

**An Evaluation Of Improving Access To Psychological Therapies  
(IAPT) Services Offered To Culturally And Ethnically Diverse (CED)  
Communities: A Mixed-Methods Approach**

**Paige Clarke-Jeffers**

BSc (Hons), MSc

Thesis Submitted In Partial Fulfilment Of The Requirement For The  
Degree Of Doctor of Philosophy (PhD)

Birmingham City University

Faculty of Business, Law & Social Sciences

**May 2025**

## **Declaration**

This thesis is submitted in partial fulfilment for the degree of Doctor of Philosophy (PhD) at Birmingham City University within the School of Psychology, Faculty of Business, Law & Social Sciences (BLSS). I declare that no material contained in this thesis has been used for any other submission for an academic award. I confirm that this thesis is entirely my own work and based on my own research. Where the words or material of others are used, these are clearly placed in quotation marks and referenced.

Signed:

P.Clarke-Jeffers

Date: 05/05/2025

## **Dedications**

Firstly, I need to say thank you to God for carrying me through my PhD. *“I can do all things through Christ who strengthens me”* (Philippians 4:13 - NIV). A reminder that even in challenging times, through faith and trust in Jesus Christ, I know that You will help me through anything. Even taking me on a PhD journey that I never originally set out to do.

I want to dedicate my thesis to Mom. I know how incredibly proud you would have been to see me become Dr Paige Clarke-Jeffers. I love and miss you.

Lastly, I want to say thank you to my Dad, Nanny and my sisters for their constant encouragement throughout this process. Additionally, I am sending love to all my friends and family who have helped me along the way, be it a phone call, a message, holidays/trips, roller-skating or other fitness-related activities, you have all contributed in some way to my PhD trajectory.

## **Acknowledgements**

A massive thank you to my supervisors, Dr Athfah Akhtar, Dr Silvio Aldrovandi and Dr Panagiotis Rentzelas for their continued support throughout my PhD trajectory. Thank you for the group and one-to-one meetings that allowed me to take leadership towards the direction and accomplish what I wanted to get completed within each phase of my project. As well as being flexible to my alternative learning styles (watching my mini clips) to make sure we were all on the right track. Also, thank you for providing me with ongoing verbal and written feedback as well as sticking to my deadlines. We made a great team. I thank you all for your expertise; I could not have asked for a better supervisory team! Additionally, I would like to extend my thank you to my adviser, Dr Samantha Martin, for the support within my qualitative chapters. I am grateful to have you all as part of my PhD thesis.

Thank you to all the participants who were involved in any of my studies and the NHS Trusts, and the individuals involved in helping me obtain the secondary data.

Finally, thank you to all the individuals who proofread my work (within a short time frame). I want to say that I am grateful that I could rely on you for your input. My gratitude goes to: Demi Clarke-Jeffers, Channelle Clarke, Tara-Leanne Jeffers, Stephanie Clarke, Roy Davis, Bryhanna Campbell, Dionne Allen, Shanice Silvera, Jakub Krajewski, Amy Bass and Todd Capes.

## **Abstract**

**Purpose.** Previous literature has outlined that Black, Asian and Mixed/Dual-Heritage groups have lower recovery rates with the Improving Access to Psychological Therapy (IAPT) service compared to white service users in the United Kingdom. The research rationale is to understand and address mental health disparities between the two groups. The aims are to explore both clinicians' and service users' perspectives on their IAPT experiences. Also, the aim is to investigate variables such as autonomy, religious affiliation and referral pathways on clinical outcomes. The purpose of these aims is to explore what factors are contributing towards the health inequality gap and lower recovery amongst Black, Asian and Mixed/Dual-Heritage groups.

**Methods.** A mixed methods approach was used, which included 1) Clinicians' IAPT Experiences (qualitative), 2) CED service users' IAPT Experience (qualitative), 3) Effects of Autonomy and Ethnicity on Mental Health Outcomes (quantitative, primary data) and 4) Ethnicity and Recovery Determinants (quantitative, secondary data).

**Findings.** Study one highlighted that IAPT clinicians ( $N = 14$ ) want to feel confident to make psychological adaptations if needed to enhance the therapeutic alliance and aid recovery for CED service users in particular. Also, participants denoted that cultural competency training needs to be improved, although caution was expressed regarding not getting burnt out. Study two was interviews with current IAPT service users ( $N = 12$ ). Similarly to study one, participants expressed the importance of diversity, representation within healthcare and accessibility (knowing what the IAPT service is, what the service does and how they can be referred to the IAPT service). As well as considering how sessions are delivered (one-to-one and group sessions), which can aid their IAPT trajectory to recovery. Study three ( $N = 203$ )

highlighted that autonomy and more specifically self-awareness and capacity to manage new situations were linked with better outcomes for anxiety, depression and functional impairment. Specifically, self-awareness reduced anxiety and depression, especially for CED groups. Lastly, study four showed that the effect of receiving IAPT therapy was comparable between white and CED participants (n = 28,793), though CED groups revealed higher pre- and post-outcome scores for anxiety, depression and functional impairment. Additionally, when exploring what determinants helped or hindered recovery, it was suggested that religious affiliation could have acted as a protective barrier, and those referred by 'other' routes showed the worst recovery outcomes for anxiety and depression compared to GP and self-referral routes.

**Conclusion.** Though study four showed no significant (pre- and post-scores) differences between CED and white individuals for recovery, the findings did reveal that CED groups have a higher severity of anxiety and depression when they enter the IAPT services. Thus, the combination of all the findings demonstrates that when addressing mental health disparities among CED individuals, a multi-faceted approach is required. Exploring an individual's autonomy (SA, CNS and SO), religious affiliation, the referral pathway, fostering inclusivity and enhancing clinicians' cultural competency are all factors that should be considered to ensure that CED groups are receiving appropriate treatment to aid recovery. Considerations and implications are discussed in each relevant chapter in the context of future research, policy and practice.

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## **List of Abbreviations**

ACS-30 – Autonomy Connectedness Scale 30

ADSM – Anxiety Disorder Specific Measures

APA<sup>a</sup> – American Psychiatric Association

APA<sup>b</sup> – American Psychological Association

BA – Behavioural Activation

BAME – Black, Asian and Minority Ethnic

BIQ – Body Image Questionnaire

BLSS – Business, Law and Social Sciences

CA – Culturally Adapted

CBT – Cognitive Behavioural Therapy

CED – Culturally and Ethnically Diverse

CMHDs – Common Mental Health Disorders

CNS – Capacity to Manage New Situations

DRE – Delivering Race Equality

DSM – Diagnostic and Statistical Manual

EM – Ethnic Minority

EMDR – Eye Movement Desensitisation and Reprocessing

GAD – Generalised Anxiety Disorder

GCP – Good Clinical Practice

GP – General Practitioner

HAI – Health Anxiety Inventory

HI – High-Intensity (therapy)

IAPT – Improving Access to Psychological Therapy

IPT – Interpersonal Psychotherapy

IRAS – Integrated Research Application System

LI – Low-Intensity (therapy)

MEG – Marginalised Ethnic Group

MI – Agoraphobia-Mobility Inventory

MM – Marginalised Majority

NCCMH – National Collaborating Centre for Mental Health

NHS – National Health Service

NICE – National Institute for Health and Care Excellence

OCD – Obsessive-Compulsive Disorder

OCI – Obsessive-Compulsive Inventory

OSF – Open Science Framework

PCL-5 – Posttraumatic Checklist

PDSS – Panic Disorder Severity Scale

POC – People Of Colour

PTSD – Post-Traumatic Stress Disorder

PWPs – Psychological Well-being Practitioners

RCTs – Randomised-Controlled Trials

RM – Racially Minoritised

RTA – Reflective Thematic Analysis

SA – Self-awareness

SAD – Social Anxiety Disorder

SO – Sensitivity to Others

SPIN – Social Phobia Inventory

TA – Thematic Analysis

TAU – Treatment as Usual

WSAS – Work and Social Adjustment Scale

## **Chapter 1. Reflexivity and Positionality**

I will be capitalising the letter 'B' in Black to highlight the power and identity of Black individuals without minimising or simplifying '*black*' as a general descriptor. Typically, African/Afro-Caribbean individuals refer to themselves as Black, as do I (the researcher). As a researcher, I strive to always empower Black people, especially with the long history [and still present] of individuals trying to reduce one's race and ethnicity. This also explains why the letter 'w' is lowercase for white individuals, as they have not historically been racialised or oppressed in the same manner as Black people.

I was originally using the term BAME or B-A-M-E, as throughout my academic trajectory, BAME was a commonly used phrase; thus, I felt that it was an expectation to comply with the term used within the fields of academia and healthcare. When I first started my PhD, I started off using the term BAME. When conducting my first study with Improving Access to Psychological Therapy (IAPT) health professionals, some participants brought to my attention their dislike of the acronym BAME. The comments made by the participants made me reflect on whether I should continue using the term BAME, even though this was not a term I have used outside of higher education. I could have easily dismissed these comments and changed nothing. However, doing nothing was not conducive to the fact that I aim to maximise the voices of Black, Asian and Mixed/Dual-Heritage groups; hence, I proactively wanted to change my language. I read books/articles on race, ethnicity, culture and language. I planned for this thesis to bring the voices that are often lacking in research to fruition, to get a clear insight into what terms other academics and I should be using.

Additionally, I conducted a supplementary study (See, Chapter 10.1, study five) by gathering people's preferences towards different terminology since study one emphasised

the dislike towards the term BAME. The participants from the supplementary study did not vote BAME as the most preferred term due to its grouping of individuals, leaving no oversight for unique experiences between different cultures. Furthermore, analysing the results made me understand how detrimental specific words such as 'minority' and 'marginalised' can be and the negative connotations that can adversely impact Black, Asian and Mixed/Dual-Heritage groups, which is often rooted in racism and discrimination. Due to participants expressing confusion and/or distress about these terms, the results from study one, paired with the supplementary study, provided a strong rationale for the term BAME to be obsolete in my PhD trajectory. Instead, I will be using the most preferred term 'Culturally and Ethnically Diverse' (CED), which was the most favourable term from the outcome of the supplementary study. Even though some of the participants and I have emphasised that grouping is harmful as it can remove the unique experiences that each cultural group experiences, using the 'grouping' term CED allowed me to encompass Black, Asian or Mixed/Dual-Heritage individuals in order to perform statistical analyses. Using specific ethnicity groups when making comparisons to white individuals can cause an imbalance in groups when exploring ethnic differences, thus reducing the statistical power which is why in subsequent chapters CED is used. This is typically seen within the health/clinical sector as Black, Asian or Mixed/Dual-Heritage individuals are less likely to participate in clinical trials/research (Brown, 2018; Montaque & Stewart, 2024), which explains why previous research and for this thesis, I group Black, Asian or Mixed/Dual-Heritage individuals into CED as a category. Though it is salient to understand, which I am aware of, that the term CED should not be used as a replacement when directly discussing experiences or research that pertains to specific ethnic groups. I will endeavour, where possible in the thesis, to refer to

individual groups as either Black, Asian or Mixed/Dual-Heritage to maximise the voices of individuals who do not always feel represented in research (Lamb et al., 2012).

In addition, I believe it is essential to be reflective regarding Crenshaw's (1990) intersectionality framework, which I employed in this thesis. Crenshaw (1988) originally set out to use the framework for 'Black Women' to address structural inequalities and legal/social-political issues. Crenshaw (1990) specifically highlighted 'Black Women's' experiences and how we should view them as intersecting identities. Rather than viewing race (racism) and gender (sexism) as two separate categories that are typically seen in anti-discrimination and feminist theory (Crenshaw, 1988; 2013a). Intersectionality helps to explain how racism and sexism intertwine to form unique disadvantages amongst 'Black Women'. Since the intersectionality framework originated, it has diversified from its intended use. Intersectionality has been used to explain multiple identities such as age, religion, immigration and class (Al-Faham et al., 2019). In my thesis, I use intersectionality that expands beyond how it was originally meant to be used, as I include different demographic identities (not just 'Black women') as well as aspects such as religion and referral pathway. Therefore, it was important for me to be reflective and to acknowledge the expansion of Crenshaw's original focus.

## **Chapter 2. General Literature Review**

### **2.1 Background**

Mental health disorders such as Depression, Schizophrenia, Bipolar and Anxiety can have a detrimental impact on an individual's life (American Psychiatric Association [APA<sup>a</sup>], 2013). Mental health disorders range from mild to severe (National Institute of Mental Health, d., p.1). According to the Diagnostic and Statistical Manual (DSM) 5-TR criteria (APA<sup>a</sup>, 2013; 2022), mental health disorders are categorised based on the duration and pervasiveness of symptoms that affect individuals' daily functioning (Kendrick & Pilling, 2012; Zimmerman et al., 2018). In England, there is a one in four likelihood of an adult experiencing a mental illness in their lifetime (McManus et al., 2009; NHS Digital, 2007). Mental illnesses can have a deleterious impact on an individual's well-being (Connell et al., 2012; Sebastianski et al., 2019), leading to difficulties such as sleep disturbances (Lalji & Pakrashi, 2020), low self-esteem (Mann et al., 2004; Whitehead et al., 2017), feeling isolated (Wang et al., 2017), or adopting unhealthy lifestyle choices, for example, poor diet and smoking (Brose et al., 2020; Fezeu et al., 2015). On a societal level, poor mental health can cause a strain on health services (Riley et al., 2018). Four per cent of individuals with poor mental health issues take statutory sick pay, contributing to the financial burdens on employers due to decreased work productivity (Evans-Lacko & Knapp, 2016; OECD, 2014).

#### **2.1.1 Mental Health Service**

To combat the rising levels of poor mental health in the United Kingdom (UK) (Barr et al., 2015; McManus et al., 2009; 2016) as well as supporting the Government's strategy 'No health without mental health strategy' (Department of Health, 2011) the Improving Access to Psychological Therapies (IAPT) service was introduced in 2008 (National Health

Service [NHS], n.d.), which is now called NHS talking therapies.<sup>1</sup> In addition, the IAPT service was implemented to increase the opportunity for individuals to receive psychological treatment (Clark, 2011; Clark et al., 2018) and helped 1.06 million additional people gain access to IAPT services between 2009/10 and 2020/21 (Department of Health, 2012; NHS Digital, 2023). The IAPT service is an NHS programme approved by the National Institute for Health and Care Excellence (NICE; n.d.) that increases accessibility for individuals with Common Mental Health Disorders (CMHDs) which include: Depression, Generalised Anxiety Disorder (GAD), Panic Disorder, Obsessive-Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD) (Goldberg & Huxley, 1992; NICE, 2011a) to be offered psychological therapy. The CMHDs listed are known as “common” due to affecting more individuals compared to other mental health disorders (NICE, 2011a). The CMHDs can vary from mild to severe (National Institute of Mental Health, n.d, p.1) and are treated in the IAPT service. In order for individuals with a CMHD to access the IAPT service, an individual can refer themselves directly or seek advice from their General Practitioner (GP). Pre-IAPT, the common practice for individuals was to seek support for mental health was by booking an appointment with their GP, but there were typically availability and accessibility issues such as long waiting times (regarding booking a GP appointment and then for the GP to refer the individual to receive psychological therapy) to obtain psychological therapy (Campbell et al., 2000; Knapp et al., 2006; Saraceno et al., 2007; Turner, 2015; Trusler et al., 2006; Wilson, 2009). Therefore, to improve the provision of care, when the IAPT service was introduced, the Department of Health (2008) highlighted the importance of implementing self-referrals. Self-referrals can be beneficial to aid with the referral process, as evidence has shown that

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<sup>1</sup> Though it is now called ‘NHS talking therapy’ the researcher has referred to it as the ‘IAPT service’.

some individuals may be deterred from seeking psychological support via a GP referral (Brown et al., 2010). Similarly, the benefits of self-referral can save time by speeding up the process for individuals, bypassing their GP and improving accessibility (Brown, 2018; Brown et al., 2010, 2014).

Additionally, to increase the awareness of the IAPT service and promote the benefits of self-referrals, the IAPT service recognises that working in silos within healthcare is ineffective (Ruprah-Shah, 2009). Thus, IAPT has formed partnerships with primary and secondary care services, as well as faith centres, independent, voluntary and community organisations such as Mind and Age UK (National Collaborating Centre for Mental Health [NCCMH], 2018) to provide a collaborative and accessible service to assist and treat their clients (Holland, 2009). Thus, the implementation of the IAPT service has improved the availability of evidence-based psychological therapies, which have demonstrated a positive and applied effect for public mental health outcomes (Clark, 2018; Saunders et al., 2020). Furthermore, the IAPT service has been salient in addressing therapeutic needs to meet the demands of the NHS by providing an expansion to access provision for evidence-based psychological therapy. Before IAPT was introduced in 2008, the NHS only spent 3% of the mental health budget on psychological therapy (Insight Health Care, n.d, p.10). Since 2012, the IAPT service has tripled that budget (Insight Health Care, n.d, p.10). In addition, it has been suggested that the NHS has committed to ring-fencing mental health investment worth £2.3 billion by 2023/2024 (NHS, 2019), with the aim of supporting 1.9 million adults in the IAPT service in 2023/2024 (NHS, 2019)<sup>2</sup>.

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<sup>2</sup> Currently, there has been no evidence that £2.3 billion has been ring-fenced as of 2025, when this thesis was written, as well as a lower figure of 1.83 million people accessing the IAPT service (NHS Digital, 2024).

### **2.1.2 Overview of the IAPT Service**

Within the IAPT service, an individual is labelled as having completed treatment if the service user has attended a minimum of two sessions during the referral (NHS Digital, 2017). An individual is only labelled as 'recovery' if a client's symptoms are at clinical caseness before treatment starts and then not at clinical caseness when the treatment has finished (NCCMH, 2018). Alternatively, service users can be labelled as 'reliable improvement' regardless of whether they meet the clinical caseness threshold or not at the beginning of treatment. Reliable improvement measures the difference between individuals' initial and final clinical scores on the well-being questionnaires after a course of treatment. The scores would show a reduction in both measures for depression and anxiety (NCCMH, 2018). Furthermore, the IAPT service categorises service users as being 'reliably recovered' if they meet the criteria for 'reliable improvement' as well as 'recovery'.

When assessing a client's symptoms within the IAPT service, there are specific questionnaires that are used to measure their clinical caseness. The Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2001) and the Generalised Anxiety Disorder Questionnaire-7 (GAD-7; Spitzer et al., 2006) are used to assess clients' symptoms for their overall depression and anxiety severity. The PHQ-9 cut-off score for caseness is ten out of 27; for the GAD-7, the score is eight out of 21 (NCCMH, 2018). The Work and Social Adjustment Scale (WSAS; Mundt et al., 2002) is also used in the IAPT service, but the scale does not have a clinical caseness threshold (NCCMH, 2018). Nonetheless, the WSAS helps clinicians to assess service users' functioning impairment in terms of their ability to function at home, work and socially. The scores range from zero to 40, and clinicians use the WSAS to identify what areas need improvement based on specific service users' needs. Service users

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will complete the three different assessments after every session to monitor progression and track changes in terms of the effectiveness of the intervention on individuals' levels of anxiety, depression and functional impairment. The questionnaires not only help assess recovery but to help inform the clinician if treatment adjustments are required, such as increasing the number of sessions or adjusting the intensity or type of psychological treatment (NCCMH, 2018). There are also additional Anxiety Disorder Specific Measures (ADSMs) that clinicians can use as well such as Agoraphobia-Mobility Inventory (MI), Body Image Questionnaire (BIQ), Health Anxiety Inventory (HAI), Obsessive-Compulsive Inventory (OCI), Panic Disorder Severity Scale (PDSS), Posttraumatic Checklist (PCL-5) and Social Phobia Inventory (SPIN) (NCCMH, 2018) so they can gather further data about the service user's mental health diagnosis to better assess what treatment will be suitable.

The IAPT service stepped-care approach utilises NICE-recommended low and high-intensity interventions. The stepped-care approach is beneficial for matching service users to appropriate intensity psychological treatment. Simultaneously, employing a stepped-care approach increases access to the IAPT service due to the resources being allocated effectively (Boyd et al., 2019; Richards et al., 2012). Step one is the assessment stage and watchful waiting. The health practitioner will screen service users using the GAD-7 and PHQ-9 to recognise what type of CMHD a service user has and to monitor symptoms before offering psychological treatment (Chan & Adams, 2014). Once an assessment has been made, the IAPT service encourages utilising the stepped-care approach; usually, all service users start with low-intensity treatment first (Gyani et al., 2013). However, there are exceptions where the severity (moderate to severe) of a service user's symptom results in

them receiving high-intensity treatment after the initial assessment rather than being stepped up later on (Clark, 2011; Clark et al., 2009).

Step two is low-intensity interventions, ranging from six to eight sessions, lasting 30-60 minutes (NICE, 2009) delivered by Psychological Well-being Practitioners (PWP's) to treat mild to moderate CMHD's (NHS, 2016). The low-intensity treatments consist of Guided Self-help based on Cognitive Behavioural Therapy (CBT), computerised CBT, Behavioural Activation exercises and psychoeducational groups (NCCMH, 2018). Clinicians provide service users with didactic material based on the principles of CBT. Service users can use what has been learnt in the sessions and integrate the practices into their daily living (Delgadillo et al., 2017). During the review process, which occurs when the client has completed all the sessions they were initially offered, there is a decision to cease, continue or step up individuals. If the treatment has been unsuccessful in step two, which is determined by the PHQ-9, GAD-7 and WSAS as the questionnaires provide useful indications of service users' symptomology, then clinicians make an informed decision, guided by the NICE stepped-care recommendations (Gyani et al., 2013; NICE, 2011b). The clinician may continue with the low-intensity treatment but provide additional sessions for their client, or if clinicians do not feel that the service user is benefiting from the current treatment (Boyd et al., 2019), then the service user is stepped up to stage three.

Step three consists of high-intensity interventions, ranging from 12 to 20 sessions lasting 60 minutes (NCCMH, 2018), delivered by a trained therapist (NHS, 2016). The IAPT high-intensity programme offers a variety of evidence-based psychological interventions such as CBT, Counselling for Depression, Mindfulness-based Cognitive Therapy, Brief Psychodynamic Therapy, Interpersonal Psychotherapy and Couple Therapy (Clark, 2011;

NCCMH, 2018). Service users are reviewed after every session, where they may continue the intervention, be stepped-down or terminate therapy if the PHQ-9 and GAD-7 scores are below the caseness threshold (NCCMH, 2018). Only in specific cases where the severity and complexity of a service-user's needs longer support then the IAPT service will step-up an individual to step four or step five. Step four can involve receiving psychological treatment such as CBT and Eye Movement Desensitisation and Reprocessing (EMDR) that is delivered by experienced and specialist mental health professionals. Whereas step five is when there is a severe risk to a service user's life, where inpatient care and crisis teams are needed (Martin et al., 2021; Weir et al., 2021). In both steps four and five, individuals are more likely to receive medication in conjunction with psychological treatment and will likely have a longer duration and intensity of treatment (NICE, 2011a; Perfect et al., 2016).

This current research will be focusing on steps two and three of IAPT's stepped-care approach and assessing service-user responses to the standardised questionnaires that the IAPT service uses. The benefits of administering assessments to service users after each session allow clinicians to monitor key outcomes of service users' performance/recovery levels. Also, the data collected has provided public transparency of the effectiveness of IAPT's provision, which is disseminated on websites such as NHS Digital. The national average recovery rate in the IAPT service was 51% in 2017/18 and 50% in 2021/22 (Clark, 2018; NHS Digital, 2022). The national recovery based on ethnicity from the 2021/22 data found that the recovery rate for white individuals was 50.8%, Asian individuals was 47.3%, Black individuals was 50.2%, Mixed individuals was 46.5%, and other ethnic groups was 45.3%. (NHS Digital, 2022). However, recovery outcomes between ethnicity groups were lower in more recent years (2023/24). Recovery for Asian individuals was 45.2%, Black individuals was 49.5%, Mixed individuals was 45.8%, and other ethnic groups was 43.9%,

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whereas white individuals had a 51.2% recovery outcome (NHS Digital, 2024). NHS Digital (2022; 2024) also provide further breakdowns for each specific subgroup, for instance Bangladeshi and Indian, which is advantageous to see how specific groups recover within the IAPT service. Recovery rates vary amongst IAPT sites due to structural and administrative influences such as waiting times, overload of the service, dose response (i.e., how many sessions offered), therapeutic approaches, for example, the chosen psychological treatment or if they utilise cultural adaptations (Delgadillo et al., 2014; 2016; 2017). Also, the variation of service user's demographic, which includes ethnicity, religion, culture, age, gender identity, and social-economic deprivation, can impact recovery levels (Gyani et al., 2013; NICE, 2017). Due to this, it presents a limitation in evaluating service equity across diverse populations.

In 2019/20, the IAPT service had 1.69 million referrals to psychological therapies, up 5.7% from 1.60 million in 2018/19 (NHS Digital, 2020) and up 17.3% from 1.44 million in 2017/18 (NHS Digital, 2019b). In 2019/20, 87.4% of patients started treatment within six weeks of being referred, which was a decrease of 2.0% from 89.4% in 2018/19. In the year 2019/20, out of the 1.69 million referrals, 606,192 completed the course of treatment, which is an increase of 4.1% from 582,556 in 2018/19. However, even though completion of treatment has risen, there was a 1% decrease in recovery levels. In 2018/19, patients that moved to recovery were 52.1% in contrast to 2019/20, patients' recovery were 51.1% (NHS Digital, 2019b; 2020). The suggested reasoning for the slight decrease in recovery could be due to the recent COVID-19 pandemic (Jia et al., 2020; Xiong et al., 2020), which may have put a strain on the IAPT service, disrupting the quality and reporting of the data (NHS Digital, 2020). In 2021/22, 1.81 million referrals were made, that was up 24.5% from 1.46 million in 2020/21 (with COVID-19 continuing to impact the results). Within six weeks, 91.1% accessed

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IAPT services in 2021/22 compared to 90.0% in 2020/21. There was a 4.6% increase from 634,649 referrals completing the course in 2020/21 to 664,087 completing in 2021/22.

Although, referrals that moved to recovery were 50.2% in 2021/22 compared to 51.4% in 2020/21 (NHS Digital, 2022). A similar trend of the referral rates to the IAPT service increasing from 1.83 million in 2023/24, up 4% from 1.76 million referrals in 2022/23 (NHS Digital., 2024). In 2023/24, there were 90.5% of individuals who accessed the IAPT service within the first six weeks compared to 89.3% in 2022/23. The completion of the course of treatment was down by 0.1% from 671,648 in 203/24 to 672,193 in 2022/23. Then a slight increase of 0.2% in recovery of 50.1% in 2023/24 compared to 49.9% in 2022/23 (NHS Digital, 2024). The full report for the recent data for 2024/25 has not yet been published.

### **2.1.3 Intersectionality and Mental Health Challenges**

Individuals from CED<sup>3</sup> groups are unrepresented and disadvantaged within the mental health sector (Arday, 2018; Arthur et al., 2010; Memon et al, 2016). Previous research suggests that CED groups are more likely to have higher rates of CMHDs in comparison to their white counterparts (Bhui & McKenzie, 2008; Equality and Human Rights Commission, 2016; Williams et al., 2007). Within Bailey et al.'s (2019) research, they stated that CED groups are more likely to have prolonged and debilitating types of depression that impact their daily functioning compared to white individuals. Additionally, the Adult Psychiatric Morbidity Survey found that any form of CMHD was highest in Black/Black British individuals with a rate of 24.0% compared to 16.9% in white British individuals (McManus et al., 2016). It is important to recognise the long-standing challenges (discrimination and

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<sup>3</sup> The term CED encompass individual's that identify as Black, Asian or Mixed/Dual-Heritage. The term CED was used rather than the acronym BAME due to the inadequacy and persistent agreement that BAME does not capture all individual's that identify as non-white (Aspinall, 2020; 2021).

racism) that CED groups experience within mental health services (Clarke-Jeffers, 2025; Williams & Rucker, 2000). Thus, it is imperative for IAPT services to ensure they are providing effective psychological therapy so that CED groups can recover, regardless of being more likely to have CMHDs or increased severity of symptoms (Memon et al., 2016; Stochl et al., 2022; Tuffour et al., 2019). However, it must be noted that there is a paucity of research, particularly pertaining specifically to the IAPT service, as well as the scarcity of psychological interventions that provide details on the cross-cultural disparity between CED and white individuals and their recovery. As a result, this literature review draws on broader mental health research to explore the challenges experienced by CED groups, which highlights the gaps and limitations within IAPT-specific literature.

Recognising stigma in isolation is harmful, as CED groups experience discrimination on more than one level. Discrimination is multifaceted and is categorised by the historical oppression of racism, sexism, classism, disablism and ageism that society uses to identify an individual or group (Brown & Moloney, 2019; Huang et al., 2020; Vines et al., 2017); this approach is known as intersectionality (Carbado et al., 2013; Cho et al., 2013). Also, the intersecting factors of one's social identity, '*who and what am I*' (Bamberg, 2011), can further inhibit their experiences within the health sector (Bauer, 2014; Bowleg, 2012; Hall et al., 2016).

Individuals from CED communities are more likely to experience a double and even a triple-stigma (or more) due to the compound disadvantages of co-occurring stigmatised characteristics that lead to unique challenges (Grey et al., 2013; Leamy et al., 2011; Mantovani et al., 2017). The double/triple stigma can relate to an individual's ethnic origin, culture, religion, identity, geographical location and the negative connotations of mental health that can discourage them from seeking help (Gary, 2005; Keating & Robertson, 2004).

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For example, in Black and Asian communities, there is often a cultural stigma that labels mental illness as disgracing the family or spiritual weakness, which can discourage seeking help due to the stigma (Matthews et al., 2006; Misra et al., 2021; Ran et al., 2021).

Furthermore, Misra et al. (2021) systematic review outlined four cultural themes, such as public, structural, affiliative and self-stigma amongst CED groups (Asian, Black Americans and Latinx Americans). Misra et al. (2021) emerged themes included aspects such as the lack of knowledge about mental health (public stigma), how to access mental health services and if good quality of treatment will be provided (structural stigma), being a burden to others (affiliative stigma), and maladaptive emotional coping mechanisms (self-stigma). All the specific types of double/triple-stigmas experienced, particularly relating to an individual's ethnic and cultural identity, can significantly impact CED groups. Such stigma can increase the likelihood of CED individuals being deterred from seeking help, which may explain why mental health rates go underreported and why the severity of symptoms is frequently greater by the time they access health services (Corrigan et al., 2014; Warden et al., 2009). Additionally, experiencing an array of barriers, such as language barriers with a lack of translators available, minimal ethnic representation, culturally insensitive treatment, long waiting times, and receiving inadequate treatment, can lead to poor engagement and outcomes when individuals finally receive psychological interventions. The barriers experienced suggest reasons why CED groups may be less likely to participate in or drop out of psychological treatment or research (Baker, 2020; Kohn-Wood & Hooper, 2014; McGuire & Miranda, 2008; Naz et al., 2019; Nazroo et al., 2020).

Furthermore, the type of stigma experienced by CED groups may be perpetuated by the lack of trust in the mental health system (Corbie-Smith et al., 2002; Snowden, 2003).

The mistrust in the system can be attributed to the institutional and systemic racism,

discrimination, and prejudice within the services (Alang et al., 2020; Hackett et al., 2020; Samra & Hankivsky, 2021; Nazroo et al., 2020; Williams & Rucker, 2000). Black people are four times more likely to be detained under the Mental Health Act (GOV.UK, 2021a), more likely to be in inpatient users in compulsory detention (Department of Health, 2005) and receive inadequate doses of treatment (Fortuna et al., 2010). Also, a disproportionate number of Black African/Caribbean people are more likely to die in detention centres (GOV.UK, 2018a). As highlighted, having preconceived ideologies can negatively impact how CED groups are diagnosed and treated, solely based on their ethnicity and culture (Henderson et al., 2013; Mays et al., 2007). Taylor and Richards (2019) portrayed the triple jeopardy of being a young, Black woman trying to seek mental health support. Being associated with multiple marginalised identities can increase individuals' fears of being further stigmatised. Thus, these biases can exacerbate mental health problems amongst CED individuals, therefore, making it harder for them to seek or be cautious to accept help (FitzGerald & Hurst, 2017; Vidourek et al., 2014; Williams, 2018).

Similarly, intersectionality is crucial to recognise, as the literature pertaining to the effectiveness of mental health interventions for CED groups is limited. With research being heavily conducted on white participants, the way mental health is assessed, diagnosed, and treated is through a white lens that CED groups are measured against, which is not generalisable (Alarcón, 2009; Alcántara & Gone, 2014; Dadlani et al., 2012). The ethnic disparities in receiving treatment are yet to improve (Cardemil et al., 2015), which warrants equitable provision for individuals with protected characteristics. Thus, it is quintessential to gather data on how the IAPT service supports and delivers treatment to underrepresented ethnic groups to enable recovery. This further elucidates the increased need for cultural competency to reform mental health services. Factors such as language, geographical

location, religion, ethnically diverse staff, and gender-specific support (Grey et al., 2013; McKenzie & Bhui, 2007; Raleigh et al., 2007) may be beneficial to address intersectionality in mental health research. Understanding intersectionality can help avoid the erasure of individuals with multiple identities, hence can allow researchers to have a deeper perspective into the CED communities' interlinked experiences of discrimination. Listening to and understanding unrepresented groups allows their voices to be heard (Edge, 2013), which can help health professionals render inclusive practices for CED groups. Hence, for this reason, this project used a mixed-method approach to capture and understand the nuanced perspectives of CED service users within the IAPT service. There is a particular focus on CED individuals' identities, because these have not been comprehensively examined by prior literature; therefore, this thesis will help illuminate critical gaps.

