancashire, will inform the development of IAPT services that meet the specific needs of children and young people. Moreover, the expanded provision offers an earlier intervention for young people suffering depression and anxiety disorders, which could be due to bullying, family breakdown, or bereavement and which is also often linked to conduct disorders.

A data review of first wave sites included the age profile of IAPT users. First wave sites reported the proportion of people of varying ages and further analysis revealed the under-representation of older people. The analysis of first wave sites also showed that some sites provided psychological therapies to young people aged under 16.

c. Disability: Long Term Conditions

Providing psychological therapies for people with long term physical health conditions will be based upon a similar criterion to disabled people. The 2001 Census recorded that 18 per cent of people reported an impairment or long term illness that limited their everyday activities. Under the Equality Act 2010, the definition of a disabled person is 'someone who has a mental or physical impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities'. Similarities in the definition of long-term conditions and disability, alongside expanded access to psychological therapies for people with long term conditions (LTC) mean that the future focus of IAPT involves one of advancing disability equality and the promoting the UN Convention on The Rights of Persons with Disabilities. The UN Convention on The Rights of Persons with Disabilities provides a recognised international standard for disabled people's human rights.

Advancing disability equality will be through the development of a collaborative care approach to managing the co-morbidity of a long term condition and depression/anxiety. In particular, the collaborative care approach is designed to increase recovery rates should routine treatment by IAPT therapists fail to move people towards recovery, and so eliminate inequalities in the number of people recovering from depression/anxiety.

The IAPT Data Review reported that disabled people represented two per cent of those entering the first wave of IAPT sites. This figure is likely to include people with a long-term physical health condition, but may not reflect

the true proportion of disabled people using IAPT. The low percentage of disabled users included those with a sensory and physical impairment and those with a learning disability. However, further analysis of the two per cent figure did not reveal sufficient information to gain an accurate picture of the level of equality or inequality experienced by deaf people or those with physical, learning or other sensory impairment.

This lack of information is due to the low number of service users that chose to disclose impairment and queries in the validity of disability data derived from the data review. One of the problems in identifying the impact of IAPT services for disabled people is that data on physically disabled people was routinely captured more than that for those with sensory or learning disabilities. As a result, evidence about the experiences of talking therapy users with a learning disability or sensory impairment was insufficient to draw firm conclusions.

There is evidence that deaf people's access to IAPT is affected by the availability and use of British Sign Language (BSL) interpreters who are often used by services when offering treatment. Partially sighted and some blind people are more likely to use non-GP care pathways because health care services can prioritise the impairment over emotional or mental well-being. A strategy to enhance access for deaf users of talking therapies is being developed. This includes plans to train deaf people as qualified therapists and non-deaf staff as competent BSL communicators.

There is also evidence that a range of psychological interventions can make a considerable difference to the long-term health and well being of someone living with HIV, including how well they manage their condition and adhere to treatment. This is underlined for people living with HIV who are more likely to develop a mental health problem than the general population. There is some evidence that people living with HIV experience inconsistent access to psychological services. Equally, people with mental health problems are at a higher risk of HIV infection and their ability to manage a chronic illness is affected[3]. People with HIV will be included in the strategic approach to expanding access to talking therapies to people with long-term conditions.

d.   Disability: Medically Unexplained Symptoms

The expansion of talking therapies to meet the needs of people with medically unexplained symptoms (MUS) will help meet the needs of disabled people by ensuring that any extension includes a review of care pathways and stigma associated with the term 'psychological therapy'. Medically Unexplained Symptoms refers to physical health symptoms which may be caused by psychological distress. Within the IAPT Data Standard, the criterion for people with LTC and MUS is similar to that of disabled people. This will produce an increased opportunity to identify the disabled people using IAPT services, their recovery rates and the capacity for employment support to help people with LTC and MUS back to work where appropriate.

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[3] 2010 'Psychological support for People Living with HIV'. National AIDS Trust

e. Choice and Equity for patients

<u>Gender Reassignment</u>

Information about the experiences of trans people was not collected within review of first wave IAPT sites, so was not available for this AIE. Research from an Equality Review of transgendered and transsexual people concluded that 29 per cent of respondents felt that being trans negatively affected the way they were treated by health care professionals. Equally, one of the areas where trans people said they felt discrimination and inequality most impacted upon their lives was healthcare access[4]. IAPT services will continue to promote service standards that enable accessibility to trans people through cultural competency training frameworks.

<u>Pregnancy and maternity</u>

30 per cent of women who experience post natal depression still experience the condition one year after childbirth[5] and 54 per cent of women who took their own lives had diagnoses of psychoses or severe depression[6]. Future talking therapy plans are to extend service monitoring to include perinatal mental health services in order to better understand and respond to women's mental health during pregnancy and after childbirth. Perinatal refers to the period before birth and up to one year after childbirth. In addition, the children and young people aspect of the plan of action will have due regard to child development and maternity.

