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Review Article

Considerations in the provision of mental health helpline services for minority ethnic groups: A systematic review

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Abstract. ***Objective*** *There are concerns that individuals from minority ethnic groups in Western countries have higher rates of mental health need but underutilise mental health services compared to white majority groups. International research has shown that helplines can be useful in providing support and advice for mental distress and might go some way to helping address these concerns. This systematic review was conducted to identify challenges in the provision of helpline services for ethnic minority groups in Western countries and potential solutions to them.* ***Method*** *A systematic review of the literature using the search engines Medline, Embase, Psychinfo, HMIC, Healthbusinesselite, BNI, AMED and Cinahl.* ***Results*** *The literature revealed a number of specific challenges that require careful consideration in the provision of helplines for minority ethnic groups. These included the perceived usefulness of helplines, marketing strategies, confidentiality and trust, age considerations, gender differences and cultural competence.* ***Conclusions*** *There are various challenges and potential solutions to providing helpline services that effectively support minority ethnic groups and meet the specific cultural needs of different communities. The issues outlined must be considered in order to provide helpline services that are effective and inclusive.*

Keywords: Helplines; ethnic; minority; services; mental health.

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INTRODUCTION

Helplines

Mental health helplines can take the form of telephone or email helplines and online support, including social media. They are thought to enable mental health providers to support service-users out-of-hours and provide confidential listening and emotional support for people with mental health or psychosocial problems (Rethink, 2004). They can enhance client access to care, the provision of immediate crisis support when required and anonymity (Coman *et al*, 2001). One UK study based upon a sample of 1,787 adults from the general population aged over 16 found 18% of respondents were aware of specialist mental health helpline services and that 5% had used a helpline (Taylor Nelson Sofres Consumer, 2002). The study also found that service users were positive about the role of the helplines in providing support when they were feeling depressed or anxious, or at risk of self-harm. They were said to reduce isolation as well as provide useful advice, particularly out of hours. However, lines were criticised for limitations of access, and it was concluded that further resources were needed to ensure that more lines were available to callers. It was felt that the helplines could benefit from

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greater awareness in statutory and primary care agencies and further promotion to black and minority ethnic communities (Taylor Nelson Sofres Consumer, 2002).

Ethnic minorities

Many Western countries have significant ethnic minority populations with different characteristics and needs to the ethnic majority. In the UK for example, according to the 2011 Census there are 15.5 million people from an ethnic minority accounting for 14% of the total population of England and Wales (ONS, 2011). There was record immigration between 2004-2011, with around 375,000 people from Eastern Europe coming to work in the UK between 2004-2006 according to Home Office (BBC, 2006). Asians of Indian origin accounted for 1.4 million and Asians of Pakistani origin for 1.1 million of the total population of England and Wales. 990,000 of minority ethnic people described themselves as Black African and comprised the third largest group within the minority ethnic population in the UK (ONS, 2011).

The majority of today's Black and Asian population are British-born and in some cases are three or four generations removed from their countries of ancestral origin. The age distribution of these groups is significantly different from the population as a whole. The ethnic minority population is comparatively young: the median age of Bangladeshis and Pakistanis living in the UK is 24 and 25 respectively, compared with a median age of White Britons of 42 (ONS, 2011).

Various studies have found that certain ethnic minority groups in the UK have a higher prevalence of mental disorders. For example, Shaw and colleagues (1999) compared the incidence of depressive disorder in African-Caribbeans with White Europeans in Manchester, UK and found an 8% increase in prevalence in African-Caribbean women as compared with White European women. Similarly Bhugra and colleagues (1999) reported that the attempted suicide rate of young Asian women (under 30 years old) in west London was 2.5 times that of young white women.

Reports have highlighted the underutilisation of mental health support services by people from non-white backgrounds (NIMHE, 2003). The publication of the UK government's action plan *Delivering Race Equality in Mental Health* (Department of Health, 2005) stressed the need to provide services and information that meet the needs of minority ethnic groups. Similar situations exist for a range of ethnic minority groups in other Western countries (Oquendo *et al*, 2001). This suggests a need to improve access to and utility of mental health services, including helplines, for ethnic minority groups and developing helpline services that meet the specific needs of these communities.

