

BCOM COUNSELLING SERVICE

HOW IT ALL BEGAN

BY

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(DRE) Delivering Race Equality.
The government Action Plan



Through my counseling experience at St Georges' and my training as a counselor, I knew that 'talking therapies are not essentially designed for the white majority of this country there was the potential of equal benefits there for the ethnic minorities too. (Mearns & Thorne, 2002, p.67) But unfortunately such a service was not available and neither were the GPs and the health professionals referring the ethnic minority people to the already existing services for one reason or another. This disparity and inequality had to be addressed. I contacted the Bolton Council of Mosques, as they are one of the key players in the ethnic minority, to award me the opportunity to set up a service designed around the needs of the minority groups with minority issues. There response was very positive and through their trust in my ability there now exists a flourishing and a ever growing service, catering for the needs of the ethnic minority, which can provide counseling in languages other than English in a place where the clients feel confident to attend, with total confidentiality and privacy.

BOLTON Council of Mosques' (BCOM) Counseling Service

A Reflective Commentary by Yunus Mohamed

DESCRIPTION

Ever since my graduation from an Islamic college in Bury in January 1995, I have aspired to dedicate my life in helping and assisting others; hence the appeal towards counseling was obvious for me. I enrolled on the 'Introduction to counseling' course, graduating with a diploma in 'Professional counseling'. Additionally, I commenced my experiential learning in counseling through my counseling placement at the St Georges' counseling service in Bolton in January 2005.

This essential experiential learning from the placement has provided me with an opportunity to think more deeply and intensely about myself and my relationship with other people. As a teacher in a college, my whole attitude towards teaching, rapport building with students and tolerance of others has also changed for the better owing to this exposure to clients in a 'person centered' approach.

The whole experience of theoretical learning at the college moving to experiential learning at the placement has been a positive experience and a means to my development from dependent to independent learning. Also the opportunity to develop my transferable skills, discourse analysis, clinical analysis and cognitive skills would, I feel, not have been possible without the opportunity of this placement.

I remained with the St Georges' counseling service until January 2008, by which time I had amassed approximately 200 client contact hours. During my time at this placement it was gradually becoming apparent to me that around 85% of my clients are referred to the agency by GPs or mental health clinics with some self referrals. The question arising in my mind was that the clients were almost all from white origin, where are the potential blacks & minority ethnic clients going?

Over time this internal worry became quite extreme, to the point that a deep feeling emerged within me; something had to be done to address this disparity in client referrals from the relevant sectors. Was it that the BME groups were simply not in need of counseling? That obviously could not be true as the 'Inside outside report (Inside outside Improving Mental Health Services for the BME communities in England report, 2003, p.9) states: 'Generally, people from various ethnic groups experience much worse health than the ethnic majority in this country'. Also, a 2001 Bolton health survey states: 'The ethnic minority in Bolton have considerably higher proportion of people with mental health problems. In Pakistani Muslims the rate is 33.6%, following 33% in Indian Hindus and 30.08% in Indian Muslims'. (Bolton Health Survey 2001 p.33)

I knew this disparity and inequality could not be addressed at St Georges' day centre, to have the required effect, for the primary reason that some ethnic groups would not embrace the idea of entering the church, seeking help for their needs. This was evident by the lack of clients from the BME groups to date, despite some marketing carried out by St Georges.

Therefore, I arranged an initial meeting with the chairman and the secretary of Bolton Council of Mosques (BCOM) to whom I explained the need for counseling in the BME groups of Bolton. I chose BCOM to set up this service because they were and still are, by far, the biggest faith based organization in Bolton with a very good working relationship with the Local Authorities. BCOM was not aware of this health need neither did they have any funding or infrastructure in place to cater for such a service. Despite this they provided me with every opportunity to set up a culturally sensitive counseling service, where clients had the choice of therapy in their first language. Such a service would be the first of its kind in Bolton.

In addressing the lack of BME clients for counseling I felt strongly that there was an opportunity to encourage and change the 'mind set' of GPs and mental health service providers in considering 'Talking therapies' as a mode of treatment for the BME groups. This was not just my understanding that the BME groups were not generally accessing and were not being referred to the required health services the 'Inside Outside report (Inside outside Improving Mental Health Services for the BME communities in England report, 2003, p.9) states: 'Despite the higher levels of ill health and disability amongst the minority ethnic groups they appear to have poorer access to health services'. Therefore I took the opportunity to present my findings to the BCOM Health forum which comprises of more than 10 GPs and other professionals from the health sector. Their response was very positive, after initial reservations whether such a service was beneficial to the ethnic minority in Bolton. My stance was always that 'counseling could have a positive outcome for every type of client, irrespective of their ethnicity. (Hough, 2004, p.103)

BCOM was also immensely helpful and instrumental in marketing and promoting this service to the ethnic minority, especially the 22,000 Muslims in Bolton (BCOM figures) who live in some of the most deprived areas in Bolton. (Reducing Inequalities in Health in Bolton Strategy and Implementation, 2004, p.3). I designed a poster and a leaflet in Urdu, Gujarati and English detailing the service, venue and a brief explanation of counseling. These leaflets and flyers were distributed to all the Mosques, temples, GP surgeries and health clinics all over Bolton.