A recent report[7] also discussed issues of need which arose out of the overlapping aspects of ethnicity, culture, language and gender. The report identifies useful approaches for influencing the commissioning and provision of services. This, in turn, can mean that services are better able to respond to the presenting needs of women. The proportion of women using IAPT is in line with the Adult Psychiatric Morbidity Survey.

<u>Race</u>

Research has indicated that the rate of mental health problems is higher in black and minority ethnic (BME) groups than among the white population[8]. Yet BME groups are less likely to have their mental health problems detected by a

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[4] (2007) Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination. Whittles, S, Turner, L and Thom, B.

[5] (2006) Mind, Motherhood and Depression

[6] (2006) Mind's Out of the Blue Motherhood and Depression

[7] (2010) Edge, D. National Perinatal Mental Health Project Report, Perinatal Mental Health of Black and Minority Ethnic Women, National Mental Health Development Unit

[8] Aetiology and Ethnicity of **... Cooper** C, Morgan C, Byrne M, Dazzan P, Morgan K, Hutchinson G, Doody G, **...** P., Morgan K. et al. (2008)

GP[9]. Data analysis of first wave sites concluded that black and minority ethnic groups were 12 per cent under-represented in IAPT[10]. Further analysis within the IAPT central team revealed that a higher proportion of BME groups had not disclosed their ethnic origin than those that had. Equalities guidance *Being Fair: Including All* http://www.iapt.nhs.uk/2010/11/12/being-fair-including-all was issued to commissioners to enable better demographic data collection and analysis across protected characteristics and some socio-economic groups.

The IAPT demonstration site in Newham (2006/07) developed a service that increased access for BME communities, by improving people's ability to self-refer. The specific BME communities that were least likely to be referred to IAPT were difficult to identify due to data recording issues. This resulted in a higher proportion of BME groups that did not disclose their ethnicity in comparison to those that were recorded. Of the data analysed, it was evaluated that the treatment received by BME people was at least as good as that received by non-BME groups.

The Delivering Race Equality Action Plan[11] recommended a more balanced range of effective therapies, for instance psychotherapeutic and counselling treatments for BME communities. This would address the finding that BME patients that do want psychological therapies are less likely to get them.
An increase in the number of practitioners, training in the non-CBT modalities of Brief Dynamic Interpersonal Psychotherapy, Interpersonal Psychotherapy, Counselling therapy and Couple therapy for depression will also increase the availability of a range of treatments across communities and ensure that treatment is more personalised to meet the specific needs of each individual.

The Delivering Race Equality clinical trailblazer report (2009) found that a number of factors affected BME communities' access to psychological therapies including:
- Lack of trust of services/practitioners
- Worries about confidentiality of services
- Deficient availability of information
- Language barriers

Achieving increased access to talking therapies involves raising awareness among the workforce of the value of good data collection and analysis. This will ensure that the ethnicity of those with medically explained symptoms, children and young people, older adults and people with long-term physical health conditions is captured and the impact of expanding access to psychological therapies efficiently analysed.

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[9] Inside Outside: Improving Mental Health Services For Black and Minority Ethnic Communities in England, National Institute For Mental Health In England (2003)

[10] (2010) Improving Access to Psychological Therapies - Year One Sites Data Review, North East Public Health Observatory.

[11] From Jane Fountain and Joanna Hicks (2010), Delivering race equality in mental health care: report on the findings and outcomes of the community engagement programme 2005-2008
http://student.uclan.ac.uk/schools/iscri/files/DRE_CE_Summary_Report.pdf

Moreover, introducing cultural competence within the IAPT Competence Frameworks for practitioners of Brief Dynamic Interpersonal Therapy, Couple therapy, Counselling for Depression and Interpersonal Psychotherapy aims to ensure that the individual needs of patients inform the nature of service delivery so that it is sufficiently responsive to demonstrate personalised care, meet individual need, such as language or culture, and advance service user satisfaction with the services provided.

f. Delivering Improved Quality Standards

Religion or belief

The stigma attached to poor mental health can mean that some groups and communities base their choice of treatment on religion or cultural beliefs. Capturing the religion or belief of patients was challenging for first wave IAPT services, because it was only the Equality Act 2010 that introduced a requirement that this characteristic was protected in relation to the supply of goods, facilities and services as well as in employment. Consequently, an analysis of the impact of IAPT upon different religious groups or belief systems requires further analysis as services begin to collate this identity and promote the service among faith organisations as part of helping to increase referrals.