Models of helpline service for minority ethnic groups

There are a variety of models for helpline service provision for minority ethnic groups. Whilst many helpline services are open to the general public and are also accessed by those of minority ethnicity, some organisations provide helpline services specifically for cultural, religious or ethnic groups only e.g. the Muslim youth helpline in the UK aimed at young Muslims in distress. Others include a helpline service as part of a package offering other forms of support. For example, the Chinese population living and working in London's Soho have access to the Chinese Healthy Living Centre that operates as part of the Soho Centre for Health and Care. It provides a helpline for Cantonese speakers as well as a walk-in bilingual GP service whereby patients can be screened and advised (Persaud, 2005). Some helplines that serve the general population have specific branches that cater for ethnic minority groups, e.g. the Asian Child Protection helpline run by the National Society for the Prevention of Cruelty to Children in the U.K. The East London organization Drugsline provides drug counselling and rehabilitation programmes and includes a freephone crisis helpline. They collaborated with local organisations to target drug problems in the local Jewish and Muslim communities and identified similar cultural responses to drug problems in the two communities, such as shame surrounding substance use (Sufrin, 2006). Specific cultural problems known to be prevalent in certain communities can also be targeted. For example, in the U.K., Honour-based violence was noted to be a particular problem in South Asian, Turkish, Afghani, Kurdish, Iranian, African, Middle Eastern, south and eastern European communities. To help support agencies and victims, The Honour

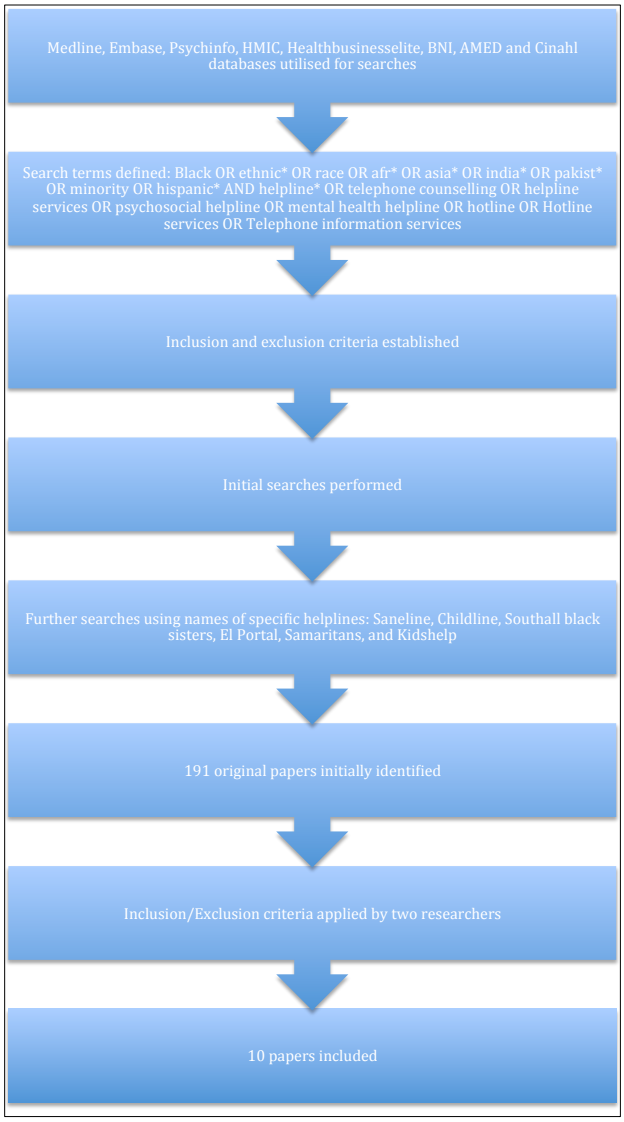
Network was launched in 2008 as a dedicated national helpline in which trained survivors answer calls (Hardy, 2008).

Regardless of the model of service delivery used, certain factors may affect the uptake of such services by ethnic minority groups and there may be common difficulties with and solutions to providing them. This paper reviews the international literature on psychosocial and mental health helplines for ethnic minority groups. We could find no previous systematic review dealing with this topic. The aims of this paper are to outline the factors that affect uptake of these services and to identify potential strategies that may improve service delivery with a view to informing future service provision.

METHOD

A summary of the search strategy is given in **Figure 1**. The specific nationalities used as search terms were chosen to reflect some of the largest ethnic minority groups in Western countries. The criteria used to screen the articles are outlined below. Disputes between the two researchers were resolved through discussion. Only papers from peer-reviewed journals were included to ensure quality and no further quality assessment was performed due to the dearth of papers addressing this area.