#### **2.1.4 Self-efficacy and Help-Seeking Behaviour within Mental Health**

Self-efficacy is an individual's belief and confidence in their capability to successfully achieve or perform well in a task or situation (Bandura, 1982). Self-efficacy is a social cognition component and an essential prerequisite for behaviour change (Holloway & Watson, 2002). Thus, high levels of self-efficacy posit that an individual's confidence levels are heightened. Which can determine individuals to put in more effort to complete a task (Bandura, 1977). As previously mentioned, for individuals to engage with the IAPT service, they can self-refer directly rather than making an appointment with their GP. High levels of self-efficacy can be beneficial for individuals to self-refer because it requires individuals to reflect on their mental health to then be motivated (Bandura, 1986) and have the confidence to reach out for support (Clarke et al., 2014; Florer, 2015; Mohebi et al., 2013; Umubyeyi et al., 2016; Wiljer et al., 2016). Clark (2011) found that self-referrals to the IAPT

service were frequent amongst CED groups. Individuals from CED communities may opt for self-referral, where their levels of self-efficacy may be higher when they do not have to physically visit their GP, where they may experience feeling marginalised. Individuals may feel marginalised because of their perceived identities, such as their ethnicity, culture, gender, educational and socio-economic status (Hui et al., 2021; Seng et al., 2012). Or if they have been previously dismissed when seeking professional provision (Liang et al., 2016; Memon et al., 2016). Evidence from the National Institute for Mental Health (2003) found that GPs are less likely to detect mental illness in African Caribbean and South Asian groups (Husain et al., 1997; Miranda & Cooper, 2004). Individuals from a South Asian background are more likely to have higher rates of psychosomatic pain (Bhui & Bhugra, 2001; Bhui et al., 2004; Jacob et al., 1998). Psychosomatic illness is onset by psychological stress, which is manifested as physical symptoms such as fatigue, chest pain, dizziness, and headaches (Bhugra & Mastrogianni, 2004; Mukherji, 1995; Patel et al., 1998). Research has found that it is typical for South Asians to express their experience of mental health in the format of psychosomatic pain rather than Westernised depressive symptoms (Bhui et al., 2002; Karasz et al., 2019; Mallinson & Popay, 2007; Mooney et al., 2016), thus making it difficult for GPs to diagnose and adequately treat individuals (Lai & Surood, 2008; Williams et al., 2015). With GPs finding it challenging to diagnose mental health, in addition to the perceived prejudice and discrimination experienced by CED groups, the option of IAPT's self-referral system is salient so that CED groups do not feel excluded from seeking help or being misdiagnosed.

Conversely, Thomas et al. (2020) conducted a qualitative study and found that low-income patients expressed that the IAPT service self-referring process is a daunting

experience. One theme that arose in Thomas et al.'s (2020) study surrounded the 'Obstacles of Self-referring'. Participants expressed that self-referring when already feeling mentally distressed and overwhelmed by additional external life factors (low income, benefits and household bills) exacerbated feelings of isolation to complete their journey to 'recovery' that further added to their distress. One participant from the study explained that "*Self-referring is a very hard process for somebody with mental health issues [...] difficult unless you have that extra push*" (Thomas et al., 2020, p.708), which emphasises how individuals find the self-referral process can be a hindrance and difficult to do alone. The study found that over 40% of participants who were advised to self-refer did not act on this recommendation. One reason not to self-refer is that individuals are unsure if they are worthy of seeking support if they do not deem their mental health experiences as severe, or if they are unsure how to navigate the self-referral process without support from a trusted source like their GP. Thus, reinforces the significance of self-efficacy within health to provide individuals with the confidence to reach out for support. Moreover, the self-referral process for low-income patients may be a barrier if they do not have the appropriate resources, like a phone, a laptop, and internet access (Thomas et al., 2020), which may prevent individuals of low socio-economic status from using the self-referral process. Furthermore, Harwood et al. (2021) IAPT research supports the notion of CED groups being less likely to self-refer in comparison to white service users; rather, it was typical for CED groups to be referred through community services. Thus, showing variations in how CED groups are likely to refer themselves or be referred to the IAPT service.

The IAPT service or other mental health services are not always the first point of call for individuals when experiencing poor mental health. Typically, CED groups may reach out

for mental health support within their local community, such as religious leaders or friends/family members (Codjoe et al., 2013, 2019; Fallot, 2001). Help-seeking behaviour through the community may be based on CED groups having historically experienced racism, discrimination, poorer access and health outcomes from mental health services (Department of Health, 2011); that may deter them from seeking professional help (Arday, 2018; Conner et al., 2010a; Noonan et al., 2016; Nuriddin et al., 2020). Evidence shows that for some Black individuals, seeking support from the community, in particular religious leaders, is beneficial (Ellison & Flannelly, 2009; Nguyen, 2020). Rather than seeking professional support, religion can be a protective barrier to aid the healing process for their mental health (Lukachk et al., 2015; Taylor et al., 2011a). Therefore, higher levels of self-efficacy may be achieved by community-based help-seeking behaviour. For instance, Black African/Caribbean groups are more likely to seek help from clergy as they view their clergy as a trustworthy ally due to regularly attending church (Rogers, 2013; Taylor et al., 2011b).

Conversely, using religion as a coping mechanism may impede mental health recovery. Mantovani et al. (2017) interviewed Christian UK men and women of African descent. Mental illness was viewed as a '*curse*' from the '*devil*' or an '*evil spirit*' that needed to be exorcised out of them, or by using prayers to take the illness away. Similarly, Knifton et al. (2010) found that amongst the South Asian community, mental health was viewed negatively as '*black-magic, jinn* or a *punishment from god*'. Participants expressed that the illness was due to being spiritually '*weak*' and not having enough '*faith*' (Mantovani et al., 2017). Religion can be used to place blame on the individual for their mental illness; this can be demoralising and can amplify the stigma that can progressively make an individual's mental illness worse (Mantovani et al., 2017) and lower levels of self-efficacy to seek

professional support (Moore et al., 2015; Tomczyk et al., 2020). Therefore, if individuals from religious backgrounds are aware that there are health professionals who can accommodate to their needs of integrating religion or spirituality in the treatment process, this may aid their recovery, due to religion being central to their lives. Hackney and Sanders (2003) support the notion of psychotherapists' involving religion in their therapy. Hackney and Sanders (2003) meta-analysis on religiosity and mental health concluded that there are practical implications if psychotherapists understand and incorporate aspects of their service users' religious beliefs to improve psychological outcomes.

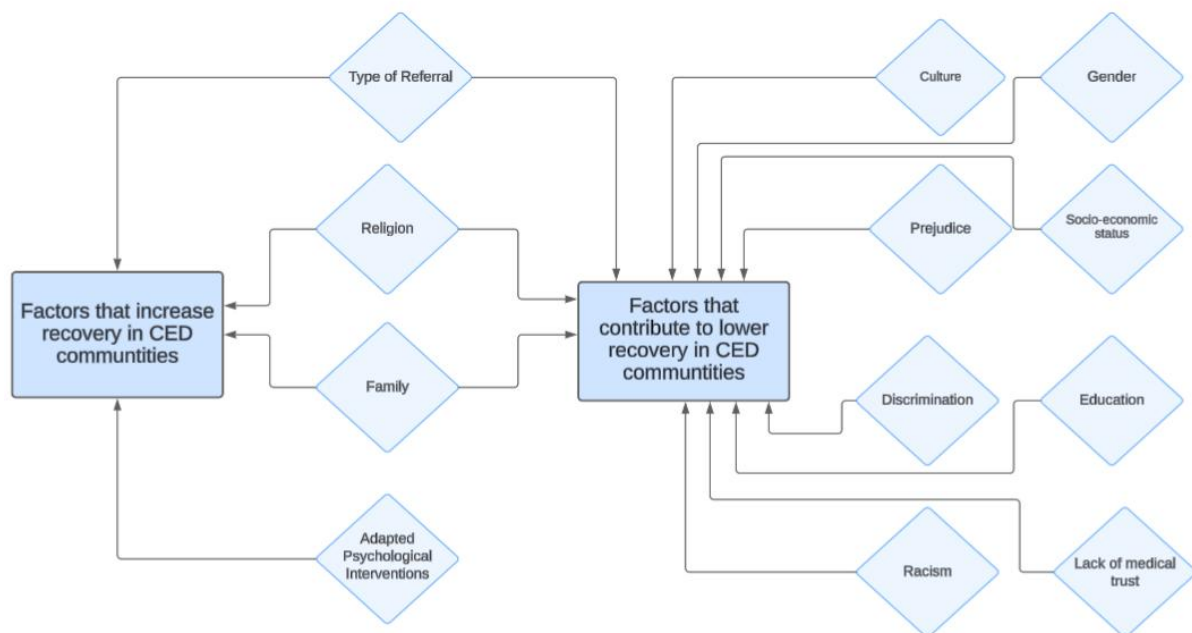
### **2.1.5 Psychological Interventions**

The Biomedical model is commonly used in the healthcare sector to diagnose and treat individuals from a biological perspective (Deacon, 2013). The Biomedical model is viewed as a flawed approach as it suggests that the mind and body are separate entities that do not interconnect (Burnett-Zeigler et al., 2016; D'Silva et al., 2012; Mehta, 2011). However, the Biopsychosocial model (Engel, 1977) combines biological, psychological, and social factors that provide a holistic approach for treating individuals (Muntinga et al., 2016). Considering all aspects of an individual is imperative to help determine what factors may hinder and/or promote participation, accessibility to mental health services and adherence to best support an individual's recovery trajectory (Llewellyn-Beardsley et al., 2019). Based on previous literature (Conner et al., 2010b; Naz et al., 2019; Nazroo et al., 2020; Yakeley, 2018), in conjunction with understanding the relevance of having a holistic (biopsychosocial) approach within healthcare, the PhD researcher has proposed what variables should be considered when clinicians aim to understand what may facilitate or inhibit service users' recovery, especially those from a CED background (See figure 2.1).

Williams et al (2015) support the notion of the multidimensional approach needed when treating individuals with mental health to improve health outcomes.

**Figure 2.1**

*Factors That Facilitate and Inhibit Mental Health Recovery for CED Communities.*



The IAPT service is acclaimed for providing evidence-based psychological treatments rather than providing medication (only in steps four and five) to treat their service users, thus incorporating elements of the biopsychosocial model. Within IAPT, *'treatment as usual'* typically refers to evidence-based interventions such as CBT that are commonly used to treat anxiety and depression by challenging individuals' maladaptive thoughts to rational thought patterns (Beck, 1963; 1976) to aid behaviour change (Blease, 2015). However, some evidence shows that CED groups are less likely to be offered and receive the recommended number of sessions for CBT compared to their white counterparts (Das-Munshi et al., 2018; Morris et al., 2020). Furthermore, CED groups are more likely to have higher symptom

severity rates of CMHDs than white individuals (Stochl et al., 2022; Tuffour et al., 2019). CED groups receiving inadequate care and having higher initial symptomology can provide suggestions towards the lower recovery rates in the IAPT service (46.7% compared to 51.7%; Moller et al., 2019).

Though if CED service users are offered the appropriate level of care, there may be implications in completing the intervention. For instance, the process of CBT involves the service-user being proactive by completing homework (Mausbach et al., 2010) that involves practising cognitive and behavioural skills learnt in their session (Hayasaka et al., 2015). Completing homework, such as symptom logging or a reflective journal to identify their thoughts (Tang & Kreindler, 2017), may be difficult for some CED service users. Groups from CED backgrounds are more likely to be in labour-intensive and lower-paid jobs compared to their white counterparts (GOV.UK, 2021b). Therefore, it may not be achievable if substantial time is needed to complete the homework (Helbig & Fehm, 2004). Additionally, in the assessment and formulation process, if clinicians do not fully understand CED service users' beliefs and values (due to a lack of cultural competency) for instance, how significant religion is for them, the role of the family, language, and how an individual perceives mental health this can impact the treatment trajectory (Corrie et al., 2015) and the therapeutic relationship (Wilmots et al., 2019). Building a strong therapeutic relationship is necessary and can act as a prelude for successful CBT implementation to aid with adherence and recovery (Weck et al., 2015).

To increase recovery and inclusivity, Beck (2016) posited the importance of culturally sensitive/adapted CBT. Culturally sensitive CBT is when the core model of CBT remains unchanged. However, the therapist ensures they are sensitive and respect the service users'

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

cultural values and norms. As well as adjusting their language and communication style so that it is suitable for the specific service user, which should be modified on a case-by-case basis. Conversely, CA CBT modifies CBT so that it is better suited to fit the cultural context of the service users. The clinician may change aspects of the therapy, such as incorporating their religious beliefs, community, translating material and using examples that are similar to the client's socioeconomic context to increase their understanding (Beck, 2016).

Culturally sensitive/adapted CBT retain CBT's traditional components but provides an emphasis on contextual factors such as cultural values, discrimination, socio-economic status, literacy level and migration history. Thus, culturally sensitive/adapted CBT interventions are invaluable as they consider an individual's cultural background that may reduce symptomology and increase treatment adherence for CED groups (Benish et al., 2011; Griner & Smith, 2006; Kalibatseva & Leong, 2014; Rathod et al., 2013).

Within the IAPT service, there is a lack of cross-cultural validity of psychological therapies, such as the adaptation of CBT for CED groups. Few programmes have been concerned with the inclusion of CED individuals. However, one exemplar, the Birmingham Healthy Minds IAPT service, provides a service to a CED population of 28.79%. For these individuals, the intervention service delivered has been CA for South Asian women, which promotes not only access but also recovery rates. The IAPT service aims to increase the number of service users having access to be treated with evidence-based interventions (NHS, n.d.a), and the aid of cultural adaptations can increase the likelihood of CED groups recovering (NICE, 2017). As discussed, the Birmingham Healthy Minds IAPT is an exemplar service that has adapted interventions to the cultural, ethnic, and spiritual beliefs of South Asian women in an attempt to enhance treatment-based positive mental health outcomes.

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Besides intervention factors, the service further considers the willingness of the individual to initially seek therapy; for example, treatment is held in community centres in order to reduce the stigma associated with treatment in a medical setting (O'Mara-Eves et al., 2013; Prajapati & Liebling, 2021). Additionally, within the Birmingham Healthy Minds IAPT service, they ensured that the Psychological Well-being Practitioner (PWP) could speak Hindi, Urdu, Punjabi or Bengali in addition to English, as some South Asian service users may not speak fluent English or be able to confidently convey their feelings and experiences. One of the interventions delivered by Birmingham Healthy Minds IAPT service was the step two, low-intensity interventions such as psycho-education groups for depression, anxiety, stress, panic, pain management and sleep hygiene aimed at the South Asian population. It was necessary to include pain management in the treatment process because it is typical for individuals within South Asian communities to express psychosomatic pain when describing mental health (Bhui et al., 2004; Mallinson & Popay, 2007; Mooney et al., 2016). The psychosomatic pain is often neglected by GPs when diagnosing for mental health due to it not being commonly understood in westernised cultures (Dzokoto, 2010; Ma-Kellams, 2014; Williams et al., 2015). Thus, the adaptation of including pain management within the service is important to help with the recovery process. In addition, within the psycho-education groups, the therapist adapted behavioural activation techniques, for instance, religious practices like time for service users to do prayers when needed and creating pictographic diaries using magazine cut-outs rather than writing. The analysis showed that 54% of the South Asian women in the low-intensity group had recovered, and the qualitative feedback from the service users stated that the programme aided in improving pain management, reducing headaches and social isolation. The programme highlighted the effectiveness of cultural adaptations for South Asian women with mild to moderate symptoms of anxiety

and depression. The Birmingham Healthy Minds IAPT service emphasised the need for similar workshops to be implemented across the UK IAPT services to address the gap of tailored interventions that are beneficial to aid recovery in CED groups (Arundell et al., 2024; NICE, 2017).

Due to the dearth of cultural adaptation of interventions within the IAPT service, there is a vast amount of literature external to the IAPT service supporting the benefits of adapted interventions. Albeit the following referenced studies are not from the last decade, it should be stated that there have not been recent studies that are interventions or outline and highlight the specific adaptations involved that particularly focus on CED groups. Rather than the recent studies, such as Degnan et al. (2018), Naeem et al. (2016; 2019), and Rathod et al. (2018), support the benefits of cultural adaptations, outline the general guidance for CA and the effectiveness of adaptations being implemented to support individuals when receiving psychological therapy. Naeem et al. (2024) conducted a meta-analysis, out of the 22 studies included, they stated: *“Only one review compared adapted versus unadapted interventions”* (p.4), which dated back to 2009. Also, their review also, acknowledged that *“Most RCTs of culturally adapted therapy do not give the details of adaptation”* and *“a need for a high-quality meta-analysis, as the current literature is almost 10 years old and consists of various psychosocial therapies from a wide range of theoretic backgrounds”* (p.12). Thus, emphasising the difficulties in obtaining present research on CA interventions.

Previous studies, such as Interian et al. (2008), provided CA CBT to 15 Hispanic patients with major depression. The CA CBT incorporated an ethnocultural assessment to comprehend the cultural context and values of the participants (Comas-Diaz & Jacobsen, 2010). To complement using an ethnocultural approach, the questionnaires and

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intervention were conducted in Spanish, which helped gain a therapeutic alliance as the therapist and client shared a mutual understanding of the same language, which helped the client to complete the required assessment. In post-treatment, they found that there was a significant decrease (57%) in depression scores and somatic symptoms. The reduction in depression scores was retained for six months (54%) following the baseline, which was statistically significant. Similarly, Kanter et al. (2010) study implemented cultural adaptation, this time for Behavioural Activation amongst 10 Latina women with depression. The adaptation initiatives included free or low-cost activities such as walking, borrowing DVDs, community groups and recreational clubs. Based on the Beck Depression Inventory-II questionnaire, remission is categorised as scoring below 10 (Dimidjian et al., 2006), in which 60% of participants achieved remission after the 12 sessions. Thus, both studies (Interian et al., 2008; Kanter et al., 2010) showed the benefits of CA interventions from a Hispanic and Latino community.

Research by Kohn et al. (2002) provided traditional CBT ( $n = 10$ ) or CA CBT ( $n = 8$ ) to 18 low-income African American women. The focus of the adaptation material was on religion, family, identity, and relationships. The women worked as a group to complete the therapy exercises, such as non-judgmentally exploring faith and sharing practices. Additionally, to build upon their identity, the intervention also included the deconstruction of Black women stereotypes and presenting images of Black role models. The topics allowed the women to explore the stigma and pressures projected on them from society. The discussions allowed them to freely express their mental health experiences to aid in improved outcomes. Thus, the women in the CA CBT group showed a greater reduction in depressive symptoms compared to the traditional CBT group (-12.6 vs. -5.9 on Beck

Depression Inventory). Both studies show that CA CBT is advantageous for CED to improve mental health outcomes.

A more recent study by Naeem et al. (2015) randomly allocated 137 participants from Pakistan to either CA CBT plus Treatment as Usual (TAU) or to the TAU-control group. The TAU involved regular hospital visits as well as prescribed medication. In the CA CBT interventions, this involved adaptations such as a session for the whole family to attend, participants being encouraged to attend sessions even if they did not finish the homework, also translations into Urdu were provided for jargon CBT words. Assessments were taken at baseline, three and nine months. The treatment group presented statistically significant improvement in depression and anxiety from baseline that continued at the nine-month assessment compared to the control group. Also, participants in the treatment group reported higher satisfaction and were more likely to recommend CA CBT to others. This study revealed that CA CBT is useful amongst the Asian community and provided an insight into how useful it is in ethnically diverse and low-income countries.

The studies aforementioned that examined CA CBT have shown promising results on how including adaptations based on CED communities' culture can improve mental health outcomes. The importance of incorporating cultural beliefs in treatment is supported by the 'Explanatory Models of illness' (Kleinman et al., 1978). The model posits that the process of understanding one's illness, severity, and how to respond (help-seeking behaviour) and treatment is influenced by an individual's cultural or religious beliefs (Khan et al., 2019; Kleinman, 1980; Kleinman et al., 1978; Lynch & Medin, 2006). This model has multi-layered constructs that integrate an individual's demographics, and the personal and social meaning of how the individual perceives and attributes their illness (Ghane et al., 2010; Kleinman &

Gale, 1982). Comas-Díaz (2011) stated that during case formulations, therapists can use the Explanatory Models of illness to improve their cultural empathy skills. Understanding an individual's demographic, personal and social beliefs about illness can subsequently inform practitioners on how they can appropriately diagnose and deliver mental health treatment to CED groups (Dinos et al., 2017). Therefore, the IAPT service should consider implementing cultural adaptations such as the role of family members participating in the sessions, adapting the language, religion, and spirituality (Degnan et al., 2018; Naeem et al., 2016; 2019, Rathod et al., 2018; 2019) into practice to improve patients' outcomes.

Research has shown the significance of cultural adaptation interventions and the frameworks to support the benefits of therapists considering different cultural aspects (Naeem et al., 2023). However, there are issues raised when translating the adaptations into practice. Firstly, the therapist needs to be aware of their implicit biases (Chapman et al., 2013; FitzGerald & Hurst, 2017; Hall et al., 2015); which are influenced by their own cultural background, in order to understand that their clients may have different spiritual values and religious beliefs from themselves (Blair et al., 2011; Boysen, 2006; Cooper et al., 2012; Greenwald et al., 1998). After the initial rapport has been established, Beck (2016) highlighted that therapists need to feel comfortable discussing issues regarding racism, ethnicity, cultural beliefs, and religion. To strengthen the therapeutic rapport, in a qualitative study by Fuertes et al. (2002), European therapists who addressed race-related issues and identity with their clients within the first two out of 12 counselling sessions built a trusting relationship. Evidence emphasises that establishing a conversation about race and ethnicity is a central component of therapy (Drustrup, 2021), especially when the therapist and clients are from opposing backgrounds to deepen therapeutic outcomes (Cardemil &

Battle, 2003; Meyer & Zane, 2013; Thompson et al., 2004). Although, it can be challenging for some white therapists to discuss topics around race, which can lead to the therapist avoiding the conversation, or they may misconstrue individuals' cultural beliefs or how the service users display their mental health symptoms (Day-Vines et al., 2016; Naz et al., 2019; Smith et al., 2021). However, avoidance behaviour only emphasises white privilege (Grzanka et al., 2019) and '*perpetuates racism*' (Brown, 2008, p. 59). Hence, it is vital that the therapist needs to be culturally competent to confidently discuss race, ethnicity, and culture to improve the quality of therapy provided for their clients (Handtke et al., 2019; Qureshi, 2020; Qureshi & Eiroa-Orosa, 2013).

### **2.1.6 Enhancing Inclusivity and Effective Practices within IAPT**

Understanding and applying the concept of intersectionality (multiple social identities, such as race, gender, and socio-economic status, that intersect to bring privileges and/or disadvantages that influence individuals' experiences) can play a crucial role in enhancing the recovery of CED groups within the IAPT service (Barnard & Turner, 2011). Organisations such as the APA<sup>b</sup> and the British Psychological Society (BPS) have good practice guidelines to understand the cultural diversity within the mental health sector (Gopalkrishnan, 2018). The APA<sup>b</sup> (2017) Multicultural Guidelines set out to understand the intersectionality of multiculturalism in consultation and practice. Similarly, the BPS (2018) acknowledges that cultural diversification is integral in practice to help service users' recovery (Ade-Serrano et al., 2017). However, the NICE, CG136 (2011b) and CG178 (2014) guidelines emphasise that healthcare practitioners lack experience working with service users from diverse ethnic, cultural, and religious backgrounds. Inexperience can make it challenging for healthcare professionals when consulting and providing appropriate

treatment, which can impede CED service users' engagement and recovery (Brown, 2018; Harrison et al., 2019; NICE [CG90], 2009).

The IAPT '*Five Year Forward View for Mental Health*' is a strategic plan which is due to be reviewed in 2020/21.<sup>4</sup> The aim of the plan is to evaluate the quality of care, the effectiveness of the service, and to narrow the treatment gap for mental health (HM Government, 2017, NHS, n.d.b). The IAPT service had a target of getting a minimum of 50% recovery of all individuals completing low or high-intensity treatment; this was achieved in 2017 (NCCMH, 2018). Individuals with anxiety and depression who accessed the IAPT service increased by 380,000 per year, which is set to increase to 1.9 million by 2023/24.<sup>5</sup> (NHS, n.d.a). With the rates of individuals accessing the IAPT service rising, the IAPT service needs to recognise that even though the IAPT programme has successfully achieved its 50% target, the level of recovery needs to increase, especially for CED communities.

To address the health inequalities amongst CED communities, the IAPT service implements good practice guidelines by enforcing appropriate values, based on '*Delivering Race Equality*' (DRE) in mental health training (Department of Health, 2005). The training addresses cultural inequalities (NHS, 2009) such as '*non-discriminatory practices*,' '*respecting difference*' and '*recognising unconscious racism*'. The activities incorporate watching videos, reading case studies, and group discussions (Bennett et al., 2007). Having DRE training allows clinicians to understand if they have any implicit biases that could impact how they assess and treat CED service users. Also, cultural competency training has the capacity for clinicians to improve their knowledge, dissect their attitudes and own

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<sup>4</sup> The document stated that it would be reviewed in 2020/21; however, no updated information or public findings appear to be available online as of the time of writing.

<sup>5</sup> The public findings were not available when checked in March 2025.

cultural beliefs that will enhance their self-esteem thus allowing them to make better-informed health decisions for their clients (Kaihlanen et al., 2019).

Additionally, the importance of having confident clinicians who understand different cultures and can acknowledge the different needs between CED groups can aid the treatment process (Alizadeh & Chavan, 2016; Campinha-Bacote, 2002; Shen, 2015). The cultural competencies learnt by the clinicians can translate into practice to enable service users to feel at ease to have open discussions about culturally related issues (Kaihlanen et al., 2019). Meyer and Zane (2013) found that CED groups were more likely to emphasise the importance of being able to discuss issues around ethnicity and race in therapy sessions in comparison to white service users. Also, CED groups in particular were more satisfied with their treatment when elements pertaining to cultural elements were evident in their sessions. Hence, it is beneficial for clinicians to create a safe space to have these conversations to aid the therapeutic process.

An additional factor that can allow some CED service users to feel at ease is if the workforce mirrors and is representative of their ethnicity, culture, religion, and values, which can help enhance the delivery of the assessments and treatments (NHS, 2009). For example, the West Midlands has the second highest ethnically diverse population mix in the UK, as 43.8% is from a CED group according to the 2011 census (GOV.UK, 2018b); thus, the IAPT clinicians in this area are more likely to depict similar cultures and faiths from their local community. Nevertheless, it is imperative not to automatically assign CED service users to CED therapists. All therapists must have the cultural competencies to deliver appropriate treatment to CED service users (Beck et al., 2019). To emphasise why all clinicians should be trained, Anand and Cochrane (2005) indicated that individuals from a South Asian community do not always want to be assigned to clinicians from the same ethnic

background because they fear being judged or assumptions being made due to sharing the same socio-cultural background. Although Gurpinar-Morgan et al. (2014) found that having ethnically similar or dissimilar therapists had both strengths and weaknesses. The mixed findings emphasise that having the option of therapists from different ethnic backgrounds is favourable and should be encouraged. Nonetheless, clinicians need to be sensitive when obtaining information on service users' beliefs and experiences to improve the therapeutic alliance. PettyJohn et al. (2020) postulated that strengthening the therapeutic alliance can help with having conversations about their intersecting social identities, which aids in creating an understanding of who that individual is and their needs. Similarly, Beck (2016) proposed that raising questions about ethnicity and culture in the assessment and formulation is pertinent to establishing a therapeutic relationship. Therefore, building a bond can increase the service users' self-efficacy to engage in the treatment, leading to positive therapeutic outcomes (Ardito & Rabellino, 2011; Gabbert et al., 2021; Urbanoski et al., 2012).

Furthermore, delivering cultural competency training such as DRE is auspicious to provide cultural competencies to health professionals to improve treatment outcomes for CED service users (Yon et al., 2018). However, there is inadequate research into the long-term effectiveness of the training in practice (Beach et al., 2005). Tamkin et al. (2003) surveyed employees who completed cultural competency training, 84% reported that the training raised beneficial race and cultural issues. Whilst 33% of employees stated that the training could aid behaviour change. The findings highlight that the training does create awareness; however, it does not necessarily lead to health professionals successfully implementing changed behaviour during clinical practice. As a result, health professionals may struggle to effectively support CED service users in practice. This questions the

effectiveness of the cultural competency training provided. Instead, a shift towards cultural competency-based training providers on how they design and implement their training needs to be considered. The re-evaluation of how the training is delivered can allow for the successful integration of knowledge and behaviour change to support health professionals appropriately support CED service users (McCalma et al., 2017).

Acknowledging the limitations of cultural competency training, it is important to note that the IAPT service has endeavoured to increase inclusivity and accessibility to its services through additional avenues. Accessibility is being targeted as there are IAPT service localities that have therapists who are proficient in a second language and interpreters to enhance engagement (Beck et al., 2019). Furthermore, the service is inclusive through self-referrals to make appointments via the online system, which allows service users to use translation apps to overcome any language barriers to access key information (Beck et al., 2019). Additionally, therapists provide service users with leaflets about their local community and faith groups for continued support after they have completed their IAPT sessions (NCCMH, 2018). The evidence of good practices shows that the service is trying to target specific barriers, such as language and community provision for CED service users.

However, even though the IAPT service is implementing inclusive elements, Moller et al. (2019) indicated that the recovery rate of CED groups is not comparable to that of white service users. The recovery rates in 2017/18 for white IAPT service users were 51.7%, whereas for CED groups it was 46.7% (Moller et al., 2019). In 2018/19, the recovery rates had a small increment, with 53% recovery for white individuals and 46% for CED backgrounds (Baker, 2020). In more recent publicised IAPT data, they have provided a breakdown amongst specific CED groups on recovery. In 2021/22 individuals from a white background had a recovery range of 50.7-51.7%, from an Asian background it was 43.4-

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51.5% (though individuals from a Chinese background had the highest recovery of 55% in that year), Black background 47.5-51.1%, Mixed background 45.1-48.2% and Other background was 43.4% (NCCMH, 2023). The lower recovery rates amongst CED groups (besides those from a Chinese background) show unjust health inequality outcomes (Equality Act, 2010), thus reinforcing this unique research to explore why CED service users are less likely to recover in the IAPT service.

Moreover, the IAPT mental health service does not have integrated psychological therapy provisions that take into consideration intersectionality issues (Dixon, 2019; Turan et al., 2019; Van Brakel et al., 2019). The treatment in the IAPT service undertakes a psychological stance, silo-sterilised from the ethnicity, cultural, social, and gender-related identities of service users they assess and treat (Beck & Naz, 2019; Bhavsar et al., 2021; Harwood et al., 2021; NCCMH, 2018). The limited consideration of understanding the multiple identities (Lloyd et al., 2021; Roy-Chowdhury, 2013; Williams, 2015) that the service users at the IAPT service hold reiterate the salience of this study to explore and intersect the issues behind CED communities not recovering as successfully as white service users (Moller et al., 2019) through the means of quantitative and qualitative analysis (Bishop & Holmes, 2013; Creswell et al., 2017).

### **Current Study**

In summary, the literature has shown that individuals from CED backgrounds experience a plethora of barriers to seeking mental health support and recovering (Grey et al., 2013; Leamy et al., 2011; Mantovani et al., 2017). Within the IAPT service, CED groups are disproportionately less likely to recover in contrast to non-CED service users (Baker, 2020; Moller et al., 2019). Such as 50.7-51.7% for individuals from a white background and

between 43.4-51.1% for CED individuals (besides Chinese individuals) (NCCMH, 2023). The literature surrounds aspects such as stigma that are extensively linked to racism and discrimination (Nazroo et al., 2020; Nuriddin et al., 2020) that impact recovery. This thesis has a particular focus on cultural competency, which includes the element of psychological adaptations (Jongen et al., 2018; Kohn-Wood & Hooper, 2014), diversity and representation (Vukic et al., 2016). As well as being religious or not (Lukachk et al., 2015; Nguyen, 2020), the way an individual is referred (GP and self-referral) to the IAPT service (Harwood et al, 2021) and an individual's culture and identity (Bauer, 2014; Bowleg, 2012). The rationale for the thesis is to understand the contributing factors for why CED individuals are less likely to recover in the IAPT service compared to white service users. Being aware of the multiple factors that interplay will then help to dissect and address the shortfalls and what specific areas need to be considered to help close the health inequality gap, so that equitable change is made. Thus, the general aim of this thesis is to explore through both qualitative and quantitative approaches the multiple factors that contribute to the disparity that hinders CED individuals from recovering. The research questions for each study are as follows:

1) How do clinicians perceive diversity, representation, and cultural competency in the IAPT service? (Study one)

1a) What are clinicians' perspectives and strategies for improving recovery outcomes for CED groups? (Study One).

2) What are CED experiences and satisfaction with receiving treatment in the IAPT service? (Study Two).

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3) How do cultural and psychological factors of autonomy contribute to mental health disparities between CED and white service users who have been treated for 3-12 months? (Study Three).

4) How do religious affiliation and referral pathway type impact mental health outcomes between CED and white individuals in the IAPT service? (Study Four).