Supported by statutory duties of the Equality Act 2010, IAPT Equality guidance for commissioners raised awareness of the value and need to gather data on a patient's religion or belief, especially among some BME groups that wish to identify via religious belief as opposed to ethnicity [12].

Sex

Depression is more commonly diagnosed in women than in men. 1 in 4 women will require treatment for depression at some time, compared to 1 in 10 men. The reasons for this are unclear, but are thought to be due to both social and biological factors. For instance, women who are isolated or living with stresses such as single parenthood on a low income are particularly vulnerable to depression. It has also been suggested that depression levels among men may have be under-diagnosed because they present to their GP with different symptoms.

Women are more likely to be referred or self-refer to IAPT for depression and anxiety disorders[13]. Among older adults, women represent a higher proportion of those entering IAPT services and this reflects the gender profile of older people in the general population. Data analysis of first wave sites showed that the proportion of men (34 per cent) and women (66 per cent) using IAPT was

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[12] (1997) Ethnic Minorities in Britain: Diversity and Difference. Madood

[13] 2010) Improving Access to Psychological Therapies - Year One Sites Data Review, North East Public Health Observatory.

in line with the Adult Psychiatric Morbidity Survey, which records the proportion as Female (61 per cent) Male (39 per cent).

<u>Sexual orientation</u>

Lesbian women, gay men and bisexual people (LGB) use mental health services more often than heterosexual people, but they report that the quality of the service is mixed. These experiences range from an absence of empathy about sexual orientation to homophobic incidents. Moreover, LGB people experience higher rates of anxiety and depression than heterosexuals do[14]. Data showing the proportion of LGB people using IAPT services will develop as local services collate information based on the protected characteristics of the Equality Act 2010.

g.   Employment and other activity support

<u>Socio-economic disadvantage</u>

Socio-economic disadvantage refers to unemployment, homelessness, poor income and housing. Studies have shown a link between unemployment, stress, low self esteem, physical illness and increased feelings of depression[15]. The Office for National Statistics Psychiatric Morbidity Survey reports that one in four unemployed people has a common mental health problem[16]. In addition to providing an income, employment can serve as a source of achievement, satisfaction, and a boost to self-esteem.

First wave IAPT sites were unable to collect data on socio-economic disadvantage because the minimum data set does not include this field. The IAPT Data Standard offers an opportunity to expand data items and collate some socio-economic experiences of groups such as veterans and the provision of economic support to help people back to work and off sick pay and benefits. A data item for veterans is to be included within a new data system that is due to be introduced in financial year 2011/2012.

<u>Service provision issues in rural areas</u>

There are particular challenges when providing talking therapy services within rural communities. Communities in rural areas are more dispersed and so can require more effort and greater resources to deliver an equitable service. Distance, travel times and availability of transport are critical for patients in accessing healthcare in rural areas. The demographic profile of people in rural areas is also different in terms of ethnicity and there are higher rates of older people. Recruiting staff with the requisite specialist skills, and the experience to work autonomously in remote rural communities is required, but may be costly and difficult.

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[14] (NIMHE 2007)

[15] (2008) Working for a healthier tomorrow – a comprehensive review. Black. C

[16] (2001) The Office for National Statistics Psychiatric Morbidity report

7. Equality Action Plan

Equality Analysis	Objective	Indicator	Timescales	Lead
Reduced morbidity/mortality	Increased access to talking therapies for ▪ People with long term physical health conditions ▪ People with medically unexplained symptoms	Number of people accessing talking therapy services	March 2015	Director IAPT Programme
Better access for older people	Improved flexibility across Talking Therapy services to meet specific needs of older people	Percentage of older people using Talking Therapy services	March 2014	Director IAPT Programme
Improved access for children and young people	Talking Therapies programme for children and young people, developing the implementation of NICE approved therapies within CAMHS.	Performance indicators include the number of children and young people diagnosed with psychological distress and using Talking Therapy services.	March 2014	Director IAPT Programme
Choice and Equity for patients	Enhance demographic data analysis of patient access by disability (including learning), race, perinatal mental health and gender in line with the Talking Therapy Data Standard	Increase in authenticated data of BME communities, transpeople, children and new mothers	March 2013	Director IAPT Programme

Equality Analysis	Objective	Indicator	Timescales	Lead
Delivering Improved Quality Standards	Development of data reporting by religion, sexual orientation and martial/civil partnership status subject to the Information Standard Board approving the development of a central repository and inclusion of these data items.	Sexual orientation and religion is routinely analysed and used to inform the Talking Therapy Delivery Plan.	March 2013	Director IAPT Programme
Employment and other activity support	Approval of data item for veterans and carers to capture the impact of Talking Therapy services upon groups vulnerable to socio-economic disadvantage	Extended identification of people staying or returning to work or socially participating.	March 2014	Director IAPT Programme