Figure 1 Search strategy



Inclusion criteria:
Articles relating to –

- Provision of psychosocial/mental health helpline services to black and ethnic minority groups

And including at least one of the following:

- Discussion of issues to consider in the provision of helpline services for ethnic minority group
- Discussion of approaches taken to solve such problems

Exclusion criteria:
Articles relating to –

- Helplines for physical health problems (e.g. cancer, HIV etc)
- Helplines for lifestyle advice (e.g. smoking cessation)
- Demographic data on callers to helplines or the nature of the problems they call with
- Planned telephone counselling or therapy

RESULTS

The 10 papers included in the review are summarised in **Table 1**. Information from these papers was grouped by themes, as presented below.

Table 1 Data extraction from relevant studies

Study Details	Participants	Intervention	Results
Azaiza (2008)	Arabs in Israel	Helpline for the Arab population in Israel	73% would use helpline 89% would recommend helpline Identified trust as a barrier
Bank et al. (2006)	Caregivers of dementia patients, Miami, USA	Telephone support group	68% found helpline improved care
Larkin (2011)	Cross sectional, random-digit dial survey of the public, USA	Evaluated responses to a suicidal friend	Recent immigrants and Hispanic Americans were more likely to use emergency services rather than a suicide hotline compared with White Americans
Stark et al. (2011)	Students attending violence prevention classes, Cleveland, USA	Use of crisis helpline	18% African American and 27.6% mixed race students would use crisis hotline compared with 40.2% of students of European descent
Aranda et al. (2003)	Users of El Portal Latino Alzheimer's Project	Bilingual helpline for help with care of patients with dementia	Increase of 50% in calls to helpline with better publicity
Usdin et al. (2005)	Soul City audiences, South Africa	Improved advertising to increase awareness of helpline for those suffering from domestic violence	41% respondents reported hearing about the helpline
Neale et al. (2009)	Black and South Asian respondents in Luton, UK	Aimed to identify barriers to use of helplines	Awareness and trust identified as major barriers to help seeking Age of users identified as important
Franks and Medforth (2005)	Callers to the Muslim Youth Helpline 37 young people from various ethnic backgrounds, UK	Focus group discussions to identify barriers to helpline access	Targeted advertising in schools identified as useful Trust and age identified as barriers Identified that email services may be more effective in engaging men in services
Nugent et al. (2010)	Young people in Lowell Massachusettes	Development and distribution of Teen Help card	10,000 cards distributed annually
Williams et al (2005)	Child & Family Services Agencies workers, Calgary, Canada	Call Centre Pilot Programme to provide culturally relevant information to workers	CFSA workers able to make better informed choices about a family's care

Perceived usefulness of helplines for ethnic minorities

Some studies have found that ethnic minority communities perceive helplines as being helpful. In a study of 200 Arabs living in Israel, Azaiza (2008) used a telephone interview to assess attitudes towards and awareness of a helpline for the Arab population in Israel. 73% said that if in crisis they would call the helpline and 89% said that they would recommend calling the helpline to someone in distress (Azaiza, 2008). Similarly, Bank and colleagues (2006) assessed the usefulness of a helpline set up to support for caregivers of people with dementia in Miami, USA. The helpline took the form of a telephone support group, the primary aim of which was to provide service users with easy access to information, resources and support. It was initially trialled with three groups of white American

English speaking carers, Hispanic-American English-speaking carers and Hispanic-American Spanish-speaking carers. Upon evaluation it was found that 68% of carers using the service felt that they were better able to care for their family member as a result of taking part in the trial and this result was found to be unrelated to demographics, indicating that ethnic minority groups found this resource as useful as the group of white American English speakers (Bank *et al*, 2006).

However, a cross-sectional, random-digit-dial survey which evaluated public responses to a hypothetical question: "If someone you knew was suicidal, what would you do first?" found that immigrants who had been residing in the U.S. for less than 15 years and Hispanic Americans were more likely to call the emergency services number (911) and less likely to call a suicide hotline than White Americans (Larkin, 2011). The Cleveland Rape Crisis Center (CRCC) conducted a retrospective review of surveys, which had been distributed in violence prevention classes in schools. Fewer respondents of African American (37%) and mixed race (48%) descent had heard of the rape crisis service than those of European descent (63.6%). When asked what advice they would give a friend who had been sexually assaulted, fewer children of African American (18%) and mixed race (27.6%) descent advised calling a crisis hotline than those of European descent (40.2%) (Stark *et al*, 2011). These studies suggest that there may be barriers to the use and access of psychosocial helpline services for minority ethnic groups.