Each study chapter provides a brief overview of what the specific study entails and what was found. See Chapter 4 for Study One, Chapter 5 for Study Two, Chapter 6 for Study Three and Chapter 7 for Study Four.

### **Chapter 3. General Methodology**

This study employed a mixed-methods approach using a sequential exploratory design (Creswell et al., 2003) to evaluate the IAPT service for CED communities. Mixed-methods research has gained significant traction in the health sector due to its ability to combine empirical data with rich contextual insights (Albright et al., 2013; O’Cathain et al., 2007, 2008). The integration of qualitative and quantitative methods allowed for a comprehensive analysis at both macro-clinical and individual levels (Aldridge et al., 1999). Quantitative methods provide robust empirical measurements to identify trends and disparities in recovery rates. Simultaneously, qualitative methods amplify participants’ voices (to have an active voice in the research), offering nuanced perspectives on the complex social, cultural, and psychological factors influencing health outcomes (Tariq & Woodman, 2013). Given the persistent disparities from previous research in recovery rates among CED groups, a mixed-method approach was suited for this thesis to explore the contributing factors behind the inequalities and identify potential improvements within IAPT services.

#### ***3.1.1 Sequential Exploratory Process***

The thesis was organised into four sequential phases, whereby the earlier phases helped to inform and shape the later phases (See, Figure 3.1). The research started off with qualitative explorations, and then the later phases used quantitative methods to empirically measure aspects that emerged from the qualitative phases. The findings were not isolated, rather a continuous flow across the phases that is the underpinning of a sequential mixed-methods design.

Phase one (study one) was qualitative research to explore clinicians' experiences within the IAPT service on topics surrounding representation, cultural competency,

disparities and service users' barriers. Study one provided a foundation for the thesis, especially towards the aspects of understanding the challenges that service users, particularly those from a CED background, experience. Thus, before directly speaking to CED service users in the first instance, the interviews with clinicians helped to provide an insightful perspective on the direction of the next phase. Before moving on to phase two (study two), it is important to note that during the phase one process, within the first few interviews, it was highlighted that the term BAME was a disfavoured term amongst Black health professionals. Hence, whilst study one was still being conducted, an additional study (See, Supplementary Chapter 10.1) was run simultaneously. Though the supplementary study was not a part of the thesis narrative, it is useful to mention that the study explored the perception of ethnic terminology using a mixed methods approach. The term CED (rather than BAME and other terminology) was chosen as the preferred term that has become the embedded term used throughout this thesis.

Maintaining the qualitative approach was phase two (study two), where the researcher explored CED service users' experiences to triangulate the findings from phase one of the clinician interviews to understand recovery disparities (Carter, 2014). The themes from the service users were linked to identity, ethnicity, cultural aspects, how the sessions were delivered and accessibility. The researcher then further investigated aspects of ethnicity, identity and culture in phase three (study three). Phase three was the start of the quantitative approach, where the researcher was focused on ethnicity and autonomy and how they can influence the mental health outcomes of anxiety, depression and functional impairment 3-12 months after service users have finished their IAPT treatment. The last phase (study four) integrated all the preceding findings to observe recovery disparities between CED and white groups using secondary data at a systemic level. Working with the

data available, the researcher included aspects such as ethnicity, religion and referral pathways to further investigate the health inequalities in recovery outcomes within the IAPT service.

### *3.1.2 Methodology Focused*

For the qualitative studies (*See*, Chapters 4 and 5), after the primary researcher completed the coding process, a secondary review was completed by some members of the supervisory team to allow for rigour and trustworthiness of the analysis. In the secondary review process, the researchers independently reviewed elements of the coded transcripts to assess the credibility and representativeness of the codes and themes. This process promoted reflectivity, which aligned with the researcher's critical realism (*See*, Chapter 3.1.3) stance to have discussions with the supervisory team to reflect on the interpretation of the data (Braun & Clarke, 2019). The secondary coding check is a process that is in line with best practices within qualitative research (Braun & Clarke, 2019).

Study four (*See*, Chapter 7), utilised a big dataset of over 31,000 cases, which provided substantial methodological value to this thesis. The large dataset increases the statistical power that enabled the observation of small but meaningful effects. Having a large dataset is advantageous in mental health research, especially when examining differences by ethnicity, referral pathway, religious affiliation and other contextual variables. Though this was a large dataset, it is important to note that there were missing data. The researcher addressed missing data by listwise deletion, i.e., removing incomplete cases. This methodological approach was used to aid analytic validity and knowing that the statistical power of the dataset was not compromised. Other techniques, such as imputation (Jadhav et al., 2019), were considered, but due to the variability of missing values within the

dataset, listwise deletion was chosen to maintain reliable analyses whilst retaining enough statistical power. Thus, the inclusion of a large dataset was a beneficial contribution towards this thesis that allowed the researcher to draw conclusions that are representative of the IAPT service.

All studies received ethical approval from Birmingham City University Ethics Committee; however, two studies required NHS ethics approval (See, Chapters 5 and 7). Studies two and four required NHS approval due to 1) working with risky groups, i.e., study two, interviewing current IAPT CED service users receiving psychological treatment. 2) using sensitive data, i.e., study four, secondary data from IAPT NHS Trusts. Thus, NHS approval was needed to further protect the participants, the researcher and legal compliance of the data. In contrast, study one did not require NHS ethical approval because, although staff were from the IAPT service, the study's intentions were not to divulge into their patients' data. Instead, the research solely focused on health professionals' experiences and perspectives, through voluntary participation via the researcher's social media platforms. Additionally, study three did not require NHS approval due to it being questionnaires with previous IAPT service users. Therefore, university ethics were sufficient to ensure all ethical procedures were maintained.

Linked to ethical considerations is the approach of choosing specific individuals for certain studies. For instance, study one (See, Chapter 4), it was essential to recruit IAPT health professionals from a diverse background to understand various groups' experiences working and delivering psychological interventions. This is why, in Chapter 4, the researcher had to further recruit CED individuals, as there was originally a lack of uptake. Similarly, in study two (See, Chapter 5), it was intentional to only have CED service users to highlight

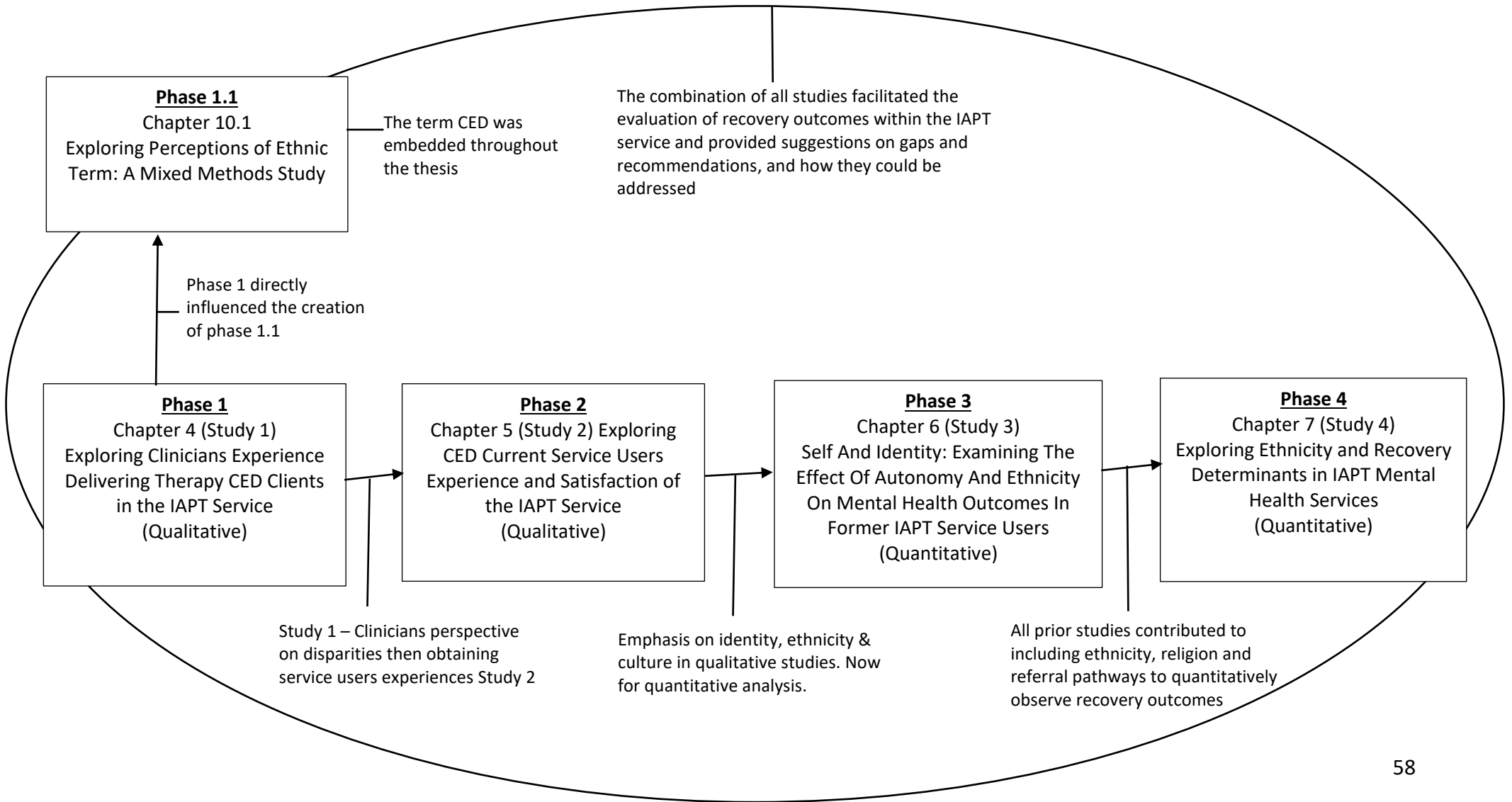
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their perspective on how the psychological treatment is going for them. Thus, linking to the overarching theme of the thesis, concerning CED groups' recovery outcomes. Furthermore, study three (See, Chapter 6) required a balance of both CED and white service users. The balance of the two groups was needed to statistically compare recovery 3-12 months after they had received psychological treatment, whilst being interested in how autonomy plays a role. Whereas, study four (See, Chapter 7), due to it being secondary data, the researcher was unable to 'hand-pick' certain individuals and wanted to remain ethical by working with the 'true data' even though the CED group sample was lower than that of white service users. Overall, ethical choices were reflected and processed accordingly, which aligned with the overarching aim of this study, which is to understand and reduce the health inequality gap while improving patient outcomes (specifically for CED groups) within the IAPT service (Kirwan et al., 2017; Regnault et al., 2018).

Recognising that health is multifaceted, a mixed-methods approach was suitable for this thesis to address the psychological determinants, intersectionality, assessment procedures, and therapeutic interventions provided to CED communities. By integrating both statistical data and lived experiences, this methodology was chosen to enrich the research findings and enhance the study's potential to inform policy and practice improvements, ultimately working towards more equitable mental health care outcomes.

Figure 3.1

Outline of the Research Methodological Process



### *3.1.3 Epistemological And Ontological Assumptions*

Positivist approach states that data is viewed objectively and is independent of human beliefs and theories (Chilisa & Kawulich, 2012), where there is 'one single truth' of empirical data (Ryan, 2018; Sousa, 2010). The IAPT service is largely underpinned by a positivist approach that observes service users' recovery based on psychometrics that provide a numerical outcome (Griffiths & Steen, 2013a; Williams et al., 2015). The numerical outcomes are supported by NICE evidence-based guidelines that uphold the gold standard methodology of randomised controlled trials (Clark, 2018; Rizq, 2012a). The IAPT service utilises data of successful recoveries as a key performance indicator (Griffiths & Steen, 2013b; Gyani et al., 2013). Thus, the ability to administer psychological questionnaires enables the service to efficiently evaluate the number of successful recoveries and allows the service to sustain the demand of patients accessing and being treated in the service (Rizq, 2012b). Conversely, the interpretivist/constructivist approach states that data is subjective due to social interactions and personal experiences. There are interactions from the social environment and interdisciplinary exploration for new, but constructed knowledge (Denicolo et al., 2016). The data is meaningful and dynamic because reality cannot exist without context and multiple truths (Denzin et al., 2005; Willig, 2016). An interpretivist/constructivist approach would allow for an insight into the narrative perspectives of clinicians' and service users' experiences of representation, cultural adaptations, accessibility and satisfaction. Therefore, to address the epistemological debate between positivist and interpretivist/constructivist approaches, the researcher undertook a critical realism stance (Bryman, 2016). Critical realism sought to merge the ontological divide between quantitative and qualitative methodologies by acknowledging an objective

reality while simultaneously understanding that knowledge is socially constructed, which is influenced by human perception and lived experiences. Critical realism provided a valuable framework for the researcher, since undertaking a mixed method design for the thesis, which enabled an integration of the strengths of both approaches, i.e., positivist and interpretivist/constructivist. Although it is important to acknowledge that there are other philosophies for mixed methods approaches, such as pragmatism (Maxcy, 2003; Tashakkori & Teddlie, 1998). Pragmatism states that '*reality*' is shaped by an individual's experience and action, which incorporates what an individual sees, their thoughts and beliefs (Allemang et al., 2022; Morgan, 2013). In contrast, critical realism states that '*reality*' exists independently of what individuals think, with deeper and hidden things occurring, such as social structures that can shape experiences even if the individual is not aware or notices them (Zhang, 2023). Pragmatism approach focuses on problem-solving to achieve 'action' for practical outcomes, which is central to the concept (Ormerod, 2006). Though this research aimed to provide practical outcomes (which it still can achieve with a critical realism stance) for the IAPT service, the pragmatic approach is not sufficient in gathering the underlying mechanisms and factors to address the recovery disparity. There is a potential, if one is holding a pragmatic stance, to overlook existing historical inequalities, systemic and systematic structures. Whereas critical realism was more aligned in getting a deeper understanding of the broader social structures (i.e., the multiple factors involved in mental health recovery amongst different ethnicity groups) to aid in providing practical outcomes. Hence, the researcher decided on a critical realism stance.

The critical realist paradigm addressed social and economic inequality and aimed to promote justice (Scotland, 2012). A critical realism stance was suited to explore the lower recovery amongst CED groups in the IAPT service. The critical realism framework allowed

the researcher to move beyond surface-level observations and instead to examine the underlying mechanisms and structures that contribute to health inequalities. This approach facilitated an exploration of the '*causal tendencies*' that shape the observed disparities in recovery rates, as well as suggestions for why and how these disparities persist (Fryer, 2020, p.24). For instance, why are CED IAPT service users more likely to have a higher severity of psychological symptoms compared to white service users? From a critical realist perspective, the answer is not simply found in statistical associations but rather in the underlying mechanisms that are both structural and psychological, contributing to these outcomes. Some of these factors may be systemic biases within mental health services, differences in the accessibility and cultural responsiveness of treatment, and individual experiences within the IAPT service or general mental health care. Critical realism allowed for a thorough investigation of these factors, rather than merely describing the disparity as a statistical occurrence.

Critical realism also acknowledged the interplay between agency and social structures that are ontological features, where they both influence each other (Fryer, 2020). In relation to this study, mental health services exist within broader social structures that have historically provided inadequate or culturally insensitive care for CED communities (McGuire & Miranda, 2008; Memon et al., 2016). These structures can create barriers to seeking, accessing and benefiting from mental health services, thus reinforcing health disparities. In addition, individual agency plays a crucial role in how CED individuals interact with mental health services. An individual from a CED background may choose not to seek help from an IAPT service due to indirect or direct experiences of racial discrimination in healthcare or a perception that services are not culturally inclusive (Hackett et al., 2020; Nazroo et al., 2020). Alternatively, some individuals may engage with alternative sources of

support, such as faith-based, community networks, or informal support systems. These decisions may be due to the historical and social perceptions that have shaped individuals' help-seeking behaviours for mental health. Therefore, critical realism enabled an exploration of both structural influences and individual decision-making, which recognises that agency and structure are interconnected, which is important for this mixed-method thesis (Fryer, 2020; Gorski, 2013).

As this research explored the social and psychological issues pertaining to service users and clinicians' experiences in the IAPT service, the critical realism approach allowed for participants' voices from marginalised groups to be heard (Burbules & Berk, 1999). Unlike the positivist approach, which prioritises objective measurements, critical realism recognised that subjective experiences are salient to understanding complex social experiences. By adopting a fluid and flexible approach to understanding participants' narratives (varying demographic factors, such as age, ethnicity, and socio-economic background), the researcher avoids static or over-generalised interpretations (Fletcher, 2017). These diverse experiences highlight how multiple realities exist within the broader structure of mental health care, reinforcing the need for contextually nuanced interpretations rather than one-size-fits-all conclusions.

Lastly, critical realism was a reflective philosophical approach whereby the synergy of quantitative and qualitative methods provided a '*whatever it takes*' approach to curate knowledge and gain a deeper insight into the research (McEvoy & Richards, 2003). Hence, being a reflexive researcher required having high levels of self-awareness and being consciously proactive throughout the research trajectory (Lambert et al., 2010). The process of introspection is a cyclic process by "*reflecting on one's own thoughts, mental images, feelings, sensations, and behaviours*" (Gould, 1995, p.719 as cited in Xue & Desmet, 2019)

and how these may impact the research project. The researcher's positionalities are a dual process where perspectives about the social world and the researcher themselves co-exist, which can ameliorate the process and outcome of the research (Palaganas et al., 2017). The process of being reflective, both quantitatively and qualitatively has allowed the researcher to immerse themselves into the research (Van der Riet, 2012) and to acknowledge the impact that the findings have, such as highlighting the challenges of systemic discrimination and racism and also the importance of CA psychological therapy to reduce the health inequality gap that could change health policies in the future. The researcher inevitably had a direct (i.e., methodological choices and data interpretation) and indirect (i.e., sociocultural influence on how the data is produced and the researcher's identity) impact within the research process; thus, it was salient to continuously acknowledge their positionality, which was aided by reflective practices (Palaganas et al., 2017).

In summary, undertaking a critical realism stance provided a solid philosophical foundation for this current research to holistically examine the factors contributing to health inequalities in IAPT services. It allowed the researcher to not only use statistics from studies three and four, but to investigate the deeper mechanisms that are contributing towards the mental health disparities. Critical realism supported the context-sensitivity of participants' narratives by ensuring their experiences are acknowledged and analysed so they can aid in informing policy and practice improvements for better mental health outcomes among CED groups.

### *3.1.4 Epistemological Position And Reflective Thematic Analysis*

A critical realism positionality was held throughout this thesis, though the researcher felt that it was important to highlight the critical realism perspective during the RTA for studies one and two.

The researcher held a critical realism position that underpinned the nature of both of the qualitative studies (Willig, 1999). Critical realism was suited for the studies as the subjective knowledge produced by participants is shaped by their experiences, such as their thoughts, feelings, attitudes, culture and language, where some authentic reality does exist that can possibly '*make a difference*' in the '*real*' world (Maxwell, 2012). Also, critical realism considers that the researcher exists independently from the data but concurrently constructs knowledge (Willis, 2022). As RTA (Braun and Clarke, 2019) was the chosen analysis for these studies, the suitability of the researcher holding a critical realism stance was further exemplified to understand how participants' realities are socially constructed and are changeable (Willig, 2019). Thus, from the information received, the researcher was able to act independently from the data whilst simultaneously constructing knowledge based on the multiple subjective perspectives of the clinicians and service users' experiences, such as belonging, stigma, accessibility and representation (Willis, 2022).

In addition to fit the flexible nature of RTA (Braun and Clark, 2013), a contextualistic method was applied (positioned between two poles of constructionism and essentialism) to acknowledge the impact of the broader social contexts that emerged (Willig, 1999). It is important to note how participants' experiences and knowledge are socially produced, in which their realities can be changeable (Kersey et al., 2023; Willig, 2019). Therefore, it was appropriate to have some ambiguities in the findings, hence, allowing for a range of realities

to co-exist (Willig, 2019). Undertaking a critical realism stance allowed the researcher to be fluid in understanding the multiple subjective social nature of participants' experiences working/delivering or receiving treatment in the IAPT service without being static towards a single perspective that is generalised (Fletcher, 2017). It was acceptable to have contradictions within the themes that arose, as the findings were based on individual experiences, so not everything said must be homogeneous. This allowed for multiple socially constructed realities to be considered (Haigh et al., 2019).

## **Chapter 4. Exploring Clinicians Experience Delivering Therapy to Culturally and Ethnically Diverse Clients in the IAPT Service (Study One)**

### **4.1 Chapter Overview**

The current chapter explored the different factors, from a clinician's perspective, that could be influencing the lower recovery rates amongst CED<sup>6</sup> groups in comparison to white service users in the IAPT service. The chapter employed a qualitative approach utilising Reflective Thematic Analysis, where 14 semi-structured interviews with IAPT health professionals were conducted. It is hoped that this chapter will provide a detailed understanding of the therapeutic alliance between clinicians and clients, which could help explain the recovery disparity. In addition, the chapter provides insight into understanding clinicians' awareness of how to support CED communities and clinicians' skill sets to deliver CA psychological treatment.

### **4.2 Introduction**

There has been increased interest pertaining to why CED groups are less likely to recover in comparison to white individuals in the IAPT service (Amati et al., 2023; Moller et al., 2019). The IAPT service is also aware of the statistical difference in recovery rates, and in 2019, they devised an updated version of the 'IAPT Black Asian and Minority Ethnic Service User Positive Practice Guide' (Beck et al., 2019). The aim of the Positive Practice Guide was to bring knowledge on improving accessibility, engagement, adapting therapy and workforce/staffing to improve the quality of the service.

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<sup>6</sup> Culturally and Ethnically Diverse individuals who identify as Black, Asian, Mixed/dual-heritage

#### **4.2.1 Workforce: Diversity, Representation and Identity**

The IAPT workforce lacks diversity and representation; 84% are from a white background, and 82% identify as female (NHS Benchmarking Network, n.d., p.38-39). Only 16% of Black, Asian and Mixed/Dual-Heritage clinicians make up the workforce (NHS Benchmarking Network, n.d., p.38), and 15.5% of Black, Asian and Mixed/Dual-Heritage individuals seek support through IAPT services (NHS Digital, 2022). There is a lack of IAPT service-focused literature which explores how Psychological Well-being Practitioners' (PWP) identity may impact treatment delivery. Though wider mental health literature has suggested that the absence of ethnically diverse representation in psychological treatment can be a barrier for service users (Cabral & Smith, 2011). Smith and Trimble (2016) found that CED individuals feel more comfortable discussing their issues with a therapist who is of a similar ethnic background. Sharing a similar ethnic background can help with relatability and reduce the feelings of being judged (Smith & Trimble, 2016). Cultural congruence can also help clients feel understood and freely discuss the nuances and institutional barriers of mental health. Drustrup (2021) found that white clinicians find it more challenging to identify with clients from a different background from them. Some white clinicians may be unaware of the deep-rooted and systemic issues of race that CED individuals experience. With a '*white worldwide view*' (Drustrup, 2021, p.65), it can become a challenge for white clinicians to relate to what their CED client may want to explore and converse about in therapy.

However, research has noted that a solution for this matter cannot be reduced to CED Health Professionals (HPs) solely accepting clients who look like them (Soucheray, 2020; Steinfeldt et al., 2020). Research has highlighted that some clients may prefer not being ethnically matched to their therapists, due to stigma, the potential of bringing shame on

their families or their private information being shared within their community (Anand & Cochrane, 2005; Yakeley, 2018). Nevertheless, ethnically diverse representation in IAPT could ameliorate inclusivity options for clients to pick the clinician they prefer.

#### **4.2.2 Confidence in Cultural Competency and Making Adaptations**

Cultural competency refers to practitioners' knowledge and skills to comprehend and interact with individuals from a myriad of cultures, beliefs and values (Castillo & Guo, 2011; Jackson, 2015). The necessity of implementing cultural competency into practice derives from evidence-based psychological assessments, diagnoses and treatments being dominated by westernised cultural standards (Gone, 2015; Gone & Kirmayer, 2010). The mainstream westernised theories and viewpoints being the default detracts from the varied cross-cultural groups that HPs engage with (Asnaani et al., 2022; Good & Hannah, 2015). Therefore, if HPs are underpinning their work with Eurocentric standards, this may lead to the lack of acknowledgement of the unique lived experiences amongst cross-cultural groups (Gone, 2015; Kirmayer, 2012).

The IAPT service does provide cultural competency training when individuals enter the service, alongside additional optional training sessions. The cultural competency training can be salient to boost HPs' confidence to integrate specific aspects of a service user's culture when deliberating the necessary assessment and treatment that should be provided (McGregor et al., 2019). Integrating and having a deep understanding of cultural competency can further aid HPs' confidence in incorporating adaptations of evidence-based interventions, which are tailored to the service user to contribute towards a patient's recovery. Cultural adaptations are when systemic modifications are made to treatment (Castro, et al., 2010) such as translating written material, having a translator present, the inclusion of culture-

specific jargon, incorporating the clients' religious beliefs into the treatment session (Cucchi, 2022; de Abreu Costa, & Moreira-Almeida, 2021; Sabry & Vohra, 2013) and including their values such as the importance of family into the treatment (Cardy et al., 2020; Sharm et al., 2020; Villatoro et al., 2014). It is noted that therapists who have a good understanding of cultural competency can understand the norms and unique experiences of different service users' cultures better, in order to make adaptations where necessary (Kaihlainen et al., 2019; Li et al., 2017; Saha et al., 2008).

Therapists who do not feel equipped to work with cross-cultural groups due to inadequate training or minimal cultural training may have lower confidence in supporting diverse groups of service users (Beaulieu et al., 2019; Soto et al., 2018). Low confidence levels from therapists may impact the therapeutic alliance. A poor therapeutic alliance can inhibit service users' recovery or may lead to clients' early termination from the service (Anderson et al., 2019; Ridley et al., 2021; Saxon et al., 2017). It can therefore be argued that it is important that HPs within IAPT feel confident and comfortable to culturally make adaptations, as a lack of confidence can have a detrimental impact on patients' overall outcomes (Moltu et al., 2017; Owens & Keller, 2018; Wasson & Coleman, 2014). Evidence shows that when service users perceive their therapist to be confident, they also feel that they can trust and respect their practitioner and open up (Crits-Christoph et al., 2019; Owens & Keller, 2018; Petrocchi et al., 2019).

### **4.2.3 Burnout**

The impact of burnout has been noted among HPs, including those within the IAPT service (Duarte & Pinto-Gouveia, 2017; Owen et al., 2021). Burnout in IAPT service has been associated with the target-based culture to reach a 50% patient recovery mark, high

demand of individuals needing the service, and long waiting times. Also, increased clinician workload, which includes administrative tasks, high caseloads, back-to-back sessions and high staff turnover, all of which can reduce the overall effectiveness of a clinician's work (Mahase, 2020; NHS England and Health Education England, 2016; Westwood et al., 2017; Walklet & Percy, 2014). Evidence has shown that the negative impacts of burnout on staff can lead to detrimental impacts on the service users' health outcomes if staff are unable to provide quality care (Delgadillo et al., 2018; Morse et al., 2012; Pakenham & Stafford-Brown, 2012).

However, there has been limited research that has specifically acknowledged the implications burnout has on IAPT clinicians' ability to proactively engage in learning cultural competency skills and performing cultural adaptations to deliver therapy to CED individuals. Scott's (2018) qualitative study with IAPT workers conveyed that the interplay of burnout can make it challenging for clinicians to thrive in enhancing their patients' required needs. In Scott's study, clinicians expressed that the emotional drain of having insufficient time to consolidate the taught material made the training less effective. As a result, clinicians are unable to appropriately implement the tailored training into practice for service users. Feeling burnout as a result of inadequate time to fulfil the numerous tasks required by the IAPT service can make it challenging for staff to incorporate cultural competency and adaptations. Therefore, there is a missed opportunity for those who need the adaptations, such as CED groups, if clinicians experiencing burnout are unable to implement tailored practices that could potentially address the recovery gap.

#### **4.2.4 Current Study**

As previously highlighted, mental health recovery for CED users in the IAPT service is lower than that of white service users. Previous research has found that cultural competency, clinicians' confidence in making adaptations, and burnout have an effect on treatment outcomes (Owens & Keller, 2018; Rushton et al., 2019; Steel et al., 2015). However, there is limited research that specifically focuses on delivering care and factors impacting treatment outcomes amongst CED clients in IAPT. Therefore, this study will aim to explore clinicians' perspectives on diversity, representation, inclusivity, cultural competency, confidence in implementing cultural adaptations and how to improve the recovery gap for CED service users in the IAPT service. The research questions were as follows:

- 1) What are clinicians' views on cultural competency within the IAPT service?
- 2) What are clinicians' perspectives on cultural adaptations for psychological therapy?
- 3) What are clinicians' perspectives on improving the IAPT service in relation to CED service users?

### **4.3 Methods**

#### *4.3.1 Design*

A qualitative design of one-to-one semi-structured online interviews was used to explore current IAPT clinicians' experiences of delivering psychological treatment and the factors hindering the recovery rates for CED service users (Carter et al., 2021; DeJonckheere & Vaughn, 2019). Semi-structured interviews enable the researcher to create a flexible

conversation environment (Braun & Clarke, 2006; Kekeya, 2016) to obtain a deeper understanding of individuals' experiences (McIntosh & Morse, 2015). Further benefits of semi-structured interviews are that they allow participants to mention additional information based on the research questions, whereby the participants can discuss their experiences in delivering treatment and factors impacting recovery, such as their cultural competency skillset.

#### *4.3.2 Participants*

A total of N = 14 IAPT HPs participated, aged between 23-35 years old (M = 26 years). Twelve out of 14 identified as female, and 7 out of 14 participants identified as being Black, Asian or Dual/Mixed Heritage. Purposive sampling through social media (See, Appendix 4.a and 4.b) was used to recruit participants (Etikan et al., 2016). Due to low uptake of CED HPs, the researcher targeted CED groups by changing the recruitment poster. The poster specified solely wanting CED HPs to participate in the study (See, Appendix 4.b) in order to have a range of diverse voices included in the study.

The study's inclusion criteria stated that IAPT service HPs, i.e., clinicians/therapists or PWP's who have been working for a minimum of six months, are eligible to participate. A minimum six-month timescale would allow clinicians to have experienced a varied caseload and spent sufficient time providing support to service users with different demographic variables such as race, ethnic background, culture, religion, age and gender identity to be able to share their experiences in depth. Participants were also required to be over 18 years old and able to speak English proficiently for the interview. Table 4.1 displays participants' demographics.

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

**Table 4.1**

### Participant Characteristics

Pseudonym	Gender Identity	Age	Ethnicity	Sexual Orientation	Religious Background
Aleya	Female	32	Mixed/ Multiple Ethnic Group -white and Black Caribbean	Heterosexual	Christian
Alice	Female	35	white Other – Greek	Heterosexual	Christian
Angela	Female	25	white British	Heterosexual	Atheist
Bianca	Female	29	white British	Heterosexual	Christian
Daisy	Female	23	white British	Heterosexual	Atheist
Diana	Female	28	Asian/Asian British - Indian	Prefer Not to Say	Muslim
Holly	Female	25	white British	Heterosexual	Atheist
Mak	Male	35	Asian/Asian British - Bangladeshi	Heterosexual	Muslim
Miya	Female	23	Asian/Asian British - Indian	Heterosexual	Sikh
Paperclip	Male	N. A	white British	Heterosexual	Atheist
Safina	Female	31	Asian/Asian British – Pakistani	Heterosexual	Muslim
Sarah	Female	23	Asian/Asian British - Bangladeshi	Heterosexual	Muslim
Summer	Female	25	white British	Bisexual	Other
Zii123	Female	25	Black/Black British - African	Heterosexual	Christian

**Note.** Participants' names have been replaced with a pseudonym.

N.A (Not available)

### *4.3.3 Procedure and Materials*

Ethical approval was granted by Birmingham City University, Business, Law and Social Sciences (BLSS) Research Ethics Committee, Clarke-Jeffers /#9637 /sub1 /Am /2022 /Jan /BLSS FAEC. The study was Open Science Framework (OSF) pre-registered (<https://osf.io/gkrf7/overview>). The 38-question interview schedule was developed prior to conducting the interviews (See, Appendix 4.c). Developing the interview questions in advance was beneficial for the researcher to consciously avoid leading questions that could have an impact on the participants' responses (Leech, 2002). Also, avoiding double-barrelled or complex questions that could confuse participants (Jenn, 2006). In addition, having open-ended questions allowed the researcher to obtain an in-depth understanding of clinicians' experiences working and delivering treatment in the IAPT service (Borg & Kristiansen, 2004; Galvin et al., 2015). The four interview sub-sections were informed by previous literature (e.g., Algahtani et al., 2019; Gaynor & Brown, 2013), which were 1) Psychosocial Factors and Identity, 2) Delivering Treatment - Diversity and Inclusion, 3) Cultural Competency and 4) Quality of the Service.

#### *4.3.3.1 Online Questionnaire*

Interested participants scanned the quick response code through social media to access the online survey via Qualtrics®. Participants accessed the Participation Information Sheet (See, Appendix 4.d) that outlined the details and expectations of the study, then participants electronically agreed to all sections of the consent form (See, Appendix 4.e). Participants created a pseudonym to maintain the confidentiality of their personal information. Participants then completed the online demographic questionnaire (See, Appendix 4.f) along with questions relating specifically to the IAPT service, such as 'How

*confident would you feel delivering CA/sensitive psychological therapy to participants?'*. The demographic online survey collected information for descriptive and contextual purposes (See, Table 4.2). Pre-asking the questions in the online survey allowed the researcher to understand who they were going to be interviewing. This enabled the researcher to know information such as how long they have been working at the IAPT service, the types of treatment they have delivered and the modality, as well as their satisfaction, ahead of the semi-structured interviews. When participants had finished, the online survey stated that they had to contact the researcher first by email to arrange the one-to-one interview date.

Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

**Table 4.2**

Clinicians Descriptive Information

<b>Pseudonym</b>	<b>Role</b>	<b>Time Working in IAPT</b>	<b>Type Of Intensity Treatment They Deliver</b>	<b>Type Of Treatment Delivered</b>	<b>Delivery Style of Treatment</b>	<b>Received Cultural Competency Training In IAPT</b>	<b>How Confident Would You Feel to Deliver Cultural Adapted Treatment</b>	<b>Rate Performance as A Clinician/PWP</b>	<b>Rate Experience Working in IAPT</b>
<b>Aleya</b>	PWP	6 months	Low Intensity Treatment	C-CBT, CBT, BA, Other - Peer support groups	Telephone, Computer	No	Very Confident	Satisfactory	Dissatisfied
<b>Alice</b>	PWP	2.5 years	Low Intensity Treatment	C-CBT, CBT, BA, PE Groups	Ind.v F-to-F, Telephone, Computer, Group online, Group F-to-F	No	Confident	Very Good	Satisfied
<b>Angela</b>	PWP	18 months	Low Intensity Treatment	C-CBT, CBT, BA, PE Groups, Mindfulness-based CT	Ind.v F-to-F, Telephone, Computer, Group online, Group F-to-F	Yes	Unsure	Good	Dissatisfied
<b>Bianca</b>	PWP	2.5 years	Low Intensity Treatment	C-CBT, BA, PE Groups	Ind.v F-to-F, Telephone, Computer, Group Online	No	Confident	Good	Neither Satisfied nor Dissatisfied

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

Pseudonym	Role	Time Working in IAPT	Type Of Intensity Treatment They Deliver	Type Of Treatment Delivered	Delivery Style of Treatment	Received Cultural Competency Training In IAPT	How Confident Would You Feel to Deliver Cultural Adapted Treatment	Rate Performance as A Clinician/PWP	Rate Experience Working in IAPT
<b>Daisy</b>	PWP	1 year	Low Intensity Treatment	C-CBT, CBT, BA, PE Groups	Telephone, Computer, Group Online Ind.v F-to-F,	Yes	Confident	Good	Satisfied
<b>Diana</b>	PWP	1.3 years	Low Intensity Treatment	C-CBT, BA, PE Groups, CR, WM, E/R Prevention	Telephone, Computer, Group Online	No	Confident	Good	Dissatisfied
<b>Holly</b>	PWP	2.3 years	Low Intensity Treatment	C-CBT, CBT, BA, PE Groups	Ind.v F-to-F, Telephone, Computer, Group Online, Group F-toF	No	Unsure	Good	Satisfied
<b>Mak</b>	Clinician/Therapist	12 years	High & Low Intensity Treatment	C-CBT, CBT, BA, PE Groups, EMDR	Ind.v F-to-F, Telephone, Computer, Group Online	Yes	Confident	Very Good	Satisfied
<b>Miya</b>	PWP	1 year	Low Intensity Treatment	CBT, BA	Telephone	Yes	Confident	Good	Satisfied
<b>Paperclip</b>	Clinician/Therapist	N. A	High Intensity Treatment	C-CBT, CBT, BA, PE Groups	Ind.v F-to-F, Telephone, Computer, Group F-to-F, Video Consultations	Yes	Unconfident	Good	Dissatisfied

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

Pseudonym	Role	Time Working in IAPT	Type Of Intensity Treatment They Deliver	Type Of Treatment Delivered	Delivery Style of Treatment	Received Cultural Competency Training In IAPT	How Confident Would You Feel to Deliver Cultural Adapted Treatment	Rate Performance as A Clinician/PWP	Rate Experience Working in IAPT
Safina	PWP	7 years	Low Intensity Treatment	C-CBT, CBT, BA, PE Groups	Ind.v F-to-F, Telephone, Computer, Group F-to-F	Not sure	I already deliver this	Very Good	Satisfied
Sarah	PWP	1 year	Low Intensity Treatment	C-CBT, CBT, BA	Ind.v F-to-F, Telephone, Computer	No	Confident	Very Good	Satisfied
Summer	PWP	3 years	Low Intensity Treatment	C-CBT, BA, PE Groups	Ind.v F-to-F, Telephone, Computer, Group F-to-F, Group Online	No	Unconfident	Good	Satisfied
Zii123	PWP	2 years	Low Intensity Treatment	C-CBT, CBT, BA, PE Groups	Ind.v F-to-F, Telephone, Computer, Group Online	No	I already deliver this	Good	Dissatisfied

**Note.**

PWP = Psychological Well-being Practitioner

C-CBT = Computerised Cognitive Behavioural Therapy

CBT = Cognitive Behavioural Therapy

BA = Behavioural Activation

PE Group = Psycho-Educational Groups

Mindfulness-based CT = Mindfulness-based Cognitive Therapy

EMDR = Eye movement desensitization and reprocessing

Ind.v = Individual

F-to-F = Face-to-face

CR = Cognitive Restructuring

WM = Worry Management

E/R Prevention = Exposure and Response Prevention

#### *4.3.3.1 Interviews*

The researcher received verbal consent before proceeding with the interview. Interviews were conducted by the author online via Microsoft Teams and were recorded. The duration of the interviews ranged from 46 to 84 minutes (M =61 minutes). Participants were sent a debrief sheet (*See, Appendix 4.g*) within 24 hours after the interview that outlined the researcher's information, how to seek external support and notifying participants they had 10 working days after the interview to withdraw if needed. All data was saved on the researcher's university OneDrive account in separate password-protected folders.

#### **4.3.4 Data Analysis**

The interviews were transcribed verbatim using orthographic transcription (Halcomb & Davidson, 2006; Loubere, 2017) and all personal identifiers were removed to ensure confidentiality (Saunders et al., 2015). Reflective Thematic Analysis (RTA) (Braun & Clarke, 2019; 2021) was chosen as it is flexible in nature to provide the researcher with an in-depth account of the data (Nowell et al., 2017). Additionally, RTA (Braun & Clarke, 2006, 2013) provides a systematic method of identifying and organising patterns into a meaningful data set, thus allowing the researcher to explore the individual and collective experiences of current IAPT clinicians working and delivering treatment to service users (Braun & Clarke, 2012; 2014).

##### *4.3.4.1 Reflective Thematic Analysis*

The researcher followed the six steps outlined by Braun and Clarke (2021). The first step was 'Data familiarisation and writing familiarisation notes', which is where the

researcher repeatedly listened to the interview alongside re-reading the transcribed data to immerse and understand the data provided by each participant. Step two was 'Systematic data coding,' where the researcher began annotating the whole transcript for each participant for topics that were relevant to the research question. The coding was done on Microsoft Word using the 'comment' function, which utilised the right-side margin for the coded notes whilst simultaneously highlighting parts of the excerpts that the coded notes related to (See, Appendix 4.h). The information from the interviews was double-coded – semantic and latent meaning (Byrne, 2022). Semantic coding is the explicit content, directly voiced by participants. In this study, semantic coding involved the researcher in identifying and capturing the surface meanings conveyed by the clinicians and focusing on what participants explicitly voiced. In addition, the researcher went beyond descriptive interpretation (semantic coding) and latent coding was utilised. The researcher searched for underlying ideologies and conceptual patterns that shaped participants' narratives and experiences (Braun and Clarke, 2019). Latent coding required the researcher to be creative, interpretive, and to delve deeper into the analysis (Braun and Clarke, 2006; 2019). Using both coding levels (semantic and latent) allowed for a more comprehensive understanding of the rich data and aligned with the researcher's critical realism position. The critical realism stance encompasses both the participants' realities that they expressed, and the wider underlying structures involved. For RTA, it is important to underpin the theoretical assumptions of the analysis by the researcher being flexible, drawing upon the researcher's pre-existing knowledge and social position to understand the role the researcher has in the study (See, Chapter 3.1.4). Step three was 'Generating initial themes from coded and collated data,' which was achieved by collating similar codes to be grouped into a

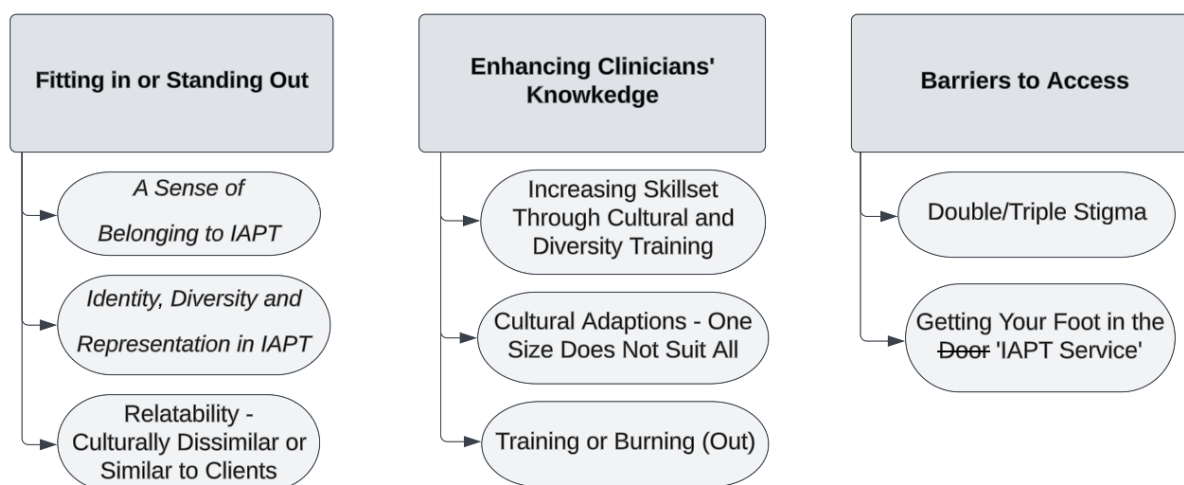
meaningful theme or sub-theme (See, Appendix 4.i). During this step, the researcher had a miscellaneous theme encompassing all the codes that were not akin or did not fit in with the remaining themes for analysis. The miscellaneous theme was then discarded as it was not suitable and lacked quotes to support a theme. Step four was 'Developing and reviewing themes', where the researcher created a visual thematic map, via the platform 'Lucid Visual Collaboration Suite,' which displayed the data's main themes and sub-themes. Then, Step five allowed the researcher to 'Refine, define and name' the themes (See, Figure 4.1). At this stage, all themes provided a coherent narrative of the dataset and helped to answer the research questions. Throughout all the steps, the researcher played an active and inventive role in generating the themes that would be used in the analysis (Braun and Clarke, 2021). Once the themes were named, the researcher moved on to step six of 'Writing the report,' which included the analysis of all the interviews and included quotes for supporting evidence. In addition, the researcher was cognisant that whilst the steps appear to be linear, the analysis was an iterative process, where the researcher needed to return to the previous steps to fulfil the relevant codes and themes that were applicable to the research question (Braun & Clarke, 2013; 2021).

#### **4.4. Results**

A total of three themes were identified from the transcript data: 'Fitting in or Standing Out,' 'Enhancing Clinicians' Knowledge', and 'Barrier to Access'. The themes and sub-themes are summarised in Figure 4.1.

Figure 4.1

Theme and Sub-Themes



#### **4.4.1 Theme 1: Fitting in or Standing Out**

This theme explores the sense of connection and disconnection that participants experience and feel as part of the IAPT community or the wider IAPT system. Participants discussed their identity and representation regarding race, ethnicity, culture and gender identity and how these factors can influence whether they feel included within the IAPT workforce. Similarly, how identity and representation can play a factor in their interactions with service users.

##### ***4.4.1.1 A Sense of Belonging to IAPT***

Participants in the study expressed that they felt like they belonged to the service due to the caring nature of the people with whom they work with which allows them to feel included and supported by their team, specifically their supervisors.

*"I belong in the service because I really get along with my work colleagues [...] we bounce ideas off with each other. And, you know, it's really a great debrief, and you've got emotional support and practical support."* (Diana, 28 years old, Indian, PWP for 1.3 years)

The participants mentioned feeling a sense of camaraderie with their colleagues. Additionally, the feeling of belonging developed from having good communication during meetings and being debriefed with supervisors. Participants felt comfortable sharing their experiences of what happened during their one-to-one session and were able to receive 'emotional support and practical support.' Being able to speak to supervisors allowed participants to feel valued in their role and that their emotional needs and well-being were equally as important as it is for the clients they support.

In contrast, some of the participants who were from a CED background discussed a lack of belonging on account of their cultural and ethnic background and fitting in at the IAPT service. Zii123 and Aleya mentioned:

*"In terms of belonging I feel like, I'm not gonna lie for a long time I felt like I was a diversity hire. I'm not gonna lie. I am the only Black person in my team."* (Zii123, 25 years, African, PWP for 2 years)

*"I'm now the only mixed-race person or person who is Black in the service. And I just think that they don't think that they need to do enough."* (Aleya, white and Black Caribbean, PWP for 6 months)

Zii123 and Aleya expressed that they felt like they did not belong due to their cultural backgrounds, which differentiated them from the rest of their IAPT team. Feeling like the 'odd one out', especially when feeling like a 'diversity hire', can create thoughts of potentially being hired solely for their cultural background and not their skillset. Moreover, the lack of belonging due to poor diversity is strengthened by Miya, who clarified the importance of diversity to help increase feelings of belonging to the service.

*"I work in an area where the population is quite heavy, like an Asian population. We have quite a lot of people from like, different cultural and ethnic backgrounds [...] which definitely helps with my own sense of belonging, like cultural impacts that I feel like I want to debrief with."* (Miya, 23 years, Indian, PWP for 1 year)

Miya underlined the importance of the workforce having varied cultural backgrounds to help with a sense of belonging. This sub-theme has shown the salience of culture needing to be embedded in IAPT.

#### *4.4.1.2 Identity, Diversity and Representation in IAPT*

Ethnicity and culture are characteristics that encompass an individual's identity. In this sub-theme, participants discussed diversity and representation of the workforce and the clients they assess/treat. For participants working in more multicultural cities, it was more likely that their clients were from diverse backgrounds.

*“It's a very wide, broad service, because we have all, we have mixed, we have Black, we have from Middle East, like, it's a very diverse borough, one of the most diverse borough.”* (Alice, 35 years old, Greek, PWP for 2.5 years)

Some participants in the study spoke about the disparity between the cultural diversity of the service users and the IAPT service staff in their locality.

*“I am the only Asian male that I know of. In terms of like staffing numbers and proportions I don't think that possibly reflects actually the size of how many maybe ethnic men from you know from a BME backgrounds are coming into our service. I think myself probably being the only BME staff member, I don't think that's probably the same proportion.”* (Mak, 35 years old, Bangladeshi, Clinician/Therapist for 12 years)

Mak described the poor representation of men, especially from CED backgrounds, within IAPT services. The poor representation was also acknowledged by white participants in their whole workforce. All participants mentioned the importance of diversity in the workforce; however, Paperclip critically analysed the issues that can arise with trying to diversify the workforce:

*“I'd love to see more diversity in our workforce. I think that would be an important thing. The danger, of course, could be then either that, you know, those people be the nominated staff that work with difference and that would be dreadful. Or that it becomes tokenistic. And that would equally be dreadful. So, I think we need a commitment to diversity.”* (Paperclip, white, Clinician/Therapist)

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Paperclip stated that the IAPT service should hire more staff from diverse backgrounds. Though an increase of diverse staff is needed, caution should be taken not to automatically ethnically match CED clients with therapists during referrals/treatment delivery to avoid CED staff feeling *'tokenistic.'* Additionally, the lack of representation can have a negative implication on service users, as Holly and Miya suggested that there is a potential correlation between having lower rates of diversity in the workforce and having fewer CED clients access the service.

*"It's daunting for anyone to come to mental health services, and then to come to a mental health service and, you know, all the practitioners being a completely different culture, race, possibly even language to you. And if you feel like that person hasn't listened or hasn't understood, or even, you know, being discriminatory towards you, that's going to stop you progressing."* (Holly, white, PWP for 2.5 years)

*"You want to see people who look like you, whether you're being treated by them or not. But you also want to be able to see that, that these services have an understanding of the cultural differences. [...] And I think that's what makes the service more accessible."*  
(Miya, 23 years, Indian, PWP for 1 year)

Both participants explained that a lack of representation can reduce progression for some clients if they do not feel that they belong in the service. This can be because they feel as though their beliefs and values are being disregarded or misunderstood. Additionally, if there is limited focus on representation within the service, this can create a barrier for

accessibility where potential service users feel that they might not be fully understood in a '*predominantly white*' service.

#### **4.4.2 Theme 2: Enhancing Clinicians' Knowledge**

This theme encapsulates how HPs (clinicians and PWP's) want to be culturally competent and confident in order to better support the service users they see. The discussions were centred around the importance of cultural awareness, satisfactory training on cultural competency and the confidence to make adaptations. Both cultural competency and adaptations were highlighted as a way to better understand the challenges faced amongst CED groups, and knowing how to effectively support clients. Furthermore, participants displayed a passion for their job role, even though burnout can be an instrumental factor in their productivity levels. Participants emphasised they wanted to improve on their cultural sensitivity skillset to enhance their expertise within the role, in order to better support their clients during the sessions and help them to progress towards recovery.

##### ***4.4.2.1 Increasing Skillset Through Cultural and Diversity Training***

Participants, who mainly were PWP's, spoke about the lack of effective training in relation to cultural competency and diversity training for the myriad service users from varied backgrounds. PWP's participants repeatedly highlighted that the training was a short, surface learning module delivered during their PWP training year before they qualified as a PWP.

*“It didn't really go into too much detail [...] we did have half a day on around sort of culture and ethnicity. But that's the only training that I've ever had [...] I probably feel as if I would benefit from like, some further training.”* (Bianca, 29 years old, white British, PWP for 2.5 years)

Participants stated that cultural competency training lacked the in-depth learning discussions about ethnicity, culture and religion, leaving participants feeling the need for additional training. Furthermore, in some cases, training felt like a simple tick-box exercise that could be easily forgotten after completion of the session and for requirement purposes for the IAPT service to reach mandated targets for qualified PWPs and clinicians:

*“I don't think IAPT cultural competency training is to the right standard at all, to be honest. [...] we have like core sort of training that we go on which, to be honest, I don't think the training at my service is great anyway. It's almost like a tick box, get it done or you're in trouble. There's, there's no sort of like, 'what did you learn from it'? It just feels very tick boxy.”* (Angela, 25 years, white, PWP for 1.6 years)

Extending on participants' discussions regarding the surface-level cultural competency training, in the following excerpt, Aleya illustrated that IAPT relies on generic characteristics to 'box' service users under the label 'protective' and without providing the means to provide provision for each specific group.

*“They tend to put all protective characteristics in a box [...] you might be educating the trainees about okay; an older adult is somebody over 65, or a Black person is somebody that identifies like this, but then you're not giving them the tools of how to respond. You're not educating them [clinicians] about the microaggressions. You're, not teaching them the nuances, because I don't think they even know it themselves. And they don't want to be seen as being not politically correct. I just don't think they see it as an important factor, to be honest. It's not developed with the times that we're in”. (Aleya, white and Black Caribbean, PWP for 6 months)*

Aleya expressed how the training she received was not equipped to deal with the intricacies of the different service users' demographic and cultural background, which in turn made it difficult for staff to understand how to appropriately assess, respond and treat their clients. Aleya also suggests that the individuals who taught the cultural competency training, on behalf of IAPT, did not come across as being open or confident to create meaningful group discussions on culture and diversity. Aleya described how the individuals teaching the sessions prioritised upholding notions of *'political correctness,'* in place of the more acute intersectional needs of diverse participants accessing the IAPT service. This was seen as a significant disadvantage to staff members taking part in the diversity and cultural sessions. Therefore, to further enhance the cultural competency training, Summer suggested:

*“Think it might be really helpful to have like, shadowing opportunities or role plays, maybe with a fake interpreter, or just having role phases of if this scenario came up. I think that would be really helpful.”* (Summer, 25 years, white, PWP for 3 years)

Rather than making the training feel like a tick-box exercise, the training sessions could be proactive by incorporating role-playing based on real-life scenarios, with the aim to help consolidate learning and create an opportunity to apply the theory taught into practice.

Overall, when participants were asked to rate the usefulness of having cultural competency training, the majority of participants scored either 9 or 10. Participants described the training as extremely useful and that it should be integrated within the IAPT services to help clinicians form a deeper connection to understand their clients, regardless of being from a different cultural background than themselves.

*“10! It's extremely useful [...] I feel as if it's really important to sort of know about people's values. And for that, to build up a rapport, with patients, and for them to get the most out of treatment. If you're not taking into account sort of that their values and them as a person, then then they're not going to get the most out of treatment.”* (Bianca, 29 years old, white British, PWP for 2.5 years)

Participants clearly expressed the need for cultural competency and stated the training should be purposeful, in-depth and critical as opposed *“for it to become just another mandatory training that people have to”* (Paperclip). The majority of participants

suggested that regular cultural competency training should be a requirement for all staff, and should be continuously incorporated every six months or year in the IAPT service:

*“I’ll say minimum twice a year. And the reason why I say that is because there’s such a high turnover of staff within the IAPT service [...]. So, if you’ve got a standard that you want to set and keep, keep refreshing it.” (Zii123, 25 years, African, PWP for 2 years)*

Regular training and booster sessions are beneficial within the health field to help refresh and consolidate health professionals’ knowledge whilst fitting around their busy schedules (Liu et al., 2021).

#### **4.4.2.2 Cultural Adaptations - One Size Does Not Suit All**

Cultural adaptations are implemented within psychological therapy to support clients from a range of different backgrounds. Participants recognised that sometimes the standard Westernised treatment is not always appropriate for their clients. Therefore, participants understood the need to implement adaptations such as translated material, working in a triad with interpreters, ethnically matching clients and being well versed to understanding an array of attitudes, beliefs, and values of different cultures and religious groups. Some participants postulated the challenges and having less confidence to make adaptations for CED groups.

*“I feel unconfident [...], I think I just feel quite unsure of how you could adapt or what that might mean. I’m one of those people who really likes concrete examples of what that means.” (Summer, 25 years, white, PWP for 3 years)*

The majority of the participants who felt unconfident making the cultural adaptations were from a white British background. Participants may want to avoid the shame of making mistakes, which can lead to avoidance, especially if they are unsure how to configure the steps towards implementing adaptations. In addition, some participants in this study had less exposure to different demographic characteristics, which further reinforces feelings of anxiety and uncertainty about how to make the adaptations if they have had less exposure to different clientele. Thus, participants expressed that training is needed, similar to cultural competency training, but supplemented with '*concrete examples*' on adaptations to help support them.

Contrastingly, other participants felt more confident about cultural adaptations due to being from a similar background as their client. Or even when the clinician is from a different background, they can still understand the benefits of making small adaptations and try to incorporate adjustments where possible to support their client.

*"I've actually done a few sessions like direct in the language I speak, which is, Urdu and Punjabi. So, I've been able to do some sessions in in, in that specific language."* (Safina, 31 years old, Pakistani, PWP for 7 years)

*"I am willing to make adaptations to ensure that regardless of their cultural and ethnic background, that, you know, they feel comfortable, and they are heard for their own experience."* (Sarah, 23 years old, Bangladeshi, PWP for 1 year)

Participants are more than happy to provide cultural adaptations, and they truly understand that their clients respect and appreciate when they go the '*extra mile*' within

the treatment to ensure suitable adaptations are applied, to further support their clients' well-being throughout their treatment trajectory.

Overall, participants have expressed that making cultural adaptations is advantageous for their clients and they understand the benefits of implementing them, *rather than assuming one size fits all' (Paperclip)*. Even though embedding cultural adaptations can come with its challenges, this study's foci point was participants showing the salience of cultural adaptations despite the difficulties that can arise.

#### *4.4.2.3 Training or Burning (Out)*

Explicitly portrayed in the previous sub-themes (4.4.2.1 and 4.4.2.2), participants underlined the importance and the need for cultural competency training, so that they can better understand the different beliefs, attitudes and values that their clients have, as well as embedding cultural adaptations to best support them through their IAPT trajectory. However, numerous participants denounced how burnout is typical to experience working in the IAPT service.

*"I've got literally no time to do anything. And I'm relying on cancellations and people not attending their appointments to get my admin done. And that is quite stressful. But I still enjoy what I do. I just wish that the caseloads and the demands weren't so high."* (Sarah, Bangladeshi)

The majority of the participants, when they spoke about burnout, attributed this to the lack of time, high demands of clients needing support and insufficient workforce footfall. The above-mentioned factors have subsequent impacts on clinicians' working

ability, their mental and physical health, which further inhibits their performance to efficiently support their clients. Participants emphasised experiencing burnout that can result in a lack of time and energy to get involved in cultural competency training, thus leading to an unutilised opportunity to better support their clients from a CED background.

*“COVID created a huge backlog within [named NHS Trust] of people to see. So, there was this big pressure on us to kind of see back-to-back clients, as many as we can fit in a day, really. And I think that does create that pressure to just see so many people. [...] when the pressure is on, the individual differences it kind of goes out the window, ‘let’s just get through and see these people’. And I think that affects, your ability to reflect on each individual client to have space between clients to think and learn.”* (Mak, 35 years old, Bangladeshi, Clinician/Therapist for 12 years)

Participants have displayed that burnout impacts their well-being. With cultural competency training taking additional work to embed, to almost alleviate clinicians’ stress, there have been instances where participants found that they may deliver the standard CBT session. Thus, ‘*individual differences*’ can get pushed aside in order to get through as many clients as possible, especially given that cultural competency training and adaptations do require extra time to attend, engage and implement.

#### **4.4.3 Theme 3 Barriers to Access**

Participants have previously emphasised the importance of providing tailored support to their clients when they have entered the IAPT service; however, participants discussed how mental health stigma hinders progression and recovery, especially amongst

CED service users. Secondly, there are issues around accessing the IAPT service, which cause difficulties for service users who need to seek mental health support.

#### 4.4.3.1 Double/Triple Stigma

Challenges such as service users' perceptions of mental health can hinder progression. Participants in this study commented that amongst CED groups, their clients often referred to mental health stigma due to religion, family and cultural views, which are big factors affecting service users' recovery.

*"[B-M-E] they have like taboos and issues around mental health, and they're less open about them." (Safina, 31 years old, Pakistani, PWP for 7 years)*

*"Especially from Asian countries, I can hear that a lot. People are like, "Oh, my family thinks I'm just crazy. They don't understand, they think I'm lazy, but I have low mood." We don't see it so often from white people." (Alice, 35 years old, Greek, PWP for 2.5 years)*

Negative labels are attached to mental health, and participants discussed that their clients who come from diverse backgrounds often explain that their family members affix negative connotations onto them that can further push the stigmatised agenda.

Additionally, participants conveyed a double and triple stigma associated with individuals from a CED background. Hence, may result in implications for these specific groups.

*"A client who is from an ethnic background, and is also a gay individual, you know, that is a massive thing for them to tackle themselves, it does hinder their progress." (Miya, 23 years, Indian, PWP for 1 year)*

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Miya relates to the concept of the triple stigma and expresses that clients who are from a diverse background, paired with being LGBTQ+ and their mental health becomes multifaceted. Furthermore, due to clients having a stigmatised view of mental health, this can also deter or result in seeking support at a later date.

*“I've done triages with males from ethnic minorities, and they've been at crisis point, [...] felt so stigmatised to talk about it, that it's gotten to a point where IAPT isn't really even helpful at that point. [...] a difference with help seeking behaviours”.* (Angela, 25 years, white, PWP for 1.6 years)

Participants have noticed that CED groups may enter the IAPT service later, when their symptoms are more severe, and the IAPT service may no longer be an appropriate option of care. Entering the IAPT service when symptoms are severe may contribute to the difficulties in reaching recovery. Moreover, if delayed help seeking behaviour is not the factor hindering a client's progress, it may be the lack of a clear understanding of their symptoms.

*“[Individuals] from a non-white background, for instance, they might highlight more of their physical symptoms.”* (Diana, 28 years old, Indian, PWP for 1.3 years)

*“Explanation of symptoms in a very physical way [...] that psycho somatization I think, maybe the BME community is slightly a little bit more.”* (Mak, 35 years old, Bangladeshi, Clinician/Therapist for 12 years)

Participants stated that CED groups are more likely to articulate their mental health difficulties in a physical manner. Otherwise, if clients are explaining their mental health issues physically, then this can lead to an *'under report on their symptoms on the questionnaires'* Sarah exclaimed. Thus, it is important for HPs to be aware of these differences in diagnoses to be able to optimise the support for service users. The sub-theme conveyed varying factors that contribute towards inhibiting progression for CED groups and suggesting why there may be a disparity in recovery rates.

### 4.4.3.2 *Getting Your Foot in the ~~door~~ 'IAPT Service'*

Self-referrals are an option in the IAPT service to bypass GPs and to be seen at a quicker rate (Brown, 2018; Brown et al., 2014). Although, participants have mentioned that CED groups are typically the ones to be referred by GPs as the likely pathway to the IAPT service. Conversely, participants drew attention towards GP staff, not knowing what the IAPT does and wanting them to be more knowledgeable to help increase accessibility.

*"GPs don't really have a good knowledge of what IAPT actually offers (laughs)."*

(Daisy, 23 years, white, PWP for 1 year)

*"I think not as accessible as it could be. People will usually find out about IAPT through their GP [...] goes back to that point I was making about GPs being gatekeepers, especially people from ethnic minority background." (Mak, 35 years old, Bangladeshi, Clinician/Therapist for 12 years*

Mak questioned that some GPs are *'gatekeepers'* towards forwarding individuals to the IAPT service, and this may be because GPs might not be knowledgeable about the

service, which some participants suggested. Nonetheless, GPs can help bridge the gap for individuals, especially CED clients who might not be familiar with IAPT or the self-referral process, to help them get the support they need.

Another avenue to increase accessibility that participants mentioned was integrating with community groups to help educate and promote the IAPT service.

*“Going into the communities, and actually kind of informing people and giving them the knowledge of what therapy is all about, as opposed to what they think it is. And kind of breaking that stigma of that there is no shame in having therapy, as well.” (Sarah, Bangladeshi)*

Participants echoed the benefits of community outreach programmes to help educate and create social awareness about mental health support. The ideas presented by the participants offered ways to make the IAPT service more equitable and accessible for CED individuals, to either start using the service or to continue progressing while they are currently in the IAPT service.

## 4.5 Discussion

The current study explored the experiences of current IAPT clinicians’ perspectives on how they think the IAPT service can help to close the recovery gap to make equitable change for CED service users. Three main themes were constructed in the study. Theme one, participants outlined the importance of increasing diversity and representation amongst IAPT staff. Participants recognised that having more CED staff is important (especially in localities with a range of ethnicity groups) to offer a range of perspectives,

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understanding and representation for the varied IAPT clientele. Having an ethnic mixture in the IAPT service can provide the service users with a level of trust, comfortability to see people alike to them and a chance to be ethnically matched if needed to support with their treatment trajectory (Cabral & Smith, 2011). Numerous previous studies support that enhanced diversity among healthcare providers is linked to heightened quality of healthcare for patients (Ajayi, 2021; Stanford, 2020; Togioka et al., 2023).

Simultaneously, diversity also has implications for the CED staff within the IAPT service. The participants spoke about the advantages of having a sense of belonging within the workforce, which is linked to increased self-esteem, well-being and lower mental health (Waller, 2020; Walton et al., 2012). Having a sense of belonging can help staff feel valued, which is essential to feel part of the working community (Ching et al., 2022; Ruedas-Gracia et al., 2022). Various studies have positively shown that it is necessary to support the well-being of staff to reduce job dissatisfaction, burnout, physical/mental illness and increase self-esteem to foster better care for clients (Diver et al., 2021; Laschinger & Fida, 2014; Molero et al., 2018). However, CED participants in this study expressed feeling a lack of belonging to the workforce due to the poor representation that was further exacerbated by feeling like a symbolic hire (due to their ethnic background). When staff feel like a token hire it can create feelings of inadequacy (Ghosh & Barber, 2021), lead to isolation, pigeonholed and heighten anxiety and stress levels (Collica-Cox & Schulz, 2020; Dickens et al., 2019; Settles et al., 2019). Thus, participants outlined the implications that a lack of representation can have on both CED staff and service users in theme one of this study. Participants presented the importance of having a diverse workforce for the sake of both

staff and clients to feel a sense of belonging and representation, which can be translated to better practice/treatment delivery and care in the service (Gomez & Bernet, 2019).