EVALUATION

Strengths

I feel my strength for setting up such a service was my educational background both in counseling up to the diploma level in professional counseling and also the religious training I have gained throughout the years, through both my education and teaching. As a member of the BME groups in Bolton, aware of the needs and cultural sensitivities of the ethnic minority I was always confident that such a service would be highly rewarding and beneficial to many. I had seen people from the Muslim community specifically, who were referred to me informally for some form of talking therapy, obviously not known to them as counseling and it was always a productive experience for the client and rewarding for me. I have the ability to communicate in English, Gujarati and Urdu, so communication with a large chunk of the ethnic minority was never going to be an issue of concern.

Weaknesses

One of the biggest weaknesses for me was the inexperience I had in setting up such a service. The task of selling the idea to BCOM, shifting the mindset of GPs and health professionals and convincing the ethnic minority in Bolton, that 'talking therapies' is an alternative and viable mode of health service available to them. I knew that despite my success in getting BCOM on side they had competing priorities and there still was the issue of a venue for this service. BCOM in their present premises did not simply have the infrastructure in place for such a service. It was equally futile to contact other faith groups to set up such a service because they simple were not in a position to offer what BCOM had offered thus far, in terms of support and marketing.

Then there was the issue of taking in to consideration clashing cultures, gender, religion and also the fear of stigmatization for the potential clients.

Once again, BCOM put tremendous trust in my project and rented a place for counseling, where clients could come with no fear of stigma and with total confidentiality. They also permitted me to employ a female counselor for female clients who would feel uncomfortable with male counselors. Yes, the health services were very happy with such a set up, but unfortunately no funding came forth.

Opportunities

The whole idea of setting up such a service was an opportunity for me implementing the DRE (Delivering Race Equality) action plan by engaging the communities and providing a service culturally sensitive and more responsive to the needs of the ethnic minority and changing perceptions and mind sets. I firmly believed that this would in time play a part in lessening fear of mental health amongst the ethnic minority and more importantly reduce the rate of admission of people from BME groups to psychiatric inpatient units. (DRE in mental health care, 2005, p.4)

On a personal point it was also a great opportunity to serve the community I belong to and to engage the faith bodies with social issues by linking the local health establishments with the third sector organizations such as BCOM and work towards 'community cohesion' as defined by the ICOCO report 2007: 'Community cohesion advanced by the Department of Communities and Local Government (DCLG), the Local Government Association (LGA) and widely accepted by Local Authorities holds that a cohesive community is one in which there is:

- a common vision and sense of belonging for all;
- the diversity of people's different backgrounds and circumstances is appreciated and positively valued;
- those from different backgrounds have similar life opportunities, and
- strong and positive relationships are being developed between people from different backgrounds in the workplace, in schools and within neighborhoods'.(Bolton Metropolitan Borough Council, Review of community cohesion, 2007, p.3)

Threats

At the inception of BCOM counseling service the overriding threats for me was appropriate facilities for the counseling, as I was aware that people from the ethnic minority are very nervous and fearful of stigma and lack of privacy and confidentiality. Also, there was the lack of funding for expenses, membership of the British Association of Counseling and Psychotherapy (BACP) renting of premises printing and distribution of posters and leaflets. Would BCOM lose heart after all my hard work? Would other competing priorities take precedent in the BCOM agenda? Would there be a lack of support from the ethnic communities? Would there remain a persistent perception of stigma, despite my hard work to negate such a threat? Would there be a dearth of clients contradicting my whole argument of the need for such a service?

After some initial 'teething problems' the service has taken off, growing and developing each day to cater for the needs of the ethnic minority and also the ethnic majority as this is a service open to all.

ANALYSIS

Through my experience at St Georges', my research in to the health situation of the BME groups in Bolton and' external drivers' such as the DRE 'inside outside' report and government policy for equality, I knew and was convinced that there was a 'gap in the market' for this counseling service, specific to the needs of the BME members. But there were certain vital processes to be in place for this service to be successful; BCOM had to be fully committed, it needed to understand that adherence to the BACP ethics and good practice was essential, specific liability cover was paramount and my supervisory requirements were essential and mandatory. Equally it was apparent to me that BCOM was financing this project without any funding from the local authority or any other sources and the costs were mounting. How long will they be able to sustain this? Were they there for the long run? Will the Local authorities provide some form of funding or will the whole project merely dry out owing to lack of funding? There was also the potential need to fund the training of future culturally sensitive, multi lingual counselors if need did arise.

Despite all these anxieties I could also see the potential for the BCOM organisation. It could boast identifying a gap in the market which they were now fulfilling. An opportunity was also available to enhance their relationship with local authorities, make a positive mark in improving the health of the residence of Bolton and build their 'cross community relationship'.

CONCLUSION

Through my counseling experience at St Georges' and my training as a counselor, I knew that 'talking therapies are not essentially designed for the white majority of this country there was the potential of equal benefits there for the ethnic minorities too. (Mearns & Thorne, 2002, p.67) But unfortunately such a service was not available and neither were the GPs and the health professionals referring the ethnic minority people to the already existing services for one reason or another. This disparity and inequality had to be addressed. I contacted BCOM, as they are one of the key players in the ethnic minority, to award me the opportunity to set up a service designed around the needs of the minority groups with minority issues. There response was very positive and through their trust in my ability there now exists a growing service, catering for the needs of the ethnic minority, which can provide counseling in languages other than English in a place where the clients feel confident to attend, with total confidentiality and privacy.

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