Marketing

Some helpline groups have successfully increased awareness of the service they provide amongst their target groups using multi-media marketing campaigns. The El Portal Latino Alzheimer's Project, which provides dementia-care services, including a bilingual helpline to the Latino community in Los Angeles County, has used a variety of means to market the service they provide. Outreach efforts included bilingual print and electronic media advertising, marketing presentations, community fairs, and the identification of Spanish-language television and radio stations as official sponsors. These efforts resulted in over 923 calls to the Spanish-language helpline in a 45-month period, an increase of 50% (Aranda *et al*, 2003).

The Soul-City Institute for Health and Development Communication – a South African multi-media health promotion project – together with the National Network on Violence Against Women, formulated an intervention to address domestic violence. Soul City successfully reached 86%, 25% and 65% of audiences through television, print booklets and radio, respectively. On an individual level there was a shift in knowledge around domestic violence including 41% of respondents hearing about the helpline (Usdin *et al*, 2005).

Research conducted with Black and South Asian respondents in Luton, U.K., also highlighted a need for promotional material about services to be disseminated through word of mouth, a range of media (such as community-specific radio) and for helplines to have a presence in institutions such as schools and community resources (Neale *et al*, 2009). However, in a study of callers to the Muslim Youth helpline in the U.K., Franks & Medforth (2005) showed that a blanket approach to advertising might not be appropriate. As part of their research they carried out 4 focus group discussions with 37 young people from a variety of ethnic backgrounds. During one of these focus group sessions, which included discussion of the role of ethnicity in helpline access and provision, a young black woman expressed the view that publicity in schools would be more helpful than in public spaces so that adults would not have access to the information which would enable them to recognise if their child was accessing a helpline.

A novel approach was adopted by the Community Health Center Teen Coalition in Lowell Massachusetts who developed a Teen Help card, a card which contained a list of useful helpline and support numbers for local young people. Service categories include domestic violence, teen pregnancy prevention, HIV/AIDS counselling and testing, jobs, education and training, health care, gay and lesbian support programs, and drug counselling. The card was designed to appeal to young people and The Teen Coalition's Cambodian Youth Development Partnership youth leaders created a social marketing campaign, "CALL ME" to advertise the Teen Help Card. The campaign consisted of the

creation of a t-shirt that matched the design of the card which are worn by teams of youth leaders as they promote the pocket-sized cards on the street in places where youth congregate, distributing more than 10,000 cards annually (Nugent *et al*, 2010).

Confidentiality and trust

Neale and colleagues (2009) held five single sex focus groups made up of young people (14-22 years) of South Asian and African-Caribbean origin from Luton, Bedfordshire, UK. A total of 35 young people took part overall with between 6-10 participants in each of the five focus groups; Bangladeshi males, Bangladeshi females, Pakistani males, Indian males and African Caribbean females. From the discussions held with these groups it was found that a major factor in the decision to either seek or avoid help was 'trust'. Young people preferred to ignore, resolve or keep those problems to themselves. They would only consider approaching organisations for help if their trusted networks of friends and family members were not a viable option (e.g. because they were part of the problem) and if they knew something about, and therefore trusted, these organisations. They also commented that they would have to get to know helpline workers before trusting them, pointing towards increased presence of helpline staff in communities and schools.

Trust was also an issue identified by Azaiza (2008) in his study of the effectiveness of a helpline set up to provide the Arab-speaking minority in Israel with psychological support and help with mental health problems. In the course of this study, Azaiza noted that Arabs would be very cautious of disclosing information to any service identified with the government due to the political conflict between Palestinians and Israelis (Azaiza, 2008).

Similarly, participants in Franks and Medforth's study (2005) in all of the focus groups were concerned with this issue in one way or another. Male and female participants in the black and minority ethnic focus group were deeply concerned about privacy and confidentiality of helplines, in terms of both gaining access to them and talking to helpline workers. There was a problem of feeling under surveillance in the home and a fear of the consequences if their parents discovered they had contacted a helpline. Some Asian males thought it would be best to contact helplines by text because this would be less likely to raise suspicions.

Gender differences

Traditionally, engaging men with mainstream services has been considered problematic (Franks & Medforth, 2005). In contrast, during the piloting phase of The Muslim Youth Helpline, two-thirds of enquiries came from males, and this figure has subsequently remained at 50% (Franks & Medforth, 2005). This was for the whole service which included e-mail access from its inception. It was suggested that e-mail access has made the service more accessible to men. Similarly, during their focus discussion groups with members of minority ethnic communities, Neale and colleagues (2009) found that young men were happiest with 'impersonal' modes of contact whereas young women were less trusting of these. One problem with email communication is their time consuming nature. Volunteers at the Muslim Youth Helpline could take two hours to answer an e-mail inquiry (Franks & Medforth, 2005). On the other hand, the Muslim Youth Helpline coordinator suggested that the reason for the equity in access between males and females to his helpline may be because women in Muslim households are rarely alone. In extended family and joint family households this may well be the case (Franks & Medforth, 2005).