Theme two encapsulated the essence of acquiring new knowledge on cultural competency, the confidence and ability to make adaptations whilst managing the challenges of burnout. Participants stated the lack of cultural competency training they received whilst within the IAPT service. Research within the health field acknowledges the importance of continuous staff training (Ortega et al., 2015; Price & Reichert, 2017). Training elevates staff's skillsets and allows staff to add towards their Continuing Professional Development (Filipe et al., 2014) and enhance client care standards to support their recovery (Mlambo et al., 2021). Whilst training is recognised as important for staff's professional development, participants in the current study noted that the training needed to be detailed, engaging and teach staff how to put what they have learnt into practice rather than a generic '*tick box*' exercise (Noon, 2018). Participants discussed that the training should have breadth, nuances and critical discussions to help clinicians reflect on how they can improve service delivery, especially to CED service users (Jongen et al., 2018; Koshy et al., 2017). Additionally, participants mentioned role-playing as a technique for learning. Rønning and Bjørkly (2019) found that role-playing is beneficial within the health field for both participants performing the role-play and their peers observing the role-play. The advantages of role-playing can help with understanding the different issues that can arise in practice and strengthen clinicians' self-efficacy and empathy to confidently implement within their sessions, aiding client recovery and satisfaction.

Participants from a white background described the challenges of making cultural adaptations. Research has suggested that some white therapists may feel uneasy and less

confident in making adaptations for clients from a CED background, and this can heighten feelings of anxiety (Naz et al., 2019). As such, this can lead to avoidant behaviour of not making adaptations due to therapists not wanting to offend their clients. However, the participants who expressed their experiences of making adaptations mentioned how their clients valued the tailored treatment that aided with treatment progression (Carmichael et al., 2022). When HPs show compassion, it builds a rapport and can lead clients to be proactive during treatment, which can aid with treatment success (Kornhaber et al., 2016; Moreno-Poyato et al., 2021).

Furthermore, participants portrayed the issues of burnout, which is typically seen within the health field and is mainly a result of staff shortages and/or high caseloads (Adnan et al., 2022; Hall et al., 2016). A particular interest of this study is the association between burnout and cultural competency training. This study found that burnout is impacting participants' ability to be fully engaged in cultural competency training/adaptations. With IAPT staff being overworked and feeling burned out, there can be a disservice to clients from a CED background to positively progress within the IAPT service if they do not receive tailored support. Thus, to help alleviate burnout, IAPT funding is needed to improve staff working conditions to help manage burnout (Steel et al., 2015). Increasing staffing can help clinicians feel less pressured in order to more easily take up cultural competency training and implement adaptations.

Theme three is composed of participants recognising the barriers and stigma that their CED clients experience. Poor mental health holds its own stigma; however, participants noticed that when intersectional protected characteristics such as ethnic background and gender identity are in motion, further stigma is implied (Grey et al., 2013; Yu et al., 2021).

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Nelson et al. (2022) found that Black women experiencing mental health difficulties were less likely to seek professional help due to the distrust they have with HPs, along with the systemic oppression they face, and therefore, statistically are more likely to be untreated. Intersectional identities due to systems of discrimination and oppression cause disadvantages towards those impacted that can contribute to the difficulties in progressing through the treatment and going on to recover (Bauer, 2014; Fagrell Trygg et al., 2019; Sen et al., 2009). Furthermore, participants found that their CED clients in particular described their symptoms physically (Evangelidou, et al., 2020; Grover & Ghosh, 2014). Due to diagnoses being of a westernised standard, HPs may misdiagnose individuals if clients are not emulating what is in the standardised handbook. Therefore, participants described the importance of being aware of the different descriptors of mental health symptoms by CED individuals. Another aspect participants underlined was promoting various avenues for accessibility. Common points raised were the need for GPs to become more knowledgeable to facilitate accessibility, especially as CED service users are typically referred by their GP (Harwood et al., 2021). Also, a few participants expressed how useful it would be to have community outreach programmes to reach CED service users. Reaching out to CED communities can create awareness of what the IAPT service is, how to access it and the benefits of the service. Also, outreach programs can improve their knowledge and reduce mental health stigma (Codjoe et al., 2021; Puffer & Ayuku, 2022). Once outreach has been embedded in a particular community, it creates a natural wave for the information to be shared throughout the community to increase the IAPT service reputation and gain trust amongst CED groups (Hoffman et al., 2016; Lansing et al., 2023; Puffer & Ayuku, 2022).

A limitation of the study was that there were only two HPs who identified as male. It would have been beneficial to hear from more male participants to add more context on their interactions with belonging to the service, delivering treatment and cultural competency. However, the low uptake of male-identifying participants could represent the gender imbalance within the IAPT service, with 82% of the workforce identifying as female (NHS Benchmarking Network, n.d., p.38-39). Thus, a suggestion for the IAPT service is to increase the uptake of male HPs. Moreover, although this study had an equal amount of CED and white HPs, it is still necessary to increase the diversity of staff, as currently 16% of CED represent the workforce (NHS Benchmarking Network, n.d., p.38). Increasing male and CED HPs enhances representation to support clinicians to feel a sense of belonging, alongside service users to have staff akin to them, enabling the option for gender and ethnic matching. Furthermore, this study emphasised that consistent and mandatory cultural competency training is required to increase clinicians' confidence to incorporate adaptations for CED clients. Cultural competency needs to be embedded from the top down. Thus, future research may consider interviewing policyholders and senior administrations within the IAPT service to discuss how to implement appropriate cultural competency/adaptations training for staff to immerse themselves without feeling burnt out.

### **4.6 Conclusion**

This research has contributed to understanding the myriad factors that impact IAPT HPs, such as the lack of diversity and representation in their service, low knowledge on cultural competency/adaptations, clinician burnout, stigma and accessibility that can influence the lower recovery rates amongst CED service users in the IAPT service. The findings from this study allowed for a range of IAPT clinicians from different backgrounds,

religions and geographical locations to delve into their experiences of the contributing factors that result in the disparity of recovery rates. In addition, participants discussed the importance of representation in the workforce. All participants, regardless of their ethnic/cultural background, mirrored the salience of diversity in the workforce that simultaneously supports clients through their IAPT trajectory. Overall, this study's novel findings have provided meaningful perspectives and suggestions for IAPT policyholders on what strategies can be considered to target the recovery differences to enable a more equitable service for all IAPT service users.

#### **4.7 Chapter Summary**

This chapter provided a comprehensive insight into the factors influencing IAPT recovery disparities from the clinicians' perspective. There was an emphasis on increasing staff diversity, in particular clinicians who are from a CED background, that would enhance representation to not only support the multitudinous service users that enter the IAPT service but also provide a sense of belonging to the IAPT service CED staff. Additionally, the requirement is for all staff to be provided with robust and mandatory cultural competency training to equip clinicians to embed adapted psychological treatment into practice to achieve equitable outcomes for CED service users. Furthermore, intersecting identities such as ethnicity, cultural background, gender identity, sexual orientation, religion and systemic barriers can further solidify the stigma associated with mental health that can contribute towards difficulties some CED groups experience when seeking IAPT treatment. Therefore, reinforcing the need for cultural competency training for staff to effectively support the different intersecting layers of their clients. Lastly, outreach programs to create a ripple effect that can foster community engagement and awareness of the IAPT service.

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Awareness would be useful not only to individuals who want access to the IAPT service but also to those using the IAPT service to reduce the stigma, so that service users can work on their recovery trajectory in the IAPT service.

## **Chapter 5. Exploring Culturally and Ethnically Diverse Current Service Users'**

### **Experience and Satisfaction with the IAPT Service (Study Two)**

#### **5.1 Chapter Overview**

This chapter evoked an in-depth exploration of the factors contributing to the health inequality gap between CED and white IAPT service users. This chapter aims to understand CED service users' perspectives of their satisfaction and experiences of their trajectory in the IAPT service. The chapter aims to identify both positive and negative issues that are currently arising whilst individuals are actively seeking psychological support. A qualitative approach of semi-structured interviews with 12 CED service users who are currently using the IAPT service. Reflective Thematic Analysis was used, whereby three themes arose from the analysis: (1) Cultural Versatility, (2) Session Dynamics, and (3) IAPT Accessibility. This real-time approach, rather than a retrospective viewpoint after treatment ends, might help highlight areas for improvement to better support the recovery of CED service users in the IAPT service.

#### **5.2 Background**

The literature has shown that individuals from CED (encompassing individuals who identify as Black, Asian, Mixed Heritage) backgrounds have more negative perceptions of mental health, greater barriers or coercive routes to accessing support and tend to experience poorer recovery outcomes of evidence-based psychological treatment (Naz et al., 2019; Nazroo et al., 2020; Raleigh et al., 2007; Weich et al., 2017). The IAPT service provides low and high-intensity psychological treatment where individuals can typically be referred by their GP or self-referred to receive support. Specifically, within the IAPT service,

Moller et al. (2019) found that the recovery rate for CED groups was 46.7% compared to 51.7% for white individuals. Various influences can create a barrier for CED groups that can inhibit their recovery trajectory and satisfaction in the IAPT service.

### **5.2.1 Representation, Diversity and Accessibility in Health Services**

Representation and diversity are deemed to be valuable assets for CED service users using mental health services (Bradby et al., 2020; Seeleman et al., 2015), especially as some CED individuals tend to experience 'cultural mistrust' towards white health professionals (Prajapati & Liebling, 2021). The cultural mistrust stems from the historical and contemporary discrimination, oppression, and racism experienced indirectly or directly (Brooks & Hopkins, 2017; Jaiswal, 2019; Stewart & Gonzalez, 2023). The issues surrounding a lack of representation and diversity within the mental health sector for CED groups can result in some difficulties with accessibility and engagement in psychological therapy (Winsper et al., 2023). Individuals from CED backgrounds may evaluate the potential positives (improving well-being and quality of life) and the limitations (potential risks posed to their personal and cultural identities) of accessing these services. There is evidence to suggest that some CED individuals have harboured scepticism towards white service providers that has created an additional layer when receiving psychological treatment (Earl et al., 2011; Winsper et al., 2023). Individuals from CED groups may feel hesitancy towards white clinicians not being able to understand their cultural beliefs and values, religious or spiritual treatment methods, as well as the clinician making misjudgements and stereotyping (Chauhan et al., 2020; Krishan Aggarwal et al., 2022). Thus, access and seeking psychological support become a challenge (Kapadia et al., 2017; Koly et al., 2022; Pederson

et al., 2022), and if individuals do cross the accessibility barrier, then the issue of not building a strong rapport becomes another barrier in treatment (Qina'au & Masuda, 2020).

A weak or poor therapeutic rapport can lead to service users having a lack of trust that their health professional is providing the appropriate care and working in their best interest (Kim et al., 2017). In addition, representation, such as physically seeing other CED health professionals in the work environment where CED service users are being treated in can be beneficial. Seeing health professionals with the same background results in a shared ethnic identity; for Black service users, a shared identity resulted in a feeling of confidence and a better understanding of their needs (Bowl, 2007). Although it is important to note that ethnicity alone cannot be the only factor to aid in supporting an individual's mental health journey, participants in Bowl's (2007) study expressed that reliability and trust are crucial amongst CED professionals. Therefore, it is essential for health services to incorporate additional supportive tools for CED groups, such as all staff being culturally competent and the potential of ethnically matching to aid treatment recovery and satisfaction for CED individuals.

### **5.2.2 Ethnically Matching Therapist and Client**

There is mixed research into service users being ethnically matched to their therapist (Cabral & Smith, 2011; Moller et al., 2016; Naz et al., 2019; Smith & Trimble, 2016).

Ethnically matching can serve as a profound facilitator to understand the cultural nuances shared between specific groups. The shared cultural background can enable a mutual and firm foundation to be built between the service user and therapist. This can enable the therapist to delve into the cultural contexts shaping service users' values, experiences and mental health trajectory (Cabral & Smith, 2011). The therapist can delve deeper by building

a rapport based on sharing similar values, which then can strengthen the trust between the client and therapist as a sense of familiarity can be fostered (Smith & Trimble, 2016). Trust in therapy is important to help reduce the stigmatising barriers that many CED groups hold before and whilst in therapy (Kapadia et al., 2017; Stewart & Gonzalez, 2023). Furthermore, the clinician's shared background can offer a source of validation (Asnaani & Hofmann, 2012). Hence, ethnically matching in therapy allows for a relatable professional figure that can offer a safe space for the service user to be open, comfortable and feel a sense of validation. This can reduce the stigma and mistrust perceptions, especially for those individuals who have experienced discrimination, historical racism or systemic racism (Brooks & Hopkins, 2017; Jaiswal, 2019). The clinician being able to acknowledge their unique challenges can help build a healthy therapeutic relationship to aid clients' treatment trajectory. Moreover, ethnically matched clinicians have the added advantage of clearly understanding and responding in the communication style of their client. Having similar language, tones, and expressions can be crucial when approaching sensitive topics, typically if the client is describing their psychosomatic experiences or using idioms (Cork et al., 2019; Greenwood et al., 2015; Kohrt et al., 2014). Due to sharing similar ethnic and cultural backgrounds as well as experiences and upbringing, ethnically matched therapists may be more likely to tailor interventions to align with the cultural preferences of their clients (Im & Chee, 2021; Joo & Liu, 2021). The effectiveness of customised interventions can resonate with the service user, rendering suitable therapeutic strategies that result in active engagement and progress throughout treatment (Berger et al., 2014; Smith & Trimble, 2016).

A challenge to ethnically matching clinicians to service users is geographical location. In the IAPT service, 84% of clinicians are from a white background (NHS Benchmarking Network, n.d., p.38-39). The scarcity of diverse ethnic backgrounds can make it difficult to implement matching, which perpetuates the challenges that health services have to provide appropriate care for CED service users (Bansal et al., 2022). Although, from the service user's perspective, ethnically matching can pose some challenges, such as service users fear that confidentiality may be breached if they have someone from the same cultural background (Moller et al., 2016). Interviews with South Asian individuals and their experiences of accessing mental health in the United Kingdom found that some participants discussed their distrust towards having an Asian health professional (Prajapati & Liebling, 2021), despite it being advantageous to have a clinician who understands an individual's cultural and religious aspects. With the Asian community being tightly connected, participants did not feel at ease to fully disclose information to their counsellor (Moller et al., 2016) and felt the matters they would want to discuss would undergo scrutiny. Hence, some participants echoed the preference for not being ethnically matched and for preferring white health professionals. Participants viewed white clinicians as being nonjudgmental, especially towards anything that was stigmatised in their South Asian culture. The participants felt that white clinicians remained neutral, which was important to allow them to express their thoughts and emotions (Prajapati & Liebling, 2021). Furthermore, ethnical matching may take away the inability to address other intersecting identities such as socio-economic status, gender identity and sexual orientation (Carbado et al., 2013; Crenshaw, 2013b). Exclusively focusing on ethnicity may result in a missed opportunity for service users to discuss other aspects of their identity that could be crucial

to what they have/are experiencing and how they might go about processing and constructing information, especially if they feel limited to only discussing one facet of their identity (i.e., ethnicity).

### **5.2.3 Culturally Informed Practices**

Though ethnically matching can provide an additional supportive layer for some CED individuals, there is a plethora of research on the salience of cultural competence amongst health professionals (Anderson et al., 2019; Herman et al., 2007; Kirmayer et al., 2012; Olaniyan & Hayes, 2022). Weich et al. (2012) indicated that CED service users appreciated clinicians who are culturally informed, skilled and provide good care, which was important for their treatment trajectory and not necessarily due to the health professional's ethnicity. Similarly, Steinfeldt et al. (2020) denoted that having culturally competent health professionals was a more effective approach than relying on the strategies of ethnically matching service users to therapists as a means of supporting CED groups. Cultural competency amongst healthcare staff is incumbent due to CED groups typically experiencing cultural/social exclusion (Naz et al., 2019). Cultural exclusion can be perpetuated through institutional practices, systemic barriers held within the health services and the complex sociocultural challenges, for example, socioeconomic inequality and racial trauma (Kirmayer, 2012; Stewart & Gonzalez, 2023). Thus, leading CED clients to feel that services may not acknowledge specific cultural inclinations. Culturally and Ethnically Diverse individuals may sense a perceived insensitivity (this could be based on pre-existing experiences or through shared knowledge) where they do not feel safe or comfortable enough to disclose culturally related experiences, beliefs and values. This could contribute towards the discomfort felt when CED individuals use mental health services (Islam et al.,

2015; Olaniyan & Hayes, 2022). Some individual therapists' attributes go the extra mile to repeatedly support groups of service users that are commonly mistreated (Berger et al., 2014). However, it is incumbent that all healthcare staff are culturally competent to increase health professionals' confidence, knowledge and to understand the various lifestyles and experiences of different demographic groups (Kirmayer, 2012; McGregor et al., 2019; Owens & Keller, 2018).

In addition to cultural competency, other research has highlighted the importance of spiritual competency to further support an array of service users (Islam et al., 2015; Vietenn et al., 2016). It is beneficial for health professionals to understand the dyadic relationship between service users and their faith/spiritual healer. Understanding this relationship can allow service users to be open and understood in the presence of their health professional when seeking psychological support, to delve deeper into their situation to aid recovery (Rabiee & Smith, 2014; Vieten & Lukoff, 2022). Although it is noted that a person-centred approach is required, health professionals should acknowledge any biases they have to avoid assuming that the needs of one service user's cultural, religious or spiritual needs are the same across all groups (Vela et al., 2022; Yager et al., 2021). Gearing towards individuality can help provide better care for service users' psychological trajectory (Critchfield, 2012).

#### **5.2.4 Current Study**

This study aims to explore the current trajectory of CED individuals' experience and satisfaction with using the IAPT service. Additionally, this research will provide insight into understanding what could be contributing towards the poorer recovery outcomes amongst CED service users. Investigating the seldom-researched IAPT service for CED groups'

recovery is salient to further address appropriate strategies to increase therapeutic alliance and clinical practice, to allow for appropriate support for CED individuals. The research questions are as follows:

1) What are CED service users' experiences of receiving treatment in the IAPT service?

2) What are CED service users' perspectives on diversity, inclusion, and representation in the IAPT service?

3) How accessible do CED service users find the IAPT service?

## **5.3 Methods**

### *5.3.1 Design*

A qualitative design was utilised to interview 12 CED service users who were currently using the IAPT service. One-to-one, online semi-structured interviews with open-ended questions were used to explore participants' thoughts, feelings and experiences using the IAPT service. Also, to delve into participants' mental health experiences in regard to diversity, inclusion, accessibility and representation in the IAPT service. A semi-structured interview approach allowed the researcher to have a foundation of core questions while allowing the participant to have flexibility, if desired. This flexibility allowed for discussion of topics that were not considered by the researcher, and for the participant to raise sensitive topics as and when they felt comfortable (DeJonckheere & Vaughn, 2019; McIntosh & Morse, 2015).

### 5.3.2 Participants

Purposive sampling was used to recruit participants via Twitter. Twelve participants aged 24-31 years were recruited, with the mean age being 27 years ( $SD = 3.19$ ). The majority of participants were male (75%), identified as Black/Black British African (67%) and were Christian (83%). Sixty-seven percent of participants were referred to the IAPT service by their General Practitioner (GP), and the most common therapy received was Counselling for Depression (67%), followed by CBT (58%). Table 5.1 presents the demographics of the participants.

The inclusion criteria required that participants must be currently using an IAPT service and be diagnosed with a common mental health Disorder as outlined by NICE (2011), such as: Depression, Anxiety, Obsessive-Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD). The common mental health disorders listed are also the same disorders that the IAPT service treats; thus, it is appropriate to conduct the study using the same health disorders that the IAPT service focuses on. The inclusion criteria also required participants to self-identify as being from an ethnic minority background (Black, Asian or Mixed Heritage) (GOV.UK., n.d.); however, this study uses the term CED. Also, all participants were required to be over 18 years old and able to speak a good level of English to communicate in the interview, as no translators were used. The exclusion criteria stated that participants will be unable to take part if they are currently experiencing any other type of severe mental health disorder, such as Bipolar disorder, Psychosis, and Schizophrenia, as outlined by NICE (2011).

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**Table 5.1**

*Participant Demographics*

Pseudonym	Gender Identity	Age	Ethnicity	Religious Background	Referral Pathway	Rate Current Experience at IAPT
GH0420	Male	29	Mixed/ Multiple Ethic Group - white and Black African	Christian	Self-referral	Very Satisfied
JA9501	Male	27	Mixed/ Multiple Ethic Group - white and Black African	Christian	General Practitioner	Very Satisfied
JD4495	Male	25	Black/Black British - African	Christian	General Practitioner	Very Satisfied
JK9031	Male	29	Black/Black British - African	Christian	Self-referral	Partly Satisfied
JO6368	Male	25	Black/Black British - African	Christian	General Practitioner	Very Satisfied
KN3519	Female	25	Black/Black British - African	Christian	General Practitioner	Partly Dissatisfied
LT0492	Female	24	Black/Black British - African	Christian	General Practitioner	Partly Dissatisfied
MT7278	Male	31	Middle Eastern	Agnostic	Self-referral	Partly Satisfied
PDO224	Male	26	Black/Black British - African	Christian	General Practitioner	Partly Satisfied
SA4395	Female	23	Black/Black British - African	Christian	General Practitioner	Neither Satisfied Nor Dissatisfied
TL625	Male	34	Black/Black British - African	Christian	General Practitioner	Very Satisfied
YM1720	Male	26	Black/Black British - Caribbean	Jewish	Self-referral	Neither Satisfied Nor Dissatisfied

**Note.** Participants' names have been replaced with a pseudonym.

### 5.3.3 Procedure and Materials

Ethical approval for the study was granted by Birmingham City University, BLSS Research Ethics Committee (approval reference: Clarke-Jeffers /#9602 /sub1 /Am /2022 /Mar /BLSS FAEC). Further approval was sought through NHS ethics to make sure the study was scientific, ethically sound, safe and held integrity and indemnities for the service users participating. The researcher completed the 'Introduction to Good Clinical Practice (GCP)' eLearning, as well as completing forms on the Integrated Research Application System (IRAS). Ethical approval was granted by the Health Research Authority and the West Midlands Solihull Research Ethics Committee, who granted the study a favourable opinion (IRAS ethics reference: 22/WM/0086). The OSF pre-registration was submitted before the data collection commenced (<https://osf.io/rb56v/>).

The study poster (See, Appendix 5.a) was advertised on Twitter, with interested participants emailing the researcher to register their interest. The researcher provided participants with a link to Qualtrics, which is an online platform that was used to share information about the study and to collect demographic data. On the Qualtrics platform, the participants read the participant information sheet (See, Appendix 5.b), signed the consent form (See, Appendix 5.c) and created their unique pseudonym, which instructed participants to use the initials of their name and the last four digits of their phone number to protect their anonymity. Participants then filled out the demographic questionnaire (See, Appendix 5.d). The questionnaire outlined general information about the participant's ethnic background, gender identity and religion, followed by IAPT-related questions such as *"How did you access the IAPT service?"* and *"What type of psychological treatment have you received in the IAPT service?"*. Then questions on the subject appraisal of the IAPT service, for example, *"How currently satisfied are you with your therapist in the IAPT service?"*. Then,

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the participants could state their availability and were informed that they needed to e-mail the lead researcher to arrange the one-to-one interview. The interviews were arranged via Microsoft Teams with the 35-question interview schedule and prompts being developed prior (See, Appendix 5.e) based on existing mental health literature with service users (Lloyd et al., 2021; Loewenthal et al., 2012; Memon et al., 2016). The topics related to perception of mental health, accessibility to the IAPT service, experience of being in the IAPT service, therapist alliance and representation. Open-ended questions were used to elicit deep and meaningful content from participants to understand what their experience has currently been like in the IAPT service (Jamshed, 2014; Renger, 2023). Participants provided oral consent at the start of the interview before the researcher began the interview to ensure the participants were aware of what the study was about, their rights to withdraw and if they still wanted to partake. The interviews were audio-recorded via Screencast-o-matic and then uploaded onto the Audacity software to change the pitch of participants' voices to further increase anonymity. The recording was deleted from Screencast-o-matic and Audacity within 24 hours, with the recording saved to the university's password-protected OneDrive account. The interviews lasted between 31 minutes to 1 hour 13 minutes, with an average of 44 minutes. Upon completion, participants were debriefed verbally after the interview. Participants were also sent the debrief form (See, Appendix 5.f) that provided them with details of further support if they had been affected by the study, along with their unique withdrawal data if they no longer wanted to be part of the study for any reason. In addition, all participants were given a £20 Amazon e-voucher upon completion of the interview. The recording was transcribed verbatim with any personal identifies being anonymised.

### 5.3.4 Data Analysis

Reflective Thematic Analysis (TA) (Braun & Clarke, 2021) was used due to its flexible approach to identify meaningful patterns across the dataset for each participant involved (Braun & Clarke, 2006). Reflective TA involved the researcher to be actively engaged throughout the analysis process and to follow the six steps outlined by Braun and Clarke (2006; 2019; 2021), whereby the researcher played a pivotal role in coding, pattern-based analysis and generating themes related to the research question.

In the first step of 'data familiarisation', the researcher immersed themselves in the data by listening and reading the interviews whilst simultaneously writing notes on participants feelings and experiences of the IAPT service. Concurrently, the researcher had a logbook (*See, Appendix 5.g*) to bracket off to be reflective about their positionality (*See, Chapter 3.1.4*), such as being from a CED background and having preconceptions and biases. Second step, the researcher 'generated codes' using the comment function in Microsoft Word to capture descriptive content of the interview data (*See, Appendix 5.h*). The third step, 'searching for themes', the researcher colour coordinated by highlighting clusters of shared data generated by the recurring codes that shared meaning to be developed into themes (*See, Appendix 5.i*). Step four, 'reviewing themes', the researcher was aware of the recursive process during the analysis. The researcher continuously revisited steps such as re-listening and reading the interviews to fully grasp the experiences of the participants to ensure there were suitable codes to generate themes that were relevant to the research question (Braun & Clarke, 2006; 2021). Step five, 'defining and naming themes', was ensuring that the themes were succinct to provide the reader with an insight into what each theme would represent (*See, Figure 5.1*). To review the credibility of the named themes, the supervisory team checked this over. Step six, 'writing the report', the researcher ensured

that the narrative of the findings told a ‘story’ (Braun & Clarke, 2019) that produced themes that explored the suitability and satisfaction of evidence-based psychological therapy for current CED service users.

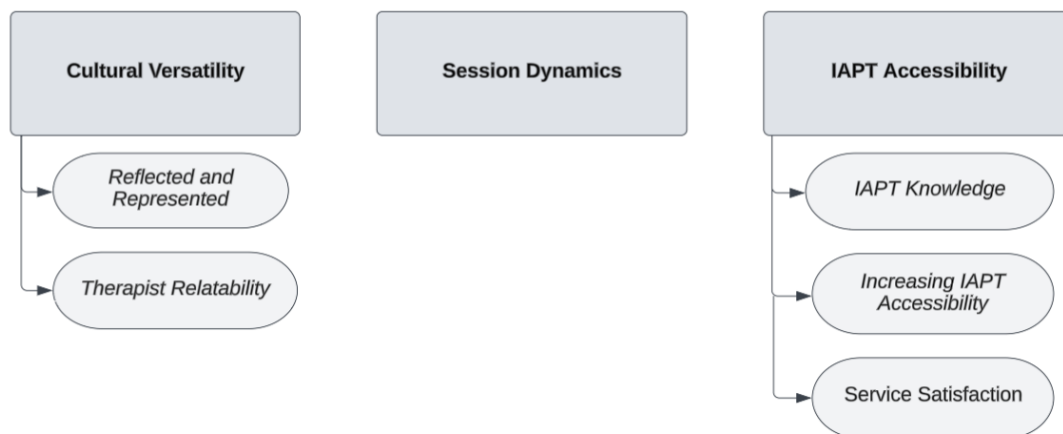
For RTA, there is no ‘optimum’ sample size (Braun & Clarke, 2021). This study halted recruitment at twelve participants. The information gathered had become sufficiently abundant and insightful to address the research questions and aims (Byrne, 2022). Data saturation was evident when the last few participants shared similar experiences to previous participants, thus no new data arose. Additionally, other mental health research with CED groups also had similar sample sizes for their interviews (Bailey & Tribe, 2021; Berzins et al., 2020; Faheem, 2023).

## 5.4 Results

A total of three themes were identified from the transcript data: ‘Cultural Versatility,’ ‘Session Dynamics,’ and ‘IAPT Accessibility’. The themes and sub-themes are summarised in Figure 5.1.

**Figure 5.1**

*Thematic Map of the Theme and Sub-Themes*



### **5.4.1 Theme One: Cultural Versatility**

Participants discussed the importance of being represented within the IAPT service. With mental health being a taboo subject for many people, particularly individuals from a CED background, and the difficulties attached to seeking support, being comfortable within a new setting is vital. One factor that can increase comfortability within the health setting is having staff who reflect the ethnic and cultural background that the individual belongs to. Being able to culturally relate was a shared consensus amongst participants, especially as individuals may already be feeling estranged, dealing with their mental health; thus, representation can aid in their mental health trajectory.

#### *5.4.1.1 Reflected and Represented*

In this sub-theme, participants deduced that the IAPT service is not culturally and ethnically representative *'They're mostly white [staff in the service]'* – KN3519. Participants desired to have a service that includes staff members who reflect their cultural background. Reflection of one's ethnic and cultural group can help to increase inclusivity, which can allow CED individuals to feel integrated and accepted in the IAPT service.

*If I go to a place, I need to see more ethnicities there so I can feel accepted [...] seeing your own person it's it's like, it feels like home."* (YM1720, male, 26 years old)

*"When you talk to your fellow [person] that looks like you, everything like you, you usually feel a little bit closer to home, it's like you're at home."* (JK9031, male, 29 years old)

In this sub-theme, participants highlighted that the visibility of one's cultural background allows them to feel *'accepted'* within an environment where they typically may have been

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deterred from using and feeling that the service was not for them. Particularly, some participants emphasised that having reflection and representation in the service felt like 'home'. Positive connotations of the word 'home' signified that participants want to feel comfortable and to have a sense of belonging to the IAPT service, which is strengthened by having staff who look like them. Thus, creating a safe environment by sharing kinship with staff that they can identify with.

Participants were concerned with the lack of diversity amongst the IAPT service staff, which led participants to be sceptical regarding white staff being culturally competent and sensitive when working with patients from diverse groups.

*"Let's say I had a therapist who was white, I don't think he could relate to what me, as a Black person, have been through, discrimination from the police to everything. I don't think they can relate, it's a real thing. You know, someone who can relate to your issues would be much better since what you're saying, he can see it's happened or seen it happening to someone else." (JK9031, male, 29 years old)*

*"More access to therapists from like from minority backgrounds that are able to understand that that patient." (MT7278, male, 31 years old)*

Participants want to feel assured that when expressing their thoughts and feelings about mental health, particularly when they are mentioning sensitive topics such as race, discrimination and prejudice, that their voices feel heard. From the participants' perspective in this study, they felt that in order to discuss specific sensitive situations, having a therapist

who reflected their cultural background would be beneficial to have their voices heard and to also relate to their issues.

Evident in this sub-theme, participants described the lack of diversity and inclusion in the IAPT service and noted that the representation of staff needs to be increased. Increasing diversity can allow CED service users to feel reflected, represented, and have their voices heard. Theme 1.2 delves deeper into service users' experiences of having psychological interventions with therapists from either the same or opposing cultural backgrounds and what their experience has been like thus far in the IAPT service.

### *5.4.1.2 Therapist Relatability*

There is not always the option for service users to be ethnically matched to a therapist in the IAPT service, which can be due to the locality lacking diverse groups of staff. However, in this sub-theme, participants expressed the benefits of having a therapist from a similar background and how salient that is for their progression in therapy. Additionally, there were some participants who spoke about their experience of not being ethnically matched. The excerpt below outlines how meaningful it was to have a therapist they could relate to.

*“This person is able to relate with your realities, and also relate with your background. [...] It's been quite easy [building a rapport]. And I think that's because we're from the same race. So, there's a way we share that common ground.” (GH0420, male, 29 years old)*

*“I think well somehow the good thing is this therapist is Black. So, I think this was our first connection. And it's just been magical how we are able to link up and just have good communication. [...] People are comfortable with people who are like them. And I think when we identify certain common grounds with people it makes us feel comfortable.”* (TL625, male, 34 years old)

Relatability was a recurring theme that allowed the service user to feel a mutual connection with their therapist based on their cultural background. Having someone they could relate to made it easier for them to feel comfortable expressing their experiences without fearing judgment or their realities not being understood. Participants who were ethnically matched (consciously or by choice) shared how much they valued having a therapist who could identify with them, not only on a surface level of being from a similar ethnic group but also deeper, such as how their cultural background can impact their views of mental health and treatment.

Conversely, other participants who had a therapist from a different cultural background articulated the challenges of not feeling comfortable to be able to express themselves, due to the fear of their perspectives not being palatable for the therapist to understand.

*“Hard because communicating with the therapists at the beginning was hard as my therapist was not from my race [...] it was not very easy for me. [...] I didn't feel comfortable to talk or to even share in the first place, maybe I was sensitive to the race. You know like a bias, that I also have so I was not feeling too comfortable to want to share.”* (JA9501, male, 27 years old)

*“Not really comfortable with [having a white therapist] [...]. Because there are some things that I would love to say, but I'll have to reserve it. [...] I'm like, "how will the other person take it?" like just having that kind of mindset, maybe this person may take it the other way around, or something else.” (SA4395, female, 23 years old)*

Apparent in the quotes, the participants felt that they did not feel comfortable enough and had to ‘reserve’ specific topics of conversation within their therapy sessions. JA9501 did allude to the fact that the therapist may hold biases, which made them feel restricted from expressing their concerns on topics related to ethnicity and their cultural background. Although participants felt wary about how their therapist may react to specific sensitive topics, it could indicate that the therapist may not be creating a safe environment where the therapist openly states and provides comfort to their patients to want to delve into sensitive conversations.

Oppositely, there were some participants who did have a therapist from a different background. Participants spoke about the positive experiences they are currently having so far in the IAPT service and being surprised by how they were made to feel comfortable to discuss topics even though they are not culturally related to their therapist.

*“At the first instance of my therapist [white British], I was actually cold because I really didn't know the kind of person he is. But I got to understand over time that my therapist is one of the best, very accommodating, very social in nature. And he is also friendly. [...] I find myself expressing myself easily to him.” (JO6368, male, 25 years old)*

*“We’ve had a lot of discussions and I have talked about my my race and identity and she tells me about hers, it's pretty just been fun because she's exposed and she's open minded. [...] That thought [having a Black therapist] did come in my mind the moment I met her [...]. But it did not linger for long because we got off on a good foot and continued the bond.” (LT0492, female, 24 years old)*

Participants who were not ethnically matched speculated that they were uneasy when first meeting their therapist from a different ethnic group. However, participants reported that they were able to gain a rapport and are currently working well with their therapist to progress through the treatment. LT0492 appreciated that their therapist provided a safe environment where they openly had discussions about their identity and background. The therapist showed their client that even though their cultural backgrounds differed, they were understanding and willing to learn, which made them feel comfortable, whereby it did not matter that they were not ethnically matched. Thus, showing that when a therapist is culturally competent and sensitive, this translates into the therapy sessions, whereby, regardless of who the patient is, the level of comfort to discuss anything is provided.

This sub-theme underlined that cultural versatility amongst IAPT staff does need to be increased to help enhance service users’ sense of belonging in order to feel represented in the service. Additionally, most participants in the study explained the advantages of having a therapist whom they can identify with to share their truths and realities with. However, the few participants in this study who did have a therapist from a different culture explained how this can also be beneficial, provided the fact that the therapist allows for an

open and non-judgmental space to discuss sensitive and personal issues. Also, being a culturally competent therapist who acknowledges and understands varying beliefs, values, ethnic and cultural groups is critical as it allows the therapist to share a mutual understanding with their client that allows for an open and safe space to be made available for service users.

### **5.4.2 Theme Two: Session Dynamics**

Participants discussed the modality of how their IAPT sessions were delivered. It was interesting to observe the varying opinions that the CED participants had on group vs individual sessions to aid with their psychological well-being.

There were some participants from this study who had positive experiences of engaging in group therapy. They mentioned the benefits of learning from other people in the group sessions that has helped support them in their current mental health trajectory.

*“I prefer group because other people were there to ask my question and [I could] learn from it.” (KN3519, female, 25 years old)*

*“I got to learn experiences of a lot of people, and then I also I was able to learn from how these people are experiences and also helping them. So, it was interesting for me, to hear real life experiences from other people [...] They are actually from a similar age, similar ethnicity and mental health diagnosis.” (JA9501, male, 27 years old)*

The preference towards group sessions was highlighted as CED participants enjoyed the fact that they had people with similar demographic characteristics that they could relate to and also learn from. Being able to identify with other people in a group can almost normalise and help CED individuals come to terms with the fact that they are not the only ones suffering from poor mental health problems. Furthermore, group sessions allowed for

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the opportunity to hear other people's questions and for topics to naturally arise. This helped participants to learn from their peers from similar cultural backgrounds in the group setting and to retrieve answers, but also to reflect on their personal trajectory and what they want to get out of treatment.

On the other hand, some participants felt that the group session could be a daunting experience. Participants explained that they wanted a space where they felt comfortable and free from any judgment of others.

*"I prefer the physical [one-to-one, face-to-face]. I usually want to talk about a lot of things, I can be talkative sometimes [...] I want to say a lot of things out that I feel because that also helps me to feel better. And I wouldn't be so comfortable saying it in a group of people." (LT0492, female, 24 years old)*

*"I actually don't get to talk so much because I don't feel so safe. Yes, I try to make a little impute but I don't get to express myself as much as I want to." (PD0224, male, 26 years old)*

Being open about mental health is a big step, especially for CED groups that hold a double stigma (Yi et al., 2023; Yu et al., 2021); thus, for some participants, it is not ideal to have group sessions if they do not feel comfortable enough to express their emotions to strangers. Therefore, there was an emphasis on participants expressing the benefits of individual sessions in relation to the time duration to work through and discuss their issues. Also, there was an acknowledgement by some participants that they felt a sense of belonging during one-to-one sessions that enabled them to gain a rapport with the therapist and say what they would like in the session.

*“I actually like sometimes that, you feel that sense of belonging, that emotional attachment is there for you with the person one to one and the experience of it also makes it better.” (JO6368, male, 25 years old)*

*“The individual, one on one appointment, I really enjoy that [...] Like, at that moment, they are ready to see your behaviour. And to ask some vital question to see you react and how you feel at that moment.” (JD4495, male, 25 years old)*

*“I prefer one to one because I can say whatever I feel like, and I can get it fixed [...] they have the knowledge the technical ability to fix it.” (YM1720, male, 26 years old)*

Furthermore, individual sessions were emphasised as being important as participants felt an emotional connection, albeit remaining professional with their therapist, where they could be honest about their experiences without any judgment from others (which may occur in group sessions). Also, individual sessions allowed participants to ask specific questions relating to their mental health journey and be provided with direct answers, rather than the discussion points being either generalised to the group or unable to get in-depth support due to time restrictions in group sessions. Participants echoed that individual sessions allowed for personalised support to work through specific issues that arise during the session.

Theme two outlined how useful it is for the IAPT service to have and offer CED service users different delivery methods of psychological sessions. Group and individual sessions both have advantages and limitations, and this study showed a split in the preference based on participants' opinions. Therefore, the study shows that there is a preference for having different delivery styles of group and individual sessions. The ability to

offer different delivery styles can enable a more comfortable and tailored experience for CED service users, where they have the option to change (group or individual sessions) if needed to get the most out of the treatment based on how the session is delivered.

### **5.4.3 Theme Three: IAPT Accessibility**

There is an increased concern from the service users' perspective regarding the awareness of what the IAPT service is; also, how individuals from CED backgrounds can easily access the service when in need of psychological support. Participants discussed the challenges experienced amongst CED groups that can deter them from receiving IAPT help. Additionally, participants spoke about the usefulness of GPs who act as a gateway to the IAPT service. Furthermore, it was salient for participants to provide their opinions on what the IAPT service can do to allow it to be more accessible for CED groups, rather than CED groups feeling marginalised, hence not seeking support. Lastly, participants summarised their satisfaction with their IAPT trajectory thus far.

#### *5.4.3.1 IAPT Knowledge*

Before entering the IAPT service, participants echoed a common consensus of CED groups not being aware of what the IAPT service is. The lack of awareness leads to individuals not knowing where to seek support or even how to approach a sensitive topic, such as mental health, to ask questions that can direct them on the right path.

*“A lot of people don't know about IAPT services, and they don't know how to get it, how to assess it, they have to ask questions.” (LT0492, female, 24 years old)*

*“My community where the Blacks there are some people that lack information, or they don't have access to proper information. So, they don't have [any] ideas [about] the IAPT service, or any other people that will try to further support to them.” (JD4495, male, 25 years old)*

Furthermore, CED groups have to deal with systemic levels of oppression that may directly and/or indirectly affect them, which can cause an avoidance of accessing the IAPT service, even if they are aware of the service. Thus, removing inequality barriers is difficult, especially when it is deeply rooted and embedded in CED thoughts. Individuals' fear of being stigmatised, being mistreated, and their symptoms worsening due to the health service not being culturally competent, as there is a focus towards treating white individuals.

*“Stigmatisation, racial discriminations, is also a challenge for people. I think a lot of people are very less comfortable with accessing help especially in the United Kingdom. At the moment, the healthcare system is mostly catered towards white people.” (JA9501, male, 27 years old)*

Therefore, to help alleviate the negative perceptions that CED groups hold, participants emphasised that accessing the IAPT service through their GP is a beneficial entry point.

*“My GP already told me that the service is very good, that they will be able to walk me through. So, I already had that expectation that it will be good for me.” (KN3519, GP referral)*

*“They always recommend to do self-referral. But it's harder to do because it's like, I have to admit I have a problem.” (MT7278, self-referral)*

Participants had trust in their GPs' expertise to appropriately refer them to the IAPT service. Moreover, in this current study, there were eight out of twelve participants who stated that they accessed the IAPT service through their GP. Thus, emphasising that CED groups are more likely to seek refuge for mental health difficulties through their GP. Nonetheless, some participants implied that the self-referring process was more challenging, particularly if one does not know how to access the IAPT service due to the lack of awareness or because one has to admit to having poor mental health, which is a challenge in itself. Hence, going to a GP can help them to identify their thoughts and feelings before seeking further support through IAPT services.

### 5.4.3.2 Increasing IAPT Accessibility

The majority of participants noted that reaching out to CED community groups would be a strong plan to help educate and create awareness of what mental health is and how they can seek support through IAPT services. Participants exhibited a passion for wanting the IAPT service to be more accessible, as they are currently benefiting from the service so far.

*“There’s a big opportunity to use community groups to use social groups and try to reach the message about the existence of service, existence of IAPT. And you know, all these things can be improved [...] minority groups have grouped themselves into community groups.” (TL625, male, 34 years old)*

*“The information about IAPT services needs to go out there into the communities, it needs to be heard in the communities, local pharmacies, the local community centres, local council, they have a lot of work there, to put the word out there for the community members.” (GH0420, male, 29 years old)*

*“Outreach is obviously very useful. I think outreach is good to discuss about mental health with someone who can speak a language with someone who is able to explain the benefits for themselves, and how it can benefit the people around them, I think might be useful.” (MT7278, male, 31 years old)*

Alongside community outreach programmes, participants mentioned that making cultural adaptations would be valuable. To have IAPT workers who can speak different languages within specific CED community settings would allow for a greater connection to be built to help increase the community’s knowledge on how and where to access IAPT services.

#### *5.4.3.3 Service Satisfaction*

Most participants in this study rated their IAPT experience positively. To objectively quantify their experience, eight participants responded by being very or partly satisfied with their current IAPT experience. The reason for the high satisfaction incorporated how they felt about the general IAPT service, their current treatment, their therapist, feeling a sense of belonging at IAPT and recommending the service for others.

*“I would say it's very helpful for me because it really helped me manage my stress and other common symptoms of mental health problems.” (SA4395, female, 23 years old, neither satisfied nor dissatisfied with IAPT experience)*

*“I found it helpful [receiving CBT and counselling for depression]. I really [seen] improvement in my mental health and I'm actually delighted that I got this help. [...] 10 because I really like it, everything. The service, the therapist. I think I am delighted with the services I'm getting.” (JO6368, male, 25 years old, very satisfied with IAPT experience)*

The optimism of participants' current trajectory in IAPT was consistent in this study. Participants expressed that they feel their mental well-being has improved since accessing the IAPT service and have noticed positive shifts in their thoughts, feelings and behaviour. Individual's expectations of the service have either been met or exceeded. Similarly, participants have appreciated the type of psychological treatment they are receiving and building a rapport with their therapist, who has been contributing to the success and enjoyment of the treatment they are receiving. In addition, PD0224 explained the importance of being proactive to get the most out of the therapy:

*"I just see it as a working progress. And it's not just about just the treatment itself, I think, from what I was told, or my therapist has said, it's about being involved, not just being a part of the process, it's also been involved in the process, wanting to get better, trying to put yourself out there. So, it's not just about just coming in and receiving treatment."*

(PD0224, male, 26 years old, partly satisfied with IAPT experience)

It is important not to be passive when receiving psychological support. An individual's attitude can directly aid behaviour change (Verplanken & Orbell, 2022). Therefore, when an individual's attitude is geared towards being involved in the psychological process, it can facilitate positive interactions and help them get the most out of the treatment. Putting in the work is essential, which could help explain why the majority of the participants in this study have found that being proactive has contributed to a satisfactory experience so far within the IAPT service. Participants are showing that what you put in is what they will get out of treatment, which has allowed them and others to see their progression.

Although, there were a few participants in this study who spoke about the challenges they have noticed in IAPT. The main issue indicated was the low footfall of staff.

*“I really disliked the understaffed nature, they are understaffed. And well, I think they could do better by having more staff.”* (TL625, male, 34 years old, very satisfied with IAPT experience)

*“I understand like, it's a limited service, the people that work in the services are limited by what they have to do.”* (MT7278, male, 31 years old, partly satisfied with IAPT experience)

Although MT7278 captured that staff themselves are doing the best they can with the resources they are limited to, so they can best support their service users. Thus, participants urged that more staff are needed who could help more CED patients to recover.

Theme three, participants conveyed that increasing the awareness by having community outreach to discuss what the IAPT service is and what they provide is quintessential to engage CED groups to access psychological treatment. Additionally, GPs are an advantageous factor to particularly aid CED groups into the IAPT service; thus, GPs' knowledge of the IAPT service is vital to ensure patients are being directed to the appropriate services. Overall, the CED participants in this study are currently having a good experience using the IAPT service, with the majority of participants rating it favourable and beneficial for their mental health. Thus, all participants are continuing their treatment with nobody raising a cause of concern to withdraw from the process.

## **5.5 Discussion**

The study aimed to explore what factors could be contributing to the health inequality gap of CED service users not recovering as much as white service users do in the IAPT service. The researcher therefore investigated current CED service users' experiences

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and satisfaction with receiving psychological therapy within the IAPT service. Three themes were generated: (1) Cultural Versatility, (2) Session Dynamics and (3) IAPT Accessibility.

Theme one encapsulated participants' perspectives on the need for cultural versatility amongst the IAPT workforce and an insight into cultural competency. In accordance with previous literature, representation and diversity of staff are salient, especially for CED service users to feel that they are being physically reflected in a service they are using (Bowl, 2007; Seeleman et al., 2015). Smith and Trimble (2016) discovered that CED individuals often feel more at ease when confiding in a therapist who shares the same or a similar ethnic/cultural heritage. The comfortability stems from a sense of relatability that can reduce the fear of judgment when discussing specific cultural beliefs. Thus, cultural relatability can facilitate better communication and understanding that can lead to effective therapy outcomes. Also, having a diverse workforce helps to reduce the health inequalities and to cultivate an environment to promote and value different cultures (Valantine & Davis, 2021). These assumptions were shown, respectively, in the narratives of this study and reinforce the importance of staff diversity. Linking with the drive for representation, depending on the IAPT locality, the diversity of clinicians allows for the option to ethnically match service users to clinicians. Participants who were ethnically matched found this type of cultural adaptation useful for their engagement in therapy. Ethnically matching can facilitate trust, understanding and effective communication for CED groups to share their cultural beliefs in relation to their mental health experiences (Smith & Trimble, 2016).

Conversely, it is salient to recognise the potential drawbacks of ethnically matching, such as service users' fear of confidentiality exposure and assumptions of homogenising CED cultural backgrounds (Aspinall, 2021; Keshet, 2019). Although some participants expressed

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the benefits of being ethnically matched, being matched is not always possible or required. Therefore, research has highlighted that all staff should be culturally competent and sensitive towards clients beliefs, values, ethnic and cultural background to understand the needs of their client in case they need to make suitable adaptations in order to support their psychological trajectory (Naz et al., 2019; Steinfeldt et al., 2020) The IAPT service must strive towards a balanced approach that acknowledges the significance of cultural competence and the complexity and intersecting identities of CED service users. By cultivating mental health awareness and understanding the different health beliefs amongst varying demographic characteristics, mental health practitioners can work towards creating an inclusive and effective therapeutic environment for individuals from CED backgrounds to be recipients of effective and empathetic mental health care.

Theme two emphasised the importance of varying how psychological treatments are delivered to individuals, i.e., one-to-one or group sessions. There were mixed reviews, with some participants endorsing the importance of one-to-one sessions while others stated that group sessions can be vital. Participants noted that one-to-one sessions allowed them to be more comfortable creating an emotional connection with their therapist, as there is no judgment from the group. Literature has consistently shown that people hold a stigma regarding mental health (Brooks & Hopkins, 2017; Pederson et al, 2022) as well as the fears of privacy and confidentiality of their information (Lasky et al., 2006; Wong et al., 2015); therefore, one-to-one sessions can help reduce the trepidation that individuals experience. Also, participants spoke about the emotional connection one can receive during one-to-one sessions. A strong therapeutic alliance is important in therapy to promote validation and emotional support to enhance an individual's mental health (Wampold & Flückiger, 2023). To have a robust therapeutic relationship, it may be easier to build a rapport during a one-

to-one session when there is more time and a greater focus on the individual (Tsai et al., 2019).

Additionally, one-to-one sessions can enable the individual to be introspective with their emotions, thought patterns and behaviours that can increase their self-awareness to promote personal growth for the well-being (Klussman et al., 2022; Sutton, 2016). Hence, showing the benefits that one-to-one sessions can offer. Conversely, some participants expressed that being in a group environment with others from similar and/or different demographic backgrounds was advantageous to learn from each other. Group settings offer individuals the ability to share their experiences, ask questions (that others may not have thought of) and provide an insight into what they have learnt on their mental health journey. Research uses the term 'peer-to-peer learning/teaching' whereby individuals have the opportunity to share knowledge, advice and have active participation to support each other's mental health needs within the group setting (Biagianti et al., 2018; Naslund et al., 2016). Topping et al. (2022) inspected 58 systematic and narrative reviews and meta-analyses on various health topics relating to peer counselling/education. Topping et al. (2022) found that peer counselling/education was an effective strategy to aid others' knowledge that resulted in behaviour changes from their teachings. The current study found that both group and one-to-one sessions hold advantages and disadvantages, which are supported by similar research (Tsai et al., 2019; Topping et al., 2022; Wampold & Flückiger, 2023). This current study showed and supported the avocation of both delivery methods as being appropriate within the IAPT service. Both delivery approaches can alleviate worries that CED groups may have about sharing their mental health concerns and provide a level of comfort to express their thoughts and feelings in a safe space. Although it would be beneficial for therapists to ask their clients during the mid-point of their sessions if they

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would prefer trying a group session, for instance (or vice versa), to aid with their recovery and satisfaction in the service. Although it is important to understand the limitations of resources in the IAPT service, that can make the aforementioned requests difficult to tend to.

Accessibility was the third and final theme highlighted in the study. Access to the IAPT service or any mental health service can be challenging for individuals (Lowther-Payne et al., 2023; Memon et al., 2016). Individuals, particularly from CED backgrounds, may lack the knowledge of what mental health support is available. Hence, making it difficult for them to ask appropriate questions to seek support on where they can access mental health services (Bansal et al., 2022). Also, the barriers of discrimination, racism and oppressive services are an additional drawback as to why CED groups often fail to reach appropriate care (Eylem et al., 2021; Kapadia, 2023). To enable CED service users to get support with access, GPs are vital in aiding the transition for CED groups to obtain further psychological support. In line with previous research, Harwood et al. (2021) also found that CED individuals typically use their GP to seek support as a preferred referral pathway.

The IAPT service does offer self-referrals as an option (Brown, 2018). Though service users discussed the challenges of the convoluted self-referral system. Service users may hold a mental health stigma, such as admitting they have a mental health difficulty, which can be an obstacle. Attached to the stigma is the associated fear and oppression that CED experience generally within the medical field that can inhibit CED service users from seeking support; thus, self-referring does not always make this process easier (Fagrell Trygg et al., 2019; Grey et al., 2013; Yu et al, 2021). Therefore, this study showed that many participants discussed that seeking initial support from the GP offered a smoother transition into

accessing support. Thus, it is salient that GPs are aware of their position as facilitators towards enabling CED groups to access further psychological support.

Another way to increase accessibility that participants spoke about was the benefits of outreach programs and going into CED communities to enhance individuals' understanding of how to access the IAPT service. The efforts of community outreach tend to have the ability to decrease stigma surrounding mental health whilst simultaneously fostering a neutral approach to disseminate information and build a solid foundation for CED groups to trust and want to access the health service, such as the IAPT service (Castillo et al., 2019). In terms of the satisfaction and the accessibility of what the service users have experienced so far in the IAPT service, it has been shown to be positively reciprocated. Previous research has indicated that CED individuals tend to have poor satisfaction when receiving psychological treatment (Nazroo et al., 2020; Raleigh et al., 2007; Weich et al., 2017). However, these study findings have shown that the majority of participants have been satisfied. A key aspect contributing to their satisfaction was the effort they invested in the therapy. The efforts discussed were making sure they attend sessions, ask questions, be open, listen to their therapist and complete the homework set. The efforts put into the therapy session have helped participants to achieve the best possible outcomes from the treatment, which has enhanced their satisfaction. Individuals who are proactive in treatment can have better clinical outcomes where engagement and adherence to the therapy are heightened (Dixon et al., 2016). Thus, the participants in the study were individuals who embodied being proactive and had positive attitudes towards receiving treatment (Verplanken & Orbell, 2022). Hence, having an encouraging attitude may explain why the majority of the participants in this study expressed that they were enjoying and receiving appropriate IAPT support. The primary limitation that hindered some participants'

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satisfaction was the issue of low staffing levels. Participants emphasised that more staff are needed in the IAPT service to help reduce the waiting times and have a range of therapists from different demographics to give participants options of which therapist they think they would be best suited to, to aid their treatment trajectory.

Overall, improving accessibility as a theme in this study is consistent with previous research, and Lowther-Payne et al. (2023) postulated that there are frequent attempts to understand and rectify the accessibility inequalities in mental health services. However, their research conveyed that amongst the systematic mapping they completed, little has changed to enhance accessibility, which was reflected in this current study of accessibility remaining an issue. Although it was noted by Lowther-Payne et al. (2023) that depending heavily on quantitative evidence does not provide a holistic insight into the challenges of accessibility. Whereas this research allowed for participants to contextualise access in various ways, such as the knowledge, help-seeking and institutional barriers. Thus, the evidence provided by the participants, with the addition of other research, could help contribute towards improving healthcare accessibility. Finally, the issue of understaffing has negative implications for the staff, such as burnout (Delgadillo et al., 2018; Owen et al., 2021). The issue of staff burnout can transcend to their clients, which can impact the quality of care that service users receive. The therapist may not take a patient-centred approach, provide empathy, nor provide effective, tailored treatments that can make service users feel dissatisfied with the care provided (Delgadillo et al., 2018; Zarzycka et al., 2021). Participants are aware of the limited resources that therapists have to offer, and that staffing is a wider IAPT service issue (Steel et al., 2015) that needs to be sorted out, which could potentially aid satisfaction amongst their IAPT clients.

### **5.5.1 Reflexivity**

I felt that being an insider, due to sharing a similar ethnic and cultural background as the service users who participated in this study, was salient for building a rapport and having a space of comfort. Seventy-five percent of participants identified as Black, just as I do, and the 25% that stated a different ethnic background are categorised as being from a CED group, thus sharing similarities in our cultures to have a common understanding of their beliefs and values. Therefore, being an insider, I felt helped when asking questions on IAPT's representation, diversity and sense of belonging. The participants were free to discuss the disproportion of Black staff and how that can impact ethnically matching with a therapist and feeling a part of the IAPT service. However, I did notice that being an insider had a limitation, as participants would assume I always understood what they meant, as we shared a similar culture. Whilst I indeed understood what they meant, I had to tell participants to expand and elaborate on their answers so that I had a clear written description of their experience (Dwyer & Buckle, 2009). Additionally, it was salient for participants to elaborate on their answers because it was important for myself not to assume what their responses meant. Or to incorrectly interpret participants' responses based off my values and presuppositions that could impact the study (Barrett et al., 2020; Le Gallais, 2008). Hence, when receiving their answers, I ensured to bracket off (See, Appendix 6.g) by taking notes in my diary, which was essential to limit misinterpretation (Dörfler & Stierand, 2020; Sutton & Austin, 2015). Furthermore, I realised that being an outsider added some benefits to the study. I do not have a role working in the IAPT service, which I feel worked to my advantage in limiting socially desirable answers. Although, I did notice in my first two interviews that the participants were sceptical when discussing things about IAPT diversity and therapist interactions. I mentioned during the interviews that I wanted

participants to be honest, open and that the data I collect is confidential to ease their hesitation. Upon reflection after the first two interviews, I decided to be clearer with participants. I needed to assure participants that I have no affiliation with the IAPT service, so they felt comfortable expressing their thoughts and experiences without fear of judgment or repercussions. Overall, being reflective was key for this study, especially during the creation of the interview schedule, the live interview and the analysis to identify my feelings and thoughts whilst also thinking about how to improve aspects of my study.

### **5.5.2 Strengths, Limitations, Future Research and Recommendations**

A strength from this study was interviewing service users whilst they were currently using the IAPT service rather than interviewing after they had left. Thinking about retrospective events has the likelihood of inaccurate memories/recall errors occurring (Althubaiti, 2016; Khare & Vedel, 2019). Thus, interviewing whilst participants had experienced a minimum of two sessions allowed participants to reflect on how their sessions had gone so far and what they expected to see in the upcoming sessions. Early reflection could allow time for possible changes, such as a different therapist or delivery of intervention (one-to-one or group) to happen as they are still in therapy. Additionally, the study had 75% men, which is surprising as male participants, particularly CED men, do not often engage in mental health research (Lipson et al., 2018; Williams et al., 2022). Hence, this study provided an insight into their experiences in the IAPT service and maximised their voices, which are often limited (Islam et al., 2021). However, the large proportion of Black males that participated did mean that this study did not offer a range of robust accounts from other CED groups and genders about their experiences using the IAPT service, which may have resulted in different answers (Jacobs & Pentaris, 2021). Future research should ensure that various CED groups are accounted for to capture the wider IAPT population.

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Another limitation was that participants were paid for their involvement. Being paid could have increased the likelihood of socially desirable answers if participants felt that they would not be remunerated for engaging in a manner that they thought was appropriate (Grady, 2019; Largent & Lynch, 2017). Although the researcher did promote the study for months with no payment incentive, there was no uptake. Therefore, due to the lack of time and knowing the difficulty that can arise in reaching out to CED groups as well as CED groups trusting researchers (Islam et al., 2021), providing financial aid was justified. A further limitation is the potential bias of interviewing proactive individuals compared to not interviewing service users who have dropped out of IAPT. Interviewing participants who have recently dropped out may have provided myriad information on the factors that led to their withdrawal and potential dissatisfaction with the IAPT service. These particular participants may have been able to offer a different understanding of the recovery and the inequality gap; thus, future research may want to include them. Moreover, a recommendation to enhance this study would be to conduct a follow-up study with the same participants to see how they feel after treatment has finished. Having an additional interview could provide the researcher with surplus information on their likes and dislikes with the type of treatment, treatment delivery, their therapist, and to see if their level of satisfaction has remained or changed.

## **5.6 Conclusion**

The current study has provided a novel insight whereby CED service users who are currently using the IAPT service were able to provide their perspective on their satisfaction and experience trajectory. It was highlighted that ethnic matching should at least be an option for individuals, as it can help with building a rapport and is useful to have a therapist who aligns with their cultural values and beliefs. However, there is a greater need for

cultural sensitivity and competence amongst health professionals (rather than exclusively ethnically matching), being a necessity so they can recognise the different mental health beliefs, how to approach conversations and navigate treatment sessions (ability to offer one-to-one and group sessions) to support the unique challenges that CED groups experience. Thus, efforts towards a culturally congruent clinical practice are required to support CED service users in the IAPT service. Overall, most participants in this study were satisfied with how their current treatment in the IAPT service was going. Although, participants did express that it would be useful to promote mental health awareness in CED communities, which would be beneficial to reduce stigma and to widen accessibility, so they can get the support needed.

### **5.7 Chapter Summary**

This chapter investigated the factors contributing to the health inequality gap between CED and white service users within the IAPT service. It explored the experiences and satisfaction levels of CED clients that generated three main themes: 1) Cultural Versatility, 2) Session Dynamics, and 3) IAPT Accessibility. The study findings highlight the importance of cultural competence, flexible session dynamics to suit the needs of the individual, and improved accessibility to enhance the therapeutic experiences and satisfaction of CED service users in the IAPT service. This chapter contributes to the ongoing discourse on health inequalities within mental health services, particularly for CED groups, to help understand what factors contribute towards the recovery gap.

## **Chapter 6. Self And Identity: Examining The Effect Of Autonomy And Ethnicity On Mental Health Outcomes In Former IAPT Service Users (Study Three)**

### **6.1 Chapter Overview**

This chapter aimed to explore the effectiveness of IAPT services, evidence-based psychological treatment for Culturally and Ethnically Diverse (CED) groups. The study investigated the effect of ethnicity and other epidemiological factors (number of IAPT therapy sessions, previous use of IAPT services) and autonomy (self-awareness, sensitivity to others, and capacity to manage new situations) on mental health outcomes (anxiety, depression, and impairment in daily functioning) of IAPT service users. The following study included service users who had finished their IAPT treatment 3-12 months ago. Findings from the mental health literature frequently point towards lower recovery levels, as well as poorer maintenance of recovery post-treatment, for individuals from a CED background (e.g., Ali et al., 2018; Maura & Weisman de Mamani, 2017). Ethnicity has been a focal point of interest in this thesis and the general literature as a variable contributing towards the disparity between CED groups and white individuals' recovery when receiving psychological treatment (Carson et al., 2014; Cook et al., 2019). Therefore, this chapter goes beyond only considering ethnicity, and though it splits ethnicity into CED and white individuals, this study delves deeper by incorporating factors such as the level of an individual's autonomy, self and identity, which are all influenced by individuals' culture. By doing so, it aims to provide a more comprehensive understanding of the factors influencing the differences in recovery outcomes. It is envisaged that this chapter's findings will provide insight into whether the level of independence plays a role in varying recovery well-being outcomes between white

and CED groups. The findings would be beneficial to further understand the therapeutic challenges that can interfere with the effectiveness of IAPT treatment for CED groups.

## **6.2 Introduction**

Self and identity are important psychological constructs representing how individuals perceive and define themselves. An individual's cultural background influences these constructs. Culturally shared norms and beliefs are factors that contribute to how individuals would define themselves. The theory of self-construal (Markus & Kitayama, 1991) posits a framework to understand how different cultures foster other ways of defining the self, i.e., an independent and interdependent self-construal. An independent self-construal prioritises personal attributes, as the self is identified as separate from others, thus focusing on autonomy and one's goals. Typically, individuals from Western cultures, such as America and Europe, are more likely to favour the independent self-construal. Meanwhile, those with an interdependent self-construal, such as in East Asian cultures, there is an emphasis on group membership and social interactions (Markus & Kitayama, 1991; Triandis, 1989). The independence and interdependence self-construals are constructs describing oneself and identity. Although they are related, they are not empirically and theoretically the same as the cultural dimensions of individualism and collectivism. Hence, showing why some research uses culture as a proxy for self-construal (Cross et al., 2011; Markus & Kitayama, 1991).

Mental health literature consistently reports disparities in treatment outcomes, such as treatment intensity, on whether individuals who received low or high intensity treatment have positive outcomes of recovery. Some literature has shown that HI treatment is advantageous in treating anxiety and depression symptomology (Barkham & Saxon, 2018). Although some may argue that the effectiveness of HI treatment is driven by service users

receiving more sessions and contact (Chan & Adams, 2014). Conversely, low-intensity treatment should not be dismissed, especially as LI treatment can be a cost-effective and accessible way for service users with anxiety and depression to receive support (Lee et al., 2023). LI intensity treatment has also shown to be useful to aid recovery by reducing anxiety and depression symptoms (Delgadillo et al., 2014; Powell et al., 2024), and within the IAPT service, LI treatment is typically offered as an initial treatment and only 'stepping up' service users to HI treatment if required (Clark, 2011). However, Ali et al. (2017) longitudinal study of service users who completed LI CBT treatment, 53% of service users relapsed within 1 year, indicating that LI treatment may not be sufficient to help individuals maintain recovery. Both LI and HI have proven to be effective treatments for common mental health problems, which is why other research has not shown differences in the treatment type (Barkham & Saxon, 2018; Fordham et al., 2021). In accordance, Barkham and Saxon (2018) explored four treatment pathways (HI CBT only; HI Counselling only; LI CBT plus HI CBT and LI CBT plus HI Counselling) for individuals with poor mental health. The study found some differences in outcomes, but they were too small to have any clinical significance differences. However, HI Counselling was more effective for patients who required fewer sessions, while HI CBT was useful for individuals who had more sessions.

Furthermore, there are treatment outcomes disparities across different ethnic groups, with individuals from CED backgrounds often experiencing poorer recovery outcomes (Ali et al., 2018; Carson et al., 2014; Cook et al., 2019; Maura & Weisman de Mamani, 2017). A meta-analysis by Windsor et al. (2014) found that CBT was more effective in reducing substance use when comparing the pre- and post-treatment therapy outcomes for white groups, compared to Black and Hispanic groups in the USA. Individuals from a white background demonstrated a significantly more beneficial impact of receiving CBT than

Black and Hispanic groups. Similarly, recovery disparities amongst ethnic groups have also been observed within the IAPT service. The IAPT service provides low and high-intensity psychological treatment, such as guided self-help, CBT and counselling for depression (NCCMH, 2018). The recovery rate in 2017/18 for CED groups was 46.7% compared to 51.7% for white individuals receiving psychological treatment in IAPT services (Moller et al., 2019). Whilst much of the literature pertains to ethnicity as an influential factor driving the recovery gap (Morris et al., 2020; Windsor et al., 2014), evidence suggests that an individual's autonomy, which can be influenced by their cultural factors, may impact the success of psychological treatment for CED groups (See, Studies One and Two).