Age considerations

The work of Franks & Medforth (2005), in which focus discussions were held with groups of young participants, illustrated that young people would prefer to talk to a young person because they thought they would understand their language better. This supports the strategy of the Muslim Youth Helpline where all the volunteers are aged 18–25.

Given the younger age distribution of Britain's minority ethnic communities, recruiting younger workers for minority ethnic helplines may prove beneficial. However, although many young people would prefer peer helplines, others may not want to speak to someone their own age in case it was

someone who knew them (Franks & Medforth, 2005). Considering the ages of potential callers to helplines is also important when targeting marketing. For example, Neale and colleagues (2009) found that young participants in their focus groups would prefer advertisements made by other young people or including celebrities.

Cultural competence

Appropriate training for staff to achieve cultural competence includes instilling an understanding of values, beliefs, practices and difficulties faced in different cultures, and developing sensitivity to these aspects of culture within trained professionals. The Alberta Children's Services (ACS), responsible for the welfare of children and families in Alberta, Canada, recognised a need to improve the cultural competence of staff members following an increase in immigration to the area. To this end, the Call Centre Pilot Programme (CCPP) was initiated which acted as a link between the four Immigrant Serving Agencies (ISAs) and five Child & Family Service Agencies (CFSA) in Calgary. The CCPP also allowed CFSA workers to access information on the culture of the immigrant family, with a particular focus on cultural child rearing practices, to enable them to make better informed choices regarding the most appropriate next steps in the family's care (Williams *et al*, 2005).

DISCUSSION

The results of this systematic review show that some individuals from ethnic minority groups may perceive helplines to be useful but others may be less aware of helplines and less likely to use them for support than the white majority population. Multimedia campaigns, which promote helplines using television, radio, print and Internet, may be valuable in raising awareness of helplines in ethnic minority communities. Special consideration may be needed to target young people such as advertising in schools, using celebrities or via 'street campaigns' in areas where youths congregate in order to create a sense of privacy and for maximum impact.

A major concern for callers to helplines is the issue of confidentiality and building trust. This encompasses trusting the helpline worker the caller is speaking to as well as being able to speak in confidence without fear of being discovered by family. This is particularly a concern for young people and may be more pronounced for women from certain minority ethnic groups, such as South Asian communities, since the burden of 'izzat' (family/ personal honour) is often placed on them rather than men. In other words, women may fear that if they were seen to be behaving inappropriately or even seeking help, this may disgrace their family in the eyes of the community. This could possibly result in a reluctance to use services (Chew-Graham *et al*, 2002). Although it could be argued that some of these practices represent cultural norms, improving confidentiality and fostering a sense of trust in helplines could address cultural barriers to improve access to helplines for young people from ethnic minority backgrounds. Developing methods of communication and a workforce which are sensitive to gender and age are significantly important. Building trust by increasing visibility of helpline staff in community institutions may be limited by resources but is also worth considering.

Although there is limited data in the literature on web-based helpline services for minority ethnic groups, their use may have helped to meet the need for anonymity and may have helped to engage more men with helpline services. However, there are problems associated with email services both in terms of data protection and confidentiality from family members. Heinlen and colleagues (2003) found that less than one quarter of websites offering counselling support used encryption software, which transforms data into an unreadable form unless the individual accessing the information has a decryption key to protect client confidentiality. Furthermore, Chester and Glass (2006) reported that 35% of practitioners did not have a strategy in place to deal with a technical failure which could put confidentiality at risk. They also acknowledged that both the client and the counsellor would have to take steps to ensure that the correspondence is not accessed by unauthorised persons at either end. Therefore, in addition to helplines using appropriate software and developing adequate contingency

plans, helpline users should be made aware of measures which will avoid detection from family members.