### **6.2.1 Cultural Variations in Autonomy**

The Autonomy-Connectedness Scale (ACS)-30, developed by Bekker and Belt (2006), provides a nuanced measure of independence through three subscales: Self-awareness (SA), Sensitivity to Others (SO), and Capacity to manage New Situations (CNS). This scale helps to explore the role of autonomy and connectedness in diverse cultural contexts, providing insights into the relationship between independence and mental health. Even if it can be argued that independence in ACS-30 is similar to the independence of self-construal's measures, the ACS-30 is not a measurement of self-construal per se (Bekker et al., 2011). Though for this thesis, the ACS-30 (Bekker & Belt, 2006) lends itself as a conceptual framework for understanding autonomy as a multidimensional psychological construct rather than a measurement tool. The sub-scales of SA, SO and CNS reflect varying levels of an individual's independence that manifest across different cultural contexts.

Self-awareness (SA) represents an individual's ability to understand their thoughts, emotions and behaviours. Self-awareness varies depending on an individual's level of independence. For example, individuals with a high independency (individualistic) are more

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likely to focus on their personal identity, goals and accomplishments (Triandis et al., 1990). Conversely, individuals with low independence (collectivists) might have a more relational form of SA by considering the larger group/communities' thoughts, feelings, and emotions (Sutton, 2016).

The subscale CNS outlines an individual's ability to navigate unfamiliar situations and to have effective coping strategies to deal with the new situation (Bekker & Belt, 2006; Maas et al., 2019a). Literature has found that individuals with a high CNS are associated with resilience and the ability to adapt to new circumstances (Tugade & Fredrickson, 2004). Individuals with high independence are likely to have strong social connections (friends and family) that provide emotional and practical support during challenging times to get them through unfamiliar situations (Chang et al., 2023; Ozbay et al., 2007). Whereas individuals with low independence may have a cultural propensity to be resilient and to ensure that they are able to adapt and be flexible to handle any new situation that arises (Hofstede, 2011).

The subscale SO is related to empathy and engaging in positive interpersonal relationships (Ringwald & Wright, 2021). Individuals who have low independence often display high SO, as their identity is closely embedded in their social network (friends/family), which can be beneficial for emotional and social support (Markus & Kitayama, 1991). However, strong social interactions can increase the likelihood of these individuals being more susceptible to emotional burdens from their inner group/social networks, which can negatively impact their mental health (Maas et al., 2019b; Roberts & Burleson, 2013). Oppositely, individuals with high independence can prioritise personal autonomy, which can help them maintain boundaries in relationships and protect their mental health (Joshani & Jarden, 2016; Joshani et al., 2021).

The autonomy-connectedness subscales SA, CNS, and SO manifest in various ways depending on the individual's independence, which is shaped by the cultural influences (Markus & Kitayama, 1991). Research suggests that individuals with high independency or an independent self-construal are likely to have a positive association with the subscales SA and CNS and a negative association with SO, which is the most dominant self-construal in individualist cultures (Somech, 2000). Whereas individuals with low independence or an interdependent self-construal (collectivist), there is a negative association with SA and CNS, but a positive association with SO (Maas et al., 2019a). However, despite the evidence from Maas et al. (2019a) that there may be a relationship between self-construal and the ACS-30's sub-scales, this has not been empirically studied, and therefore, a direct relationship between self-construal, whether this is independent (individualistic) or interdependent (collectivist), to any of the ACS-30 sub-scales cannot be claimed.

### **6.2.3 Autonomy and Mental Health Research**

Research indicates that deficits in autonomy-connectedness are characterised by high levels of SO, combined with low SA and CNS, which have been linked to psychopathologies such as greater levels of anxiety, depression symptoms, as well as eating disorders (Bekker & Belt, 2006; Kuipers et al., 2017; Maas et al., 2019b). Bekker and Belt's (2006) study explored autonomy deficits in relation to mental health. The study found that primary mental health care patients scored higher on SO and lower on SA and CNS in comparison to the control group, who were psychology students. The regression analyses revealed that low levels of SA and high levels of SO were predictors of depression and anxiety. The study posits that for those individuals who struggle with adaptability and identifying their own emotional needs (low SA), it can lead to loss of control and helplessness, which are traits of depression (Forgeard et al., 2011; Khumalo & Plattner,

2019). In addition, being overly sensitive to other people's opinions and serving others' expectations (high SO) can lead individuals to prioritise the needs of others over their own well-being, which results in increased anxiety (Dosari et al., 2023). Interestingly, the study found that increased SO alone was not linked to psychological dysfunction, whereas the combination of high SO and low SA was what predicted the vulnerability of anxiety and depression symptomology (Bekker & Belt, 2006)

Furthermore, autonomy-connectedness research within individuals with eating disorders has been investigated (Bekker & Van Assen, 2017). The study investigated patients with anorexia/bulimia nervosa who received various treatments (psychotherapy, sociotherapy, art therapy, psychomotor therapy, and meals). The treatment assessed co-morbidity, attachment security, mentalisation, and autonomy. The findings revealed that the SO was reduced, and CNS increased for individuals who went on to recover from having an eating disorder after a year of being treated. Improvements in autonomy-connectedness were evident amongst those who recovered compared to patients who did not recover. This suggests that the ACS-30 is a powerful and predictive tool for mental health outcomes. It depicts that embedding autonomy within treatment might be a useful mechanism in aiding positive changes for recovery amongst individuals with eating disorders (Bekker & Van Assen, 2017). The aforementioned studies denote that autonomy is useful to explore the link to psychopathology and the likelihood of mental health outcomes (Kunst et al., 2019; Maas et al., 2019b). Even though the findings of Bekker and Van Assen's (2017) research are not directly related to this current study, they provide evidence on the link between autonomy and mental health outcomes.

Overall, deficits in autonomy-connectedness, i.e., high SO, low SA and CNS, can contribute towards the development and maintenance of depression, anxiety and eating

disorders (Bekker & Belt, 2006; Maas et al., 2019b). Maas et al. (2019b) found that autonomy-connectedness is a significant predictor of mental health outcomes. This suggests that autonomy-connectedness is an important construct in understanding the development of psychopathology. Although it is important to note that the association between autonomy-connectedness and mental health has not been explored beyond white Westernised groups (Maas et al, 2019a).

#### **6.2.4 The Present Research**

Considering both the cultural and psychological dimensions of autonomy, self and identity, this research seeks to provide a more comprehensive understanding of mental health disparities. The present research aims to examine the differences in anxiety, depression, and functional impairment outcomes between CED and white service users who completed their treatment in the IAPT service. Additionally, the study will explore how autonomy interacts with ethnicity to influence recovery outcomes. The hypothesis is as follows:

H1: CED groups will exhibit higher post mental health outcomes (anxiety, depression and functional impairment) compared to white individuals 3-12 months after IAPT treatment.

H2: Autonomy subscales SA, SO, and CNS will show an association between ethnicity and well-being outcomes.

H3: CED individuals with lower levels of Sensitivity to Others (SO) and higher levels of Self-awareness (SA) and Capacity to manage New Situations (CNS) will report lower mental health symptomatology post-treatment compared to white individuals.

### **6.3 Method**

### *6.3.1 Design*

Autonomy is a multifaceted and valuable tool for exploring mental health that allows a comprehensive understanding of the strengths and deficits of an individual's autonomy-connectedness. Furthermore, autonomy provides a psychological lens that is a salient concept to identify specific risk indicators of mental health disorders.

An ordinal regression was conducted that had three dependent variables, which were the mental health outcome scores for anxiety, depression and functional impairment. Then there were eight predictors (independent variables), which were entered into the model in two steps. The first step included two foundational predictors of demographic and treatment variables, which were 1) the number of IAPT therapeutic sessions attended. 2) Ethnic background - A categorical dichotomised variable that compared CED and white IAPT service users.

The next six variables were introduced in the second step as they were specific psychological attributes and subscales of the ACS-30. 3) Self-awareness. 4) Sensitivity to Others. 5) Capacity for Managing New Situations. Then there was the interaction between the ACS-30 subscales and ethnicity. 6) Self-awareness \* Ethnicity. 7) Sensitivity to Others \* Ethnicity. 8) Capacity for Managing New Situations \* Ethnicity. Employing the second step allowed for the exploration of the psychological attributes beyond the demographic variables that may help to explain the variance of mental outcomes and to observe this between the two ethnic groups.

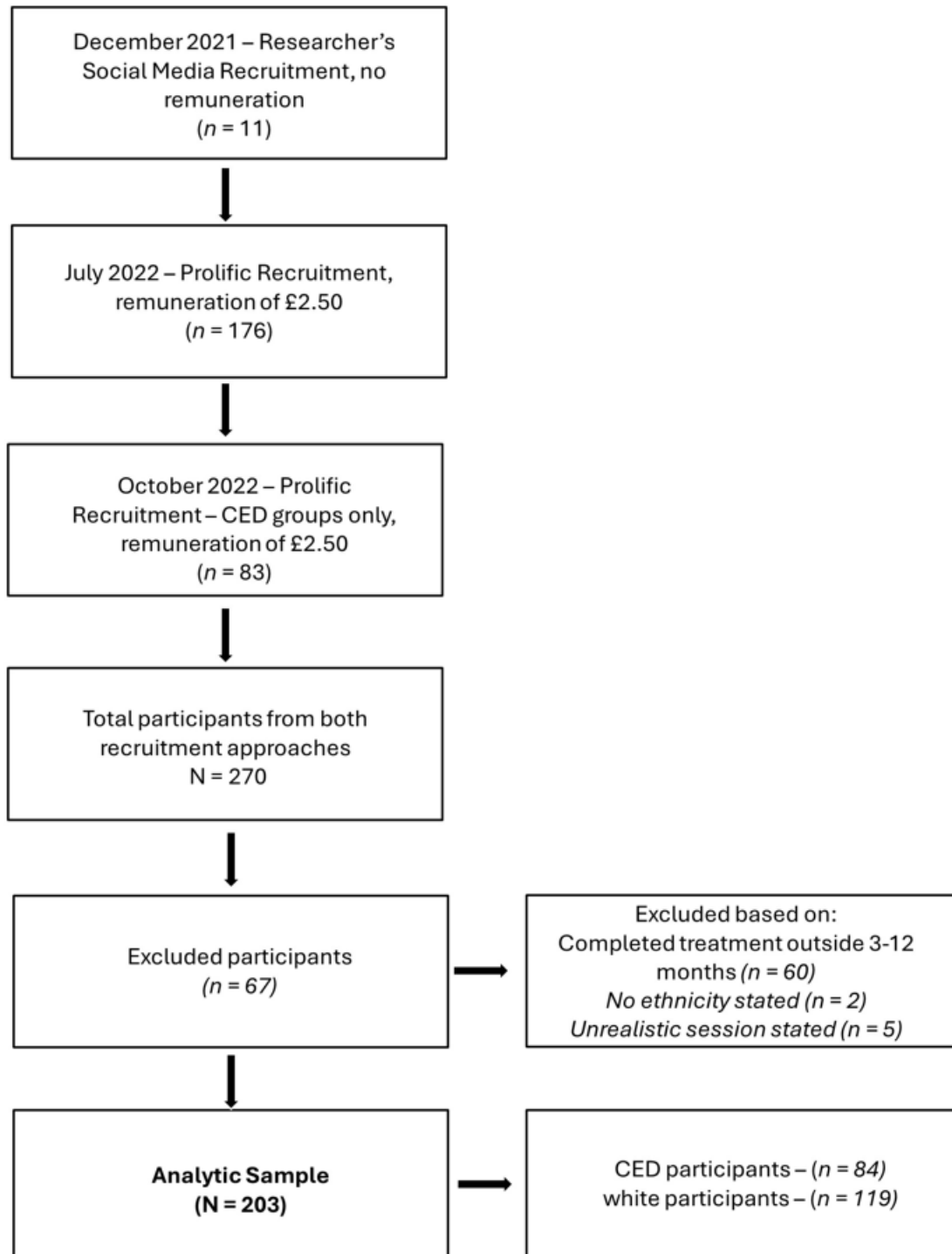
### *6.3.2 Participants*

A priori sample size calculation was performed using G\*Power (Faul et al., 2007). With a significance level of .05 and an anticipated small-to-medium effect size (e.g., Smith & Silva, 2011), in order to achieve a power of .80, the required sample size was N = 177. The study was pre-registered in the OSF (<https://doi.org/10.17605/OSF.IO/A7FHD>).

To partake in this study, participants needed to be able to read and understand English, to be over 18 years old and have completed IAPT treatment within 3-12 months. The criteria (finishing treatment between 3-12 months) were deemed suitable based on previous post-treatment studies to assess quality of life outcomes (Anderson & Ozakinci, 2018; Bandelow et al., 2018; de Maat et al., 2009; Romijn et al., 2021). Participants had to also declare that they were not currently experiencing severe mental health difficulties such as Bipolar disorder, Psychosis and Schizophrenia—as outlined by NICE (2011)—due to the sensitive nature of the study. Participants were recruited through opportunity and purposive sampling. The flow chart in Figure 6.1 provides an outline of the recruitment methods.

Figure 6.1

Flow Chart of the Recruitment Method



Eleven participants were initially recruited via Twitter and Facebook (See, Appendix 6.a), without any financial incentives. However, due to low recruitment through social

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media, an additional 179 participants were recruited through Prolific® (Prolific® sample 1), an online platform that remunerates participants based on study duration (with £2.50 provided for the current study). In Prolific® sample 1, there was an imbalance in participant demographics, with 29 identifying as CED and 158 as white. To address this imbalance, a second recruitment effort was conducted via Prolific® (Prolific® sample 2), which resulted in an additional  $n = 83$  CED participants. The total number of recruited participants was 270, which resulted in an over-recruitment compared to what was originally outlined in the OSF ( $n = 177$ ).

Sixty-seven participants were excluded from the analytic sample. Sixty participants were excluded because they completed their IAPT treatment outside the 3–12-month timeframe, two participants failed to indicate the ethnic group they belonged to, and five participants reported having undertaken over 30 IAPT sessions. A total of  $N = 203$  was retained for the analyses, the age range was 18-63 years ( $M = 31.0$ ,  $SD = 9.4$ ), 58.6% were from a white background, 41.4% were from a CED background and 65% identified as female. Table 6.1 outlines the participants' demographic information.

**Table 6.1**

Analytic sample's demographic data and type of psychological therapy received in IAPT

Baseline characteristic	Full sample (N = 203)	
	<i>n</i>	%
<b>Ethnicity</b>		
Black	17	8.4
Asian	44	21.7
Mixed Ethnic	21	10.3
Other Ethnic Group	2	1.0
Combination of the five ethnic groups above, i.e.: CED <sup>a</sup>	84	41.4
white	119	58.6
<b>Sex</b>		
Female	132	65.0
Male	69	34.0
Not Disclosed	2	1.0
<b>Referral Route to IAPT</b>		
General Practitioner	108	53.2
Self-Referral	90	44.3
Other	5	2.5
<b>Last IAPT session</b>		
3 months	22	10.8
4 months	60	29.6
5 months	18	8.9
6 months	13	6.4
7 months	19	9.4
8 months	16	7.9
9 months	14	6.9
10 months	41	20.2
<b>Type of Therapy Received</b>		
CBT	57	28.1
Self-help	16	7.9
Counselling with	13	6.4
<b>Depression</b>		
Other Treatments	24	11.8
Not Disclosed	93	45.8

**Note.** <sup>a</sup> CED (Culturally and Ethnically Diverse; amalgamation of individuals that identified as Black, Asian, Mixed Ethnic and other ethnic groups)

### 6.3.3 Measures

**6.3.3.1 Demographics:** Participants provided their gender identity (female, male, non-binary, prefer not to say, self-describe), age, and ethnicity (categories of ethnic backgrounds according to ONS, 2021; See, Appendix 6.b).

*6.3.3.2 Previous Use of the IAPT Service:* Participants answered various questions about their IAPT usage, which was measured using nominal variables. Some of the questions asked were how they previously were referred to the service (Self-referral or GP), how long (in months) since they had finished their last treatment session, the intensity of the treatment (high/low intensity or both) and the specific type of psychological treatment they received (e.g., CBT, Computerised CBT, Counselling for Depression, Self-help, Behaviour Activation, Psycho-Educational Groups, Mindfulness-based Cognitive Therapy, Brief Psychodynamic Therapy, Interpersonal Psychotherapy, Couple Therapy and to state any other treatment).

*6.3.3.3 Depression:* The Patient Health Questionnaire-9 (PHQ-9; Kroenke et al., 2010) was utilised to measure participants' depressive symptoms. The PHQ-9 has nine items that are assessed on a four-point Likert scale, ranging from 0 (not at all) to 3 (nearly every day). The questions assess service users' feelings over the previous two weeks (e.g., "Feeling tired or having little energy?" and "Little interest or pleasure in doing things?"). The scores can range from 0-27. Higher PHQ-9 scores indicate higher levels of depression. The PHQ-9 Cronbach's had high internal reliability ( $\alpha = 0.86-0.89$ ), sensitivity =0.80 and specificity =0.92 (Gilbody et al., 2007).

*6.3.3.4 Anxiety:* The Generalised Anxiety Disorder Questionnaire-7 (GAD-7) was utilised in order to assess the intensity of anxiety (Kroenke et al., 2007). The GAD-7 has seven items on a four-point Likert scale format, 0 (not at all) to 3 (nearly every day) that assesses service users' feelings over the last two weeks (e.g., "Not being able to stop or control worrying?" and "Feeling afraid as if something awful might happen?"). The scores range from 0-21. Higher GAD-7 scores indicate greater severity of anxiety. Previous studies

have shown that internal reliability ( $\alpha = 0.92$ ), sensitivity =0.89 and specificity =0.82 are high (Spitzer et al., 2006).

*6.3.3.5 Impairment in Daily Functioning:* The Work and Social Adjustment Scale (WSAS) measured the impact of mental health challenges on an individual's daily ability to function at home, work, personally and socially (Mundt et al., 2002). The WSAS has five items assessed on a nine-point Likert scale format, 0 (low) to 8 (very severe) (e.g., "My ability to work is impaired" and "My ability to form and maintain close relationships with others, including those I live with, is impaired."). The scores range from 0 to 40, higher WSAS scores reflect greater impairment in functioning. Previous studies have shown internal reliability ( $\alpha = 0.70 - 0.94$ ) and the test-retest reliability = 0.73 is good (Mundt et al., 2002).

*6.3.3.6 Autonomy:* The Autonomy Connectedness Scale-30 (ACS-30; Bekker & Van Assen, 2006) measured participant's autonomy. Participants answered 30 items on a five-point Likert scale, ranging from 1 (totally disagree) to 5 (totally disagree). Three subscales' scores were calculated: Self-awareness (SA, seven items, e.g., "It is usually obvious to me what I like best" - item numbers 1, 6, 9, 10, 15, 22 and 30), Sensitivity for Others (SO, 17 items, e.g., "I rarely care about others' feelings and experiences" - item numbers 2, 3, 4, 7, 8, 11, 13, 16, 17, 19, 20, 21, 24, 25, 26, 28, 29) and Capacity for Managing New Skills (CNS, six items, e.g., "It is difficult for me to start new activities on my own" - item numbers 5, 12, 14, 18, 23, 27). Out of the 30 items in the questionnaire, 14 of the items were reverse-scored, which were items 2, 5, 6, 7, 8, 11, 14, 16, 18, 20, 22, 26 and 29. A very low score for the SA range was from 7-18, for SO it was 17-43, and for CNS it was 6-10. An average score for SA was classed as 26-31, for SO was 50-64, and CNS was 17-22. A very high score for SA

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was considered a score range of 34-35, for SO it was 67-85, and for CNS it was 27-30. The ACS-30 has shown good psychometric qualities (Bekker & Van Assen, 2006, 2008) such as high internal consistency for each of the subscales: SA ( $\alpha = 0.81$ ), SO ( $\alpha = 0.82$ ) and CNS ( $\alpha = 0.83$ ).

### 6.3.4 Procedure

Ethical approval was granted by the Birmingham City University, BLSS Research Ethics Committee, Clarke-Jeffers /#9809 /sub1 /Am /2022 /Apr /BLSS FAEC. Participants were first recruited through social media from December 2021 to October 2022. The online survey took place on Qualtrics®. Participants read the participation information sheet (See, Appendix 6.c), signed the consent form (See, Appendix 6.d) and filled out their demographic information and then answered questions on their previous usage and subjective appraisal of their IAPT experience. Afterwards, participants were presented with the four measures (PHQ-9, GAD-7, WSAS and ACS-30) that were counterbalanced across participants to control for order effects. Participation was self-paced, and, on average, the study took nine minutes to complete. After completion, the participants accessed the debrief form (See, Appendix 6.e).

### 6.3.5 Data Analysis

An ordinal regression was conducted for each mental health outcome (i.e., depression, anxiety, and impairment in daily functioning). The study had eight predictors; at step one, the following were entered: (1) the number of IAPT therapeutic sessions and (2) ethnic background (CED vs white). At step two, entered (3) self-awareness, (4) sensitivity to others, (5) capacity for managing new situations, and the interaction terms (6) self-awareness \* ethnicity, (7) sensitivity to others \* ethnicity, and (8) capacity for managing new

situations \*ethnicity. The two-step process used was to distinguish between the baseline demographic and further psychological variables, including their interactions with ethnicity. In step one, variables 1-2 were added as foundational factors that may influence treatment outcomes and therapeutic effectiveness. In step two, variables 3-5, as well as the interaction of the psychological variables and ethnicity (6-8), were added. These variables were introduced at step two as they represent more specific psychological attributes that could influence how individuals respond to treatment. Including them at step two allowed to examine whether these traits explain additional variance beyond demographic/treatment factors. The interaction terms with ethnicity were included to examine whether the influence of these psychological factors differs based on an individual's ethnic background.

### 6.4 Results

Preliminary analyses examined normal distribution for the variables, revealing some breaches in the skewness and kurtosis. The 'number of previous IAPT sessions' variable was positively skewed, 1.272 (SE = 0.171), indicating a longer tail on the right. This is a breach as it is significantly higher than  $\pm 2 * SE$  (0.342). Additionally, the variable 'ethnicity', the kurtosis data were negative, indicating a flatter distribution, -1.894 (SE = 0.340). Also, the 'number of IAPT sessions' kurtosis was 1.821 (SE = 0.340), which was positively kurtotic, indicating a heavier tail and sharper peak. Both 'ethnicity' and the 'number of IAPT sessions' represented significant breaches as their skewness and kurtosis were outside the acceptable range of  $\pm 2 * SE$ . All the other variables were within the acceptable range  $\pm 2 * SE$  for skewness and kurtosis. As a result of the violations in the skewness and kurtosis, a non-parametric analysis was performed to address any discrepancies arising with the outcomes of the parametric analyses.

### 6.4.1 Descriptive Statistics

Table 6.2 presents the mean total scores and standard deviation of the continuous variables that were all mean-centred. There were no large group differences between CED groups and white service users across all the variables.

**Table 6.2**

Mean (Standard Deviation) of the ACS-30 (autonomy) and Mental Health Outcomes Across Ethnicity Groups

Column Label	Ethnicity		
	All	CED	white
No of IAPT Therapeutic sessions	8.15 (5.03)	8.21 (4.96)	8.10 (5.10)
Treatment Intensity <sup>7</sup>	2.04 (1.31)	2.02 (1.28)	2.06 (1.33)
GAD-7	9.02 (5.65)	8.81 (5.86)	9.16 (5.52)
PHQ-9	10.63 (6.36)	10.93 (7.09)	10.41 (5.80)
WSAS	14.81 (9.48)	15.92 (10.28)	14.03 (8.83)
SA	-0.03 (5.00)	-0.27 (5.26)	0.14 (4.82)
SO	0.04 (9.68)	-0.54 (9.58)	0.44 (9.77)
CNS	0.13 (4.77)	-0.58 (5.00)	0.64 (4.55)

**Note.** CED,  $n = 84$ ; white,  $n = 119$ . PHQ-9 = Patient Health Question, GAD-7 = Generalised Anxiety Disorder WSAS = Work and Social Adjustment Scale, SA = Self-Awareness, SO = Sensitivity to Others and CNS = Capacity for managing New Situations

Pearson's correlation coefficients between the variables of interest are reported in Table 6.3 below. Autonomy indices were significantly associated with well-being outcomes, as higher SA correlated with lower depressive ( $r = -.359, p < .001$ ) and anxiety symptoms ( $r = -.308, p < .001$ ) and lower functioning impairment ( $r = -.268, p < .001$ ). The link between

<sup>7</sup> **Note.** Treatment intensity was a variable of interest and was included in the OSF documentation. However, the analysis for treatment intensity was not included in the inferential statistics due to it not providing substantial results (partial due to unbalanced of individuals in each group – low intensity was over powering with  $n = 116$ , high intensity  $n = 14$ , both low and high intensity  $n = 21$ , not sure  $n = 52$ ) therefore was not discussed but for transparency the researcher wanted to include it here in the footnote.

SO and mental health outcomes was evident with elevated anxiety symptoms ( $r = .276, p < .001$ ), functional impairment ( $r = .150, p = .033$ ) and, albeit weaker, for depression ( $r = .183, p = .009$ ). CNS was strongly associated with all mental health outcomes such as depression ( $r = -.477, p < .001$ ), anxiety symptoms ( $r = -.429, p < .001$ ) and functional impairment ( $r = -.435, p < .001$ ).

**Table 6.3**

Pearson's r Coefficients for the Correlation Between the Variables

Variable	Ethnicity	Session	PHQ	GAD	WSAS	SA	SO
1. Ethnicity							
2. Sessions	-.01						
3. PHQ	-.04	.06					
4. GAD	.03	.10	.83***				
5. WSAS	-.10	.08	.62***	.54***			
6. SA	.04	-.03	-.36***	-.31***	-.27***		
7. SO	.05	.13	.18**	.28***	.15*	-.46***	
8. CNS	.13	-.07	-.48***	-.43***	-.44***	.48***	.44***

**Note.** \*\*\* $p < .001$ ; \*\* $p < .01$ ; \* $p < .05$ . PHQ-9 = Patient Health Question, GAD-7 = Generalised Anxiety Disorder WSAS = Work and Social Adjustment Scale, SA = Self-Awareness, SO = Sensitivity to Others and CNS = Capacity for managing New Situations

### 6.4.2 Autonomy and Well-being Outcomes – Anxiety, Depression and

#### Functional Impairment

Albeit a hierarchical regression was initially planned, as outlined in the OSF pre-registration (<https://doi.org/10.17605/OSF.IO/A7FHD>), the breaches in assumptions of normal distribution led to the use of an ordinal regression (See, Table 7.4). The results from the non-parametric analysis were generally consistent with the parametric analysis, with the exception of the two following factors, SO as well as the WSAS for the interaction of SA\*ethnicity, which was not significant.

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The significant predictors for the PHQ-9 were SA ( $B = -.415$ ,  $SE = .101$ ), CNS ( $B = -.357$ ,  $SE = .103$ ) and the interaction between SA and ethnicity ( $B = .214$ ,  $SE = .061$ ). According to the  $R^2$ , 33.3% of the variance for the PHQ-9 scores is explained by the model (see Table 7.4 below). The significant predictors for the GAD-7 were SA ( $B = -.308$ ,  $SE = .100$ ), CNS ( $B = -.305$ ,  $SE = .102$ ), and the interaction between SA and ethnicity ( $B = .161$ ,  $SE = .061$ ). The  $R^2$  showed that 28.1% of the variance for the GAD-7 scores is explained by the model (see Table 7.4 below). The significant predictors for the WSAS were SA ( $B = -.218$ ,  $SE = .099$ ) and CNS ( $B = -.232$ ,  $SE = .101$ ). The  $R^2$  showed that 22.8% of the variance for the WSAS scores is explained by the model (see Table 6.4 below).

**Table 6.4**

Three Ordinal Regression Analysis and Coefficients on PHQ-9, GAD-7 and WSAS Outcome Scores

Well-being	<i>B</i>	<i>SE(B)</i>	Wald	<i>p</i>
<b>PHQ-9</b>				
Session	.013	.025	.254	.614
Ethnicity	.191	.256	.555	.456
SA	-.415	.101	16.716	***
SO	-.098	.053	3.391	.066
CNS	-.367	.103	12.153	***
SA * Ethnicity	.214	.061	12.153	***
SO * Ethnicity	.48	.31	2.390	.122
CNS * Ethnicity	.105	.063	2.767	.096
Adjusted R <sup>2</sup>	.333			
<b>GAD-7</b>				
Session	.025	.025	1.006	.316
Ethnicity	.384	.255	2.261	.133
SA	-.308	.100	9.476	.002**
SO	-.046	.053	.771	.380
CNS	-.305	.102	9.021	.003**
SA * Ethnicity	.161	.061	6.985	.008**
SO * Ethnicity	.033	.031	1.156	.282
CNS * Ethnicity	.092	.063	21.147	.143
Adjusted R <sup>2</sup>	.281			
<b>WSAS</b>				
Session	.025	.025	.977	.323
Ethnicity	-.153	.253	.367	.545
SA	-.218	.099	4.834	.028*
SO	-.083	.053	2.506	.113
CNS	-.232	.101	5.319	.021*
SA * Ethnicity	.106	.060	3.057	.080
SO * Ethnicity	.042	.031	1.813	.178
CNS * Ethnicity	.048	.062	.598	.439
Adjusted R <sup>2</sup>	.228			

**Note.** \*\*\**p* < .0001; \*\**p* < .01; \**p* < .05. Residuals were normally distributed. Inspection of the scatterplots revealed that the assumptions of homoscedasticity and linearity were met, respectively. Low multicollinearity was evidenced by the correlation coefficients between the predictors.

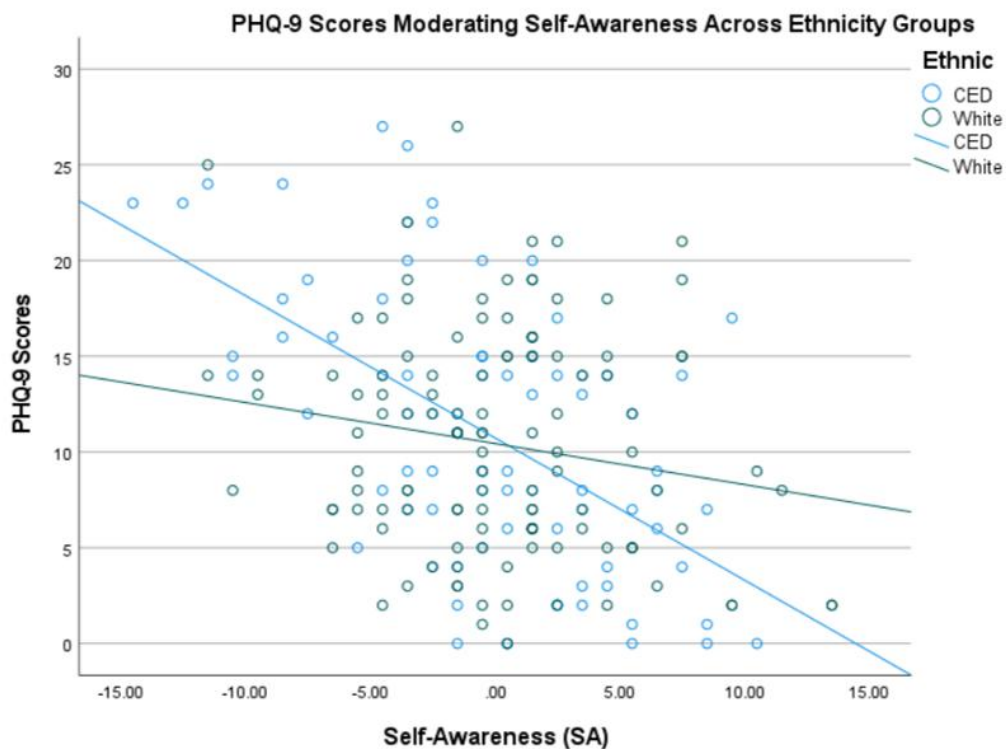
In summary, the ACS-30 subscales SA and CNS consistently showed significant negative associations with the outcome variables PHQ-9, GAD-7, and WSAS, which suggests they may be protective factors that aid in lowering symptom severity. Additionally, ethnicity interacted with SA for both PHQ-9 and GAD-7 models (See, Figures 6.2 and 6.3 below).

Figure 6.2 below explores the relationship between PHQ-9 and SA across both ethnicity groups. The data revealed a negative association for both CED and white service

users. Specifically, higher SA scores were linked to lower PHQ-9 scores, indicating lower depressive symptoms.