Providing culturally competent helpline services remains a challenge. The recruitment and employment of minority ethnic workers to mental health services, both voluntary and statutory is difficult; a UK report by the National Coalition of Black Volunteering (2000), titled *Noticeable by their absence*, showed that 41 per cent of charities in the study had no black volunteers, despite the fact that 40 per cent of these charities were based in areas with a significant black population. It has been proposed that staff and patients from the same minority groups can encourage an earlier establishment of trust in mental health services in general (Bhui *et al*, 2000). However, members of certain communities may prefer counsellors from other ethnic groups in case workers of their own ethnicity know them (Bhui, 1998). Service providers should aim for their staff to attain generic cultural competence – the knowledge and skill set necessary to work effectively in any cross-cultural therapeutic encounter – and specific cultural competence depending on the local population, which would enable them to work effectively with the specific cultural community (Ahmed & Bhugra, 2006).

The provision of appropriate helpline services may offer an alternative mode of support for minority ethnic communities, however concerns have also been raised about communication difficulties preventing individuals from minority ethnic groups from accessing telephone services. It has even been suggested that these individuals may lose out as a result of the increasing reliance on the telephone as a means of obtaining care due to language barriers (Free & Mckee, 1998). Furthermore, it may be more difficult to accurately assess a caller when the nuances that often aid evaluation of the patient seen in person (appearance, behaviour, body language, eye contact) are lost over the phone. Helplines are obviously only useful if patients have access to a telephone or other means of communication and this may be a disadvantage to some individuals from ethnic minority groups who may be living in relative poverty as new immigrants or asylum seekers. Lastly, it may be difficult to arrange urgent intervention or follow up, which could present problems particularly in patients identified as suicidal during a conversation.

LIMITATIONS There are a number of limitations to our review. Despite extensive searches only 10 suitable papers were identified. Internet sources may hold relevant information about difficulties encountered in helpline service provision for minority ethnic groups, but we did not use non-databased sources as they were not subject to peer review (as the rest of the studies we included were) making their quality less reliable. We did question the appropriateness of a systematic review to comprehensively investigate this area; other methods such as qualitative studies with helpline staff or surveys of helpline users may also have yielded useful data. However, the systematic review did assimilate findings from a range of such studies. As technology and new methods of communication develop, we may need novel ways of evaluating helpline services and assessing the quality of these evaluations.

In addition to concerns regarding the quantity of evidence obtained, there were also some reservations about its quality. Some studies used were survey based; for example, Azaiza (2008) used a telephone interview to survey the response to a helpline for Arabs living in Israel. Since difficulties with access to telephone helpline services for minority ethnic groups is a tenet of some of these papers, it follows that there may well be similar difficulties with using telephone surveys as a means of collecting data from such populations. Others were qualitative; e.g. Neale *et al* (2009) who used five focus groups of young people to assess the role of the Samaritans helpline. However focus groups serve the purpose of this paper well as they have long been recognised by social researchers as being an effective way of obtaining several perspectives about the same topic, as well as being ideally suited to facilitate dialogue and discussion among participants (Neale *et al*, 2009). Although the findings of this systematic review are based on relatively low quality evidence, the subject matter we are investigating does not lend itself easily to large clinical trials, so we have utilised the best and most appropriate research available.

Lastly, due to the lack of available literature, minority ethnic groups were considered as one entity in this review rather than as individual groups. We have also used religious grouping where these groups in fact consist of individuals from a range of ethnic minorities. Without further research, it is difficult to know if, for example, findings regarding helplines from a study looking at Muslim young people in London are generalisable to Mexican American women living in the United States. Even within ethnic groups there can be a degree of heterogeneity, e.g. Indians in the UK may have immigrated from a number of regions in India, each with distinct cultural practices and languages. However, some similarities do exist in the experiences of ethnic minority groups from different backgrounds in various settings and we have used some of these similarities to find common areas of need.

CONCLUSION Despite the limitations of this systematic review a number of common challenges to the provision of helplines were identified. Firstly, it is clear that campaigns should be developed which market helplines appropriately through a range of community-specific media, but which also acknowledge the need for sensitive advertising in certain situations. In addition, various means of access must be developed to allow both men and women from different communities to utilise helpline services, including Internet based methods. Furthermore, the recruitment of staff from specific cultural backgrounds and age groups, as well as training to achieve cultural competence for all workers will be necessary. The issues of trust and confidentiality are of prime importance and must be at the heart of policy for minority ethnic helpline service provision. A combination of these methods in addition to community-specific knowledge and a culturally informed approach could improve the uptake and subsequent benefit of helpline services for ethnic minority groups.
Helpline services for minority ethnic groups may use the findings of this review to further improve service delivery. Further work should focus on the role of helplines in each individual community before comparing results across different groups and in order to draw reliable overall conclusions regarding helpline provision for minority ethnic communities.

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