Figure 6.2

*PHQ-9 Moderation With Self-Awareness Across Two Ethnicity Groups*

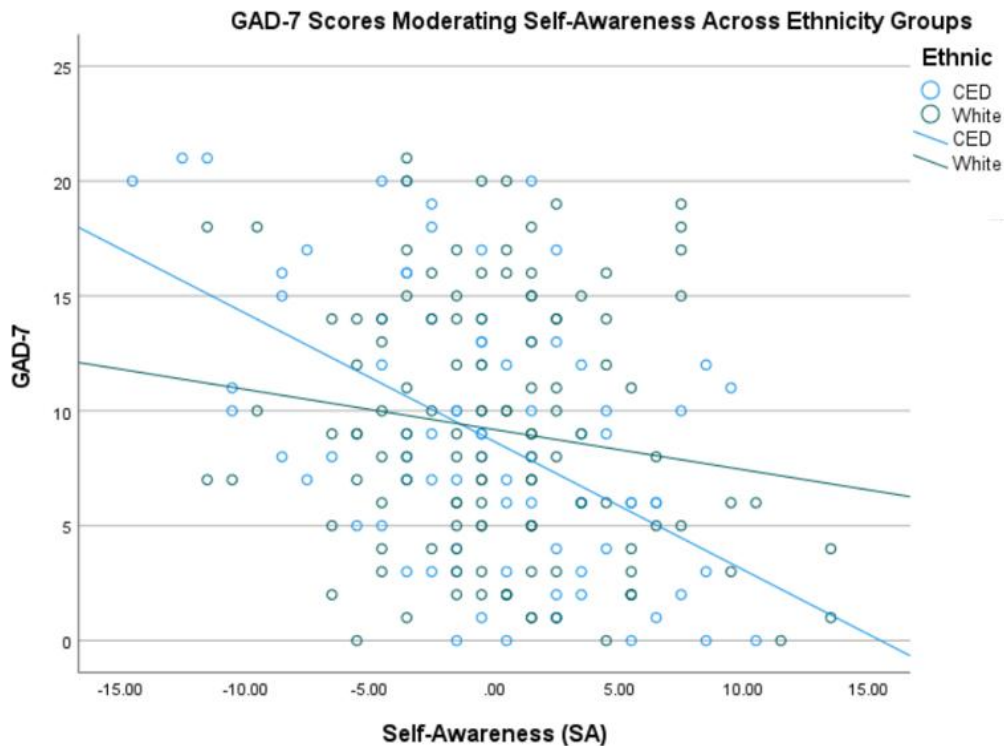


The significant interaction between SA and ethnicity, Figure 6.2 above, shows that the association between SA and PHQ was stronger for the CED group ( $r = -.55$ ) compared to white participants ( $r = -.18$ ), indicating that SA may have a stronger effect on reducing symptoms of depression for CED groups.

Additionally, the relationship between GAD-7 scores and SA for the ethnicity groups showed a negative association for both CED and white service users. Higher SA scores were linked to reduced GAD-7 scores, i.e., lower anxiety symptoms (See, Figure 6.3 below).

Figure 6.3

*GAD-7 Moderation With Self-Awareness Across Two Ethnicity Groups*



The significant interaction between SA and ethnicity, Figure 6.3 above, shows how the association between SA and GAD was stronger for CED groups ( $r = -.50$ ) compared to white participants ( $r = -.15$ ), indicating that SA may have a stronger effect on reducing symptoms of anxiety for CED groups.

## 6.5 Discussion

The study revealed that CED groups experienced poorer levels of mental health, i.e., higher levels of depression and functional impairment outcomes, compared to their white counterparts. However, when IAPT treatment (between 3-12 months) was completed, both CED and white service users exhibited a reduction across all mental health outcomes. Though the scores were slightly elevated for CED groups (still worse outcomes, but results showed that the IAPT treatment was effective at reducing their anxiety, depression and

functional impairment symptoms post vs pre). Hence, hypothesis one can be accepted. The outcome of this study follows the narrative of general literature, that has shown that CED groups tend to have higher levels of mental health challenges due to the continuous difficulty in a range of factors such as accessing mental health services, racism, discrimination and stigma that CED individuals experience thus, suggesting that their needs may not be adequately met within the healthcare setting (Hackett et al., 2020; Nguyen, 2020; Prajapati & Liebling, 2021; Shefer et al., 2013). The current data underscores how essential it is to recognise the inequities. Though this study does show the IAPT service has been effective at reducing symptomology in CED groups, it is still salient to ensure that modalities within the IAPT service are effective at supporting CED individuals to reduce the severity of their mental health symptomology outcomes and to help promote equity (Nazroo et al., 2020).

Furthermore, the research findings indicated that autonomy predicted mental health outcomes. More specifically, higher levels of SA and CNS (not with the association of ethnicity) were associated with better well-being outcomes across all measurements (GAD-7, PHQ-9 and WSAS – lower symptom severity). Whereas SO did not significantly predict any of the well-being outcomes, which could indicate potentially suppressor effects (Watson et al., 2013). Importantly, for the purpose of this study, it was observed that ethnicity and autonomy were associated in determining mental health well-being (Hypothesis 2 accepted). In particular, the association between higher levels of SA was linked to lower levels of depression and anxiety symptoms, revealing a stronger association for individuals from a CED background (depression:  $r = -.55$  and anxiety:  $r = -.50$ , respectively) compared to white service users in this study (partial acceptance of hypothesis 3). The findings suggest that, particularly for CED service users, the level of autonomy, namely high levels of SA, was

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a useful indication in determining their mental health outcomes. For CED groups, having high levels of SA could act as a protective barrier against mental health issues. CED groups are likely to experience systemic (in)direct racism, maltreatment in practice and stigma (internalised from their culture, community or society) in comparison to white individuals (Grey et al., 2013; Hackett et al., 2020; Samra & Hankivsky, 2021). Hence, high levels of SA can be salient for CED groups to recognise any distress they are experiencing. Utilising their well-developed self-awareness can aid CED groups to overcome barriers that they may experience to be more resilient, despite any difficulties that may arise through their mental health trajectory (Sims-Schouten, & Gilbert, 2022; Tugade & Fredrickson, 2004) and even seek their wider community for mental health support when needed (Klussman et al., 2022; Maas et al., 2019a).

Although this study aimed to focus on the relationship between ethnicity and autonomy in relation to predicting mental health outcomes, the sub-scales CNS and SO did not show a significant association between CED and white individuals (showing hypothesis 3 being rejected for these specific sub-scales). However, when the interaction of ethnicity was removed, having higher levels of CNS was significantly associated with lower mental health symptomology across all mental health outcomes. It is possible that ethnicity did not result in an association between CED and white individuals due to this study being conducted within the UK. The UK is a westernised country where high independence is dominant (Markus & Kitayama, 1991). Therefore, the CED participants in this study may be individuals whose autonomy favours independence due to their surrounding environment, thus resulting in no differences between ethnicity groups. Opposingly, one could also suggest that due to CED individuals having a high capability to be adaptable when faced with new and unfamiliar situations (Bekker & Belt, 2006), this has allowed them to integrate

seamlessly within the traditions and values of the UK. Choy et al. (2021) highlighted the importance of integrating one's values with the new cultures, thus translating to the ability to handle new stresses, whereby individuals may be more resilient and receptive to trying different avenues of well-being support to deal with their mental health difficulties. This demonstrates why there may not have been a difference between CED and white individuals when considering the CNS sub-scale.

Moreover, the current study found no significant effect in the ordinal regression between the subscale SO and mental health outcomes, regardless of whether ethnicity was included as a variable. This finding is in contrast with previous research, which postulates that individuals from interdependent/collectivist cultures, who typically prioritise the community needs over their own, may experience poorer well-being outcomes due to taking on the emotional burden of others' stresses (Maas et al., 2019a; Zhu, 2023). The lack of a significant effect in this study indicates the potential suppression effects, suggesting that there may be underlying factors that were not adequately addressed in the study. For instance, social support and resilience may have moderated the relationship between SO and mental health outcomes. These factors could possibly mitigate the adverse effects of high SO, as high levels of SO are associated with greater anxiety and depression symptomology (Bekker & Belt, 2006), leading to the non-significant results observed. Furthermore, cultural adaptations could suggest that CED individuals may have internalised aspects of both independent/individualistic and interdependent/collectivist values that have led to a more nuanced and complex interaction between SO and mental health outcomes. The integration of values (developed adaptive techniques to cope with the cultural demands of their environment) might have weakened the expected negative impact of high SO on

mental health and well-being, as individuals navigate between maintaining community ties and prioritising personal well-being.

There has been limited research that simultaneously examines the interplay between ethnicity and autonomy in determining mental health outcomes. Bekker and Belt (2006) provided evidence on the gender differences and suggested the importance of exploring how the three subscales (SA, SO and CNS) differ due to the influence of gender norms, beliefs and values. This study brought a novel perspective to the literature that highlights the complex interplay of autonomy and ethnicity on mental health outcomes. Specifically, no research to date has observed IAPT service users' depression, anxiety and functional impairment symptomatology after treatment completion, with the association of autonomy. Thus, it provides a new area of interest compared to solely using ethnicity as a hallmark predictor for outcomes of psychological treatment (Amati et al., 2023; Harwood et al., 2021).

### **6.5.1 Limitations and Future Research**

Although the sample size was met and surpassed  $N = 203$  for this study, future research should increase the sample size to provide a more robust and generalisable interpretation of the findings. Similarly, to expand the diversity of the sample. Homogenising CED participants may have resulted in an overrepresentation of certain ethnicities within the CED category, which could influence the generalisation of the findings. It would be interesting for future research to dissect further between specific CED groups. Expanding the diversity of CED-specific groups would allow for nuanced insights into the relationship between autonomy and mental health. Furthermore, the study was limited to the UK. The expansion could have been conducted more widely, or by making sure the study reached out to highly dense areas of other CED groups. The dominance of high

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independence in the UK may not fully reflect the experiences of CED individuals' cultural norms and values.

Another suggestion for future research is conducting a pre- and post-test where participants complete the questionnaire during their IAPT treatment and then again 3-12 months after completion to observe how the relationship between autonomy and mental health may change over the course of treatment among different ethnic groups.

Additionally, the study could incorporate a qualitative approach (a mixed method approach), incorporating one-to-one or focus groups to understand individuals' perception of their self and identity, autonomy and mental health. Gathering detailed information about an individual's background may aid in understanding their views on the aetiology, treatment and experiences of mental health. Holding additional information about one's autonomy can help to recognise potential barriers that some service users may experience in their treatment and recovery process, hence enabling more effective methods to provide appropriate support to enhance their quality of life. Thus, future research may incorporate contextual environmental factors, such as assessing and asking questions on an individual's socioeconomic status and exposure to systemic racism, as these factors can help to further understand one's level of autonomy and how it may influence their mental health outcomes.

Lastly, the study found that the sub-scale SO did not significantly predict any of the mental health outcomes in the ordinal regression, but was significant in Pearson's Correlation. Therefore, future research could explore the potential suppressor effects that might influence the relationship between SO and mental health outcomes to create a clearer understanding of the dynamics occurring. By addressing these suggestions, future research can build upon the findings in this study that could contribute to a more

comprehensive understanding of how autonomy and ethnicity interact to influence mental health outcomes. Making these improvements could lead to more effective and culturally sensitive mental health interventions to better support CED groups in particular.

### **6.6 Conclusion**

This study has highlighted the salience of self and identity, influenced by cultural factors, playing a crucial role in mental health outcomes. The ACS-30 offers a framework to explore these relationships, highlighting the importance of considering cultural context in psychological treatment. Thus, the addition of acknowledging autonomy, self and identity provides an extension of previous research whereby there was a focus on an individual's ethnic background (Amati et al., 2023; Harwood et al., 2021). This study has offered a unique insight that showed the interaction of individuals' self and identity (influenced by their culture) and ethnicity that can contribute to significant differences in well-being outcomes between ethnicity groups. The addition of the ACS-30 has helped gain insight into different autonomy values (SA, CNS, and SO) and mental health outcomes. For high interdependent individuals, there is an emphasis on social relations and for high independent individuals, it is more personal agency. Hence, acknowledging the role of autonomy has been beneficial and could be advantageous for mental health facilities and the IAPT service, specifically to understand the belief systems and values that the individual upholds, rather than generalising their belief systems based only on their ethnicity. Also, with a deeper insight into the individual, this can allow for unique and personalised support during assessments and treatment that could enhance therapeutic approaches and enable services to become more inclusive, especially to support CED groups.

## **6.7 Chapter Summary**

The study investigated how ethnicity, epidemiological factors and autonomy (measured by the ACS-30) influence mental health outcomes of anxiety, depression and functional impairment in service users who completed treatment in the IAPT service within 3-12 months. Existing literature frequently highlights lower recovery rates and poorer post-treatment maintenance for CED groups compared to white individuals. The results from the 203 participants in this study found that the autonomy sub-scales revealed that both SA and CNS were linked to enhanced outcomes across the three well-being indices. Furthermore, the impact of autonomy on ethnicity and well-being revealed that the link between SA and lower levels of anxiety and depression was more pronounced among CED groups. These findings indicate that incorporating self, identity, and autonomy, elements shaped by cultural influences, helps to provide a more nuanced understanding of recovery differences across ethnicity groups. Thus, the evidence aids in enhancing inclusivity practices tailored to help CED groups, particularly to close the ethnic disparity gap within psychological treatment.

## **Chapter 7. Exploring Ethnicity and Recovery Determinants in IAPT Mental Health Services' (Study Four)**

### **7.1 Chapter Overview**

This chapter examines different determinants, i.e., religious affiliation and the type of referral pathway, potentially being influential towards differences in recovery outcomes between CED and white service users. Research has indicated that individuals belonging to CED groups exhibit elevated levels of anxiety and depression symptoms, which consequently reduces their likelihood of recovery when receiving psychological treatment compared to white service users (Cook et al., 2017; Moller et al., 2019; NHS Digital, 2022). In this chapter, secondary data from IAPT service users from two IAPT services in the Midlands are analysed, which includes the pre- and post-well-being scores for anxiety, depression and functional impairment scores. In addition, the clinical caseness scores for anxiety and depression of IAPT service users were also obtained.

### **7.2 Recovery Background**

In 2021/2022, 1.81 million people were referred to the IAPT service, of which 1.24 million went on to receive treatment, and 688,000 finished the treatment, with 50.2% going on to recover (NHS Digital, 2022). The IAPT service strives to meet and surpass the 50% recovery marker (NCCMH, 2018). In the context of the IAPT service, recovery is defined as service users not being at clinical caseness at the end of the IAPT treatment. Clinical caseness in IAPT services is assessed via validated and standardised measures such as GAD-7 for anxiety and the PHQ-9 for depression (NCCMH, 2018). As evidenced by NHS Digital (2022), 2021/2022 recovery statistic outcomes, receiving psychological support through an

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IAPT service has aided individual's mental health and well-being, enabling service users to function with limited impairment in their daily life and to learn how to deal with challenges when they arise that will not negatively impact their mental health (Stochl et al., 2021; Wakefield et al., 2021).

Despite the positive impact of the IAPT service interventions has on service users, research indicates the existence of a mental health inequality gap for recovery between ethnic groups within the IAPT service (Cook et al., 2017; Tambling et al., 2023). Though 46.7% of individuals from a CED group went on to recover from IAPT psychological treatment (showing that the treatment is effective to some degree), the recovery rate was at a lower rate in comparison to white service users (Moller et al., 2019). More recent and nuanced data show that, for individuals from a white<sup>8</sup> background, recovery rates range between 50.7 – 52.4%. For individuals of Black<sup>9</sup> background, the recovery rate ranged from 47.5% to 51.5%, while for individuals of Asian<sup>10</sup> background, the recovery rate ranged from 43.4% to 51.5%. Individuals of dual-heritage<sup>11</sup> had a recovery rate of 45.1% to 48.2%, and individuals from other ethnic groups had a recovery rate of 43.4% (NCCMH, 2023).

Similarly, Amati et al. (2023) found that CED groups, on average, have lower recovery compared to white individuals within the IAPT service. Though not statistically significant, Amarti et al.'s (2023) results revealed that Chinese individuals had a higher odds ratio (1.10) for recovery than white individuals in Amati et al. (2023). Whereas other CED groups, such as Pakistani (OR = 0.60), Bangladeshi (OR = 0.63), Indian (OR = 0.89), African (OR = 0.68) and Caribbean (OR = 0.85), have a significantly lower likelihood of recovering compared to white

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<sup>8</sup> British, Irish or Other white background

<sup>9</sup> Caribbean, African, Other Black background

<sup>10</sup> Bangladeshi, Chinese, Indian, Pakistani, other Asian background

<sup>11</sup> white and Black Caribbean, white and Black African, white and Asian, other mixed background

individuals. Some of the factors hindering CED group's recovery are due to the higher severity and/or co-morbidity of mental health, inadequate care during treatment, experiencing systemic and institutional barriers of racism and discrimination (Fortuna et al., 2010; Grey et al., 2013; Hackett et al., 2020).

Individuals who come into the IAPT service with higher levels of anxiety and depression have to make a more substantial improvement to reach the recovery threshold (Amati et al., 2023). Stochl et al. (2022) emphasised the need for special attention to IAPT individuals who start therapy with high levels of functional impairment, known as significant difficulties in daily functioning, such as unemployment and/or reduced social interactions (Butterworth et al., 2012; Kuczynski et al., 2022; Lutz et al., 2014). These impairments are frequently associated with more severe symptoms of anxiety, depression, and other mental health conditions, indicating a worse psychopathology status. In addition, individuals with greater functional impairment (higher difficulty in undergoing normal daily activities due to mental health symptoms) may experience other obstacles such as poor engagement with, and higher chances of dropping out of from therapy early as functional impairment is linked to lower ability to concentrate and difficulties in decision-making (Aderka et al., 2011; Dixon et al., 2016). Greater functional impairment can result in the elevation of depression and anxiety symptomatology. This is supported by previous research on co-morbidity with anxiety and depression (Flory & Yehuda, 2015; Rytwinski et al., 2013). In addition, the co-morbidity is associated with difficulties with symptomatic relief (Stochl et al., 2022; Lutz et al., 2014; McKnight et al., 2016), thus making recovery more challenging.

### **7.3 Intersectionality Theory And Recovery**

Recovery should also be considered through the lens of the theoretical framework of intersectionality. Intersectionality theory proposes that individuals have multiple social

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identities (e.g., gender identity, sexual orientation, ethnicity, disability and socio-economic background) that interact to shape psychological outcomes (Crenshaw, 1990). These intersecting identities contribute to the marginalisation of certain groups through systemic structures like heterosexism, sexism, racism, and classism (Bowleg, 2012; Davis, 2008; Hankivsky, 2014; Holley et al., 2016). For example, individuals who experience multiple forms of discrimination, such as a Black woman from a lower socioeconomic background. The continuous systematic experiences can disproportionately impact an individual's access to care and recovery in comparison to white individuals (Edge, 2013; Lord et al., 2013; Taylor & Richards, 2019). Understanding the importance of intersectionality can aid in revealing different varying levels of health inequalities, as these macro-social structures reinforce disparities in mental health (Taylor & Richards, 2019). The IAPT service has acknowledged these interconnected factors and published the Black, Asian, and Minority Ethnic (BAME) Positive Practice Guide (Beck et al., 2019). This guide outlines objectives and policy frameworks to ensure equitable recovery for CED groups and to ensure that CED groups' needs in the IAPT service are addressed with the same level of attention and care as service users from a white background (Beck et al., 2019). The Positive Practice Guide main themes propose 1) increasing accessibility for CED communities, 2) tailoring and adapting psychological interventions to suit CED needs, 3) facilitating community engagement to increase awareness of what the IAPT service is, 4) increasing diversity amongst the workforce and 5) audit monitoring to address ethnicity disparities. The strategies in the Positive Practice Guide are a work in progress that incorporates the vast intersecting identities of the service users they may encounter. The aim of the Positive Practice Guide is to understand the diverse values and beliefs amongst CED groups to ensure therapies are

delivered in a culturally sensitive manner to help close the mental health inequality gap (Beck et al., 2019; NHS, 2009).

#### **7.4 Determinants: Religious Affiliation And Referral Pathway**

Other factors that may contribute to disparities in the IAPT service recovery outcomes, alongside ethnicity, should be considered. Determinants such as religious affiliation<sup>12</sup> (religious or not) and the referral pathways (GP, self-referral or other pathways) are variables under consideration. Firstly, the referral pathway has shown mixed literature on CED groups' preferred pathway to receiving psychological treatment (Brown et al., 2014; Clark, 2011; Thomas et al., 2020). The IAPT service offers a self-referral system whereby individuals can bypass seeking GP support (i.e., self-refer) to obtain evidence-based psychological treatment (Brown, 2018). Self-referral can be suitable for CED service users who have concerns about privacy and confidentiality within their local GP service (Lasky et al., 2006; Wong et al., 2015). Additionally, self-referral grants individuals' autonomy by allowing them to seek psychological support directly, thereby avoiding potential feelings of embarrassment or stigma that might arise from accessing help through a GP (Dew et al., 2007). Individuals who favour the self-referral route may have elevated self-awareness whereby they can detect mental health symptoms (less severe anxiety and/or depression) earlier on rather than waiting for a GP referral, which may increase the likelihood of clinical complexity (Punton et al., 2022; Sutton et al., 2016). Hence, by self-referring, individuals feel a greater sense of autonomy and self-efficacy, which could increase their readiness to access IAPT support and motivation in the therapeutic process, thus aiding positive recovery outcomes (Rippon et al., 2022; Ryan et al., 2011).

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<sup>12</sup> Belonging to any religious group and is not determined by how frequent one practices their beliefs.

Conversely, the self-referral pathway is not always viable, particularly for individuals unfamiliar with the IAPT service or who have limited access to technology (Harwood et al., 2021; Porter, 2023). Therefore, GPs play a critical role in disseminating information on how individuals can gain support. Raising awareness about how to access support and how poor mental health can manifest is especially important, as some CED groups tend to express symptoms psychosomatically (Cénat et al., 2022; Lanzara et al., 2019). For example, some individuals describe their symptoms of shortness of breath, dizziness, and headaches without recognising these as potential indicators of depression or anxiety, making the GP their primary point of contact (Bhugra & Mastrogianni, 2004; Karasz et al., 2019; Mooney et al., 2016). Moreover, participants in Thomas et al.'s (2020) qualitative study emphasised that the GP route lends professional legitimacy to their mental health concerns and facilitates additional support. Participants also expressed that the self-referral process can be overwhelming and that it could exacerbate mental health difficulties, thus reinforcing the preference for GP referral. GP and self-referral pathways are crucial routes to the IAPT service that may contribute towards recovery outcomes.

A further contributing factor to recovery might be religious affiliation (Lucchetti et al., 2021). Some individuals may seek additional support from a religious leader and/or community with whom they feel comfortable and can build a rapport with to open up about their challenges and aspects linked to their personal or social identity (Knifton, 2012; Ward et al., 2013; 2014). Receiving spiritual or religious guidance can provide a safe space for individuals to discuss their mental health difficulties in an environment that integrates their religious beliefs and alleviates psychological stress, anxiety and isolation (Koenig et al., 2012). Furthermore, individuals who have a spiritual or religious faith may experience an

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increased self-esteem and feeling a sense of purpose in life that can aid their recovery (Bradshaw et al., 2015; Underwood, 2006).

Previous research highlights the positive impact of involving religious or faith leaders in supporting individuals with a religious affiliation during mental health treatment. Faith leaders can aid in fostering trust, reducing stigma, and encouraging engagement with the mental health service (Acevedo et al., 2022; Meran & Mason, 2019). Therefore, faith leaders can help bridge the gap between religious or cultural beliefs and therapeutic practices to enable more accessible treatment for religious individuals. Similarly, faith leaders can provide emotional and spiritual support, which may complement the individual's psychological interventions and enhance treatment outcomes. This collaborative approach can ultimately aid treatment progression by aligning psychological interventions with the individual's spiritual beliefs and values (Freire et al., 2019; Jonas & Jonas, 2019; Levin, 2016). Additionally, in a systematic review of 444 quantitative studies, 272 (61%) indicated that individuals had lower levels of depression symptomology and quicker recovery from depressive episodes following a religious or spiritual intervention (Bonelli et al., 2021). Thus, therapy and the complement of spiritual guidance can enhance the recovery process, which can be beneficial across CED groups (Murwasuminar, et al., 2023; Nurasikin et al., 2013; Whitley et al., 2012).

Although religious affiliation can provide a source of resilience and strength, some factors may create barriers to mental health recovery for religious individuals. Conflicts between religious teachings and psychological treatments can lead to internal struggles, where individuals feel torn between their faith and the professional psychological advice (Bendeck Sotillos, 2021; Shadid et al., 2021). Also, the shame associated with experiencing mental health issues while holding religious beliefs can discourage individuals from pursuing

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or engaging in psychological treatment. This may stem from the belief that faith alone should be sufficient to overcome mental health struggles (Meran & Mason, 2019; Nanji & Olivier, 2024). A few studies report a negative or mixed association for being religious or spiritual and levels of depression and anxiety (Koenig, 2009; Malinakova et al., 2020). The studies suggest religious beliefs may not provide relief from psychological distress but instead intensify it. This may be due to feelings of guilt for struggling despite their faith or the pressure to maintain an appearance of spiritual well-being within their religious community. Hence, rather than serving as a protective factor, religious affiliation may exacerbate distress and hinder recovery (Malinakova et al., 2020).

Overall, the literature suggests that religious affiliation, referral pathways, and ethnicity all could contribute to recovery differences when receiving mental health support. Therefore, the study will explore the impact of ethnicity, religious or spiritual beliefs, and referral pathways on well-being outcomes for individuals receiving evidence-based psychological treatment within the IAPT service. The hypotheses are as follows, which were OSF preregistered (<https://osf.io/v87zd>):

H1: IAPT service users from a white background will indicate higher levels of recovery than CED service users.

H1.a: CED individuals will have higher scores of depression, anxiety and functional impairment symptomology at the start and end of treatment compared to white service users.

H1.b: IAPT treatment will improve (i.e., reduce) CED individuals' scores of depression, anxiety and functional impairment symptomology.

H2: Religious affiliation will affect recovery rates. This effect will be stronger for CED IAPT service users.

H3: The referral pathway type will impact recovery rates.

H4: CED groups will be more likely to be at clinical caseness for anxiety and depression at the end of treatment in comparison to white service users.

H4.a: IAPT treatment will improve (i.e., reduce) clinical caseness of CED individuals' scores of depression, anxiety and functional impairment symptomology.

H5: CED service users will exhibit greater functional impairment compared to white service users, which will be mediated by levels of depression and anxiety (measured using pre-scores).

## 7.5 Methods

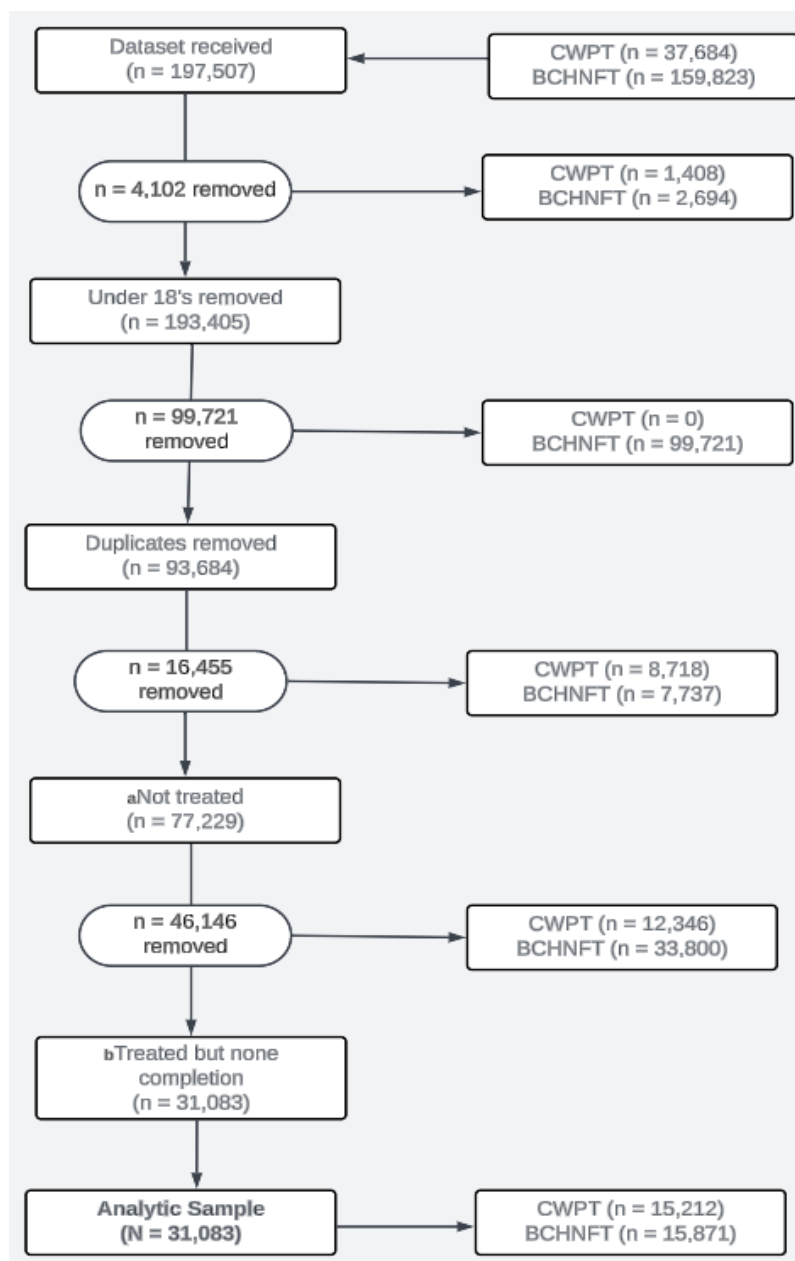
### 7.5.1 Sample

The datasets were obtained from two NHS Trusts from the West Midlands, United Kingdom: 1) Coventry and Warwickshire Partnership Trust (CWPT - comprised of three localities – Coventry, Warwickshire and Solihull) and 2) Black Country Healthcare NHS Foundation Trust (BCHNFT - comprised of three localities - Sandwell, Walsall and Wolverhampton). The collected timestamps of the datasets were between December 2018 to December 2019, and May 2020 to May 2021 across both NHS Trusts. The analytical sample was N = 31,083 service users (see Figure 7.1 for an outline of the steps to reach the analytical sample). The analytical sample excluded service users who were under the age of 18, did not receive treatment, or whose data were duplicated (See Figure 7.1).

#### Figure 7.1

Flow Chart of the quality check of the datasets

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**Note.** CWPT (Coventry and Warwickshire Partnership TRUST)

BCHNFT (Black Country Healthcare NHS Foundation TRUST)

<sup>a</sup> Entered IAPT but were not treated at all. Labelled as 'assessed', only service users were removed from the main dataset due to them not being treated; thus, no data on recovery according to GAD-7 and PHQ-9.

<sup>b</sup> Service users who were treated, but the sessions ended before the care professional planned and/or had either no pre-/post-outcomes scores on any of the well-being questionnaires (GAD-7, PHQ-9 and WSAS)

### 7.5.2 Demographic Characteristics

Descriptive data were collected for both datasets (See Table 8.1). Participants were predominantly white,  $n = 24,485$  (78.77%), followed by  $n = 3,429$  (11.03%) Asian service users. In addition, the majority identified as female ( $n = 20,490$ ; 65.92%), whilst  $n = 9,034$

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(29.06%) were between 25-34 years. A total of  $n = 19,523$  (62.81%) were not religious,  $n = 20,746$  (65.74%) who self-referred and  $n = 13,296$  (42.78%) received CBT, which was the most frequent treatment.

**Table 7.1**

Characteristics of service users aged 18 + referred to IAPT services between 2018-2021 from the two NHS Trusts.

Variables	Analytical Sample (Complete Case)		CWPT		BCHNFT	
	N	%	N	%	N	%
<b><sup>a</sup> Ethnicity</b>						
Black	1,009	3.25%	340	2.23%	669	4.22%
Asian	3,429	11.03%	1,155	7.59%	2,274	14.33%
Mixed	1,027	3.30%	372	2.45%	655	4.13%
Other Ethnic	415	1.29%	140	0.92%	275	1.73%
white	24,485	78.77%	13,056	85.82%	11,430	72.02%
<b><sup>a</sup> Gender Identity</b>						
Female	20,490	65.92%	9,963	65.49%	10,529	66.34%
Male	10,530	33.88%	5,245	34.47%	5,285	33.30%
<b>Age</b>						
18-24	5,858	18.85%	3,111	20.45%	2,747	17.31%
25-34	9,034	29.06%	4,227	27.79%	4,807	30.29%
35-44	6,315	20.32%	2,881	18.94%	3,434	21.64%
45-54	5,207	16.75%	2,380	15.64%	2,827	17.81%
55-64	3,217	10.35%	1,650	10.85%	1,567	10.01%
65-74	986	3.17%	650	4.27%	336	9.87%
75+	466	1.50%	313	2.06%	153	0.96%
<b><sup>a</sup> Religious Background</b>						
Yes – Religious	11,245	36.18%	5,167	33.96%	6,078	38.30%
No – Not Religious	19,523	62.81%	9,730	63.96%	9,793	61.70%
<b><sup>a</sup> Referral Pathway</b>						
Self-referral	20,746	65.74%	14,191	93.29%	6,555	41.30%
GP	6,081	19.56%	239	1.57%	5,842	36.81%
Primary Health (ex. GP)	252	0.81%	0	0%	252	1.59%

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Variables	Overall Sample (Complete Case)		CWPT		BCHNFT	
	N	%	N	%	N	%
<b><sup>a</sup> Referral Pathway</b>						
Community	1,523	4.90%	635	4.17%	888	5.60%
Secondary	1,383	4.45%	92	0.60%	1,291	8.13%
Internal Referral	54	0.17%	0	0%	54	0.34%
<b><sup>a</sup> Type of Treatment</b>						
CBT						
Counselling for Depression	13,296	42.78%	9,549	62.77%	3,747	23.61%
Computerised CBT	3,282	10.56%	829	5.45%	2,453	15.46%
<sup>b</sup> Other IAPT Treatments (Combined Types)	3,128	10.06%	0	0%	3,128	19.71%
	3,317	10.67%	616	4.05%	2,701	17.02%
<b><sup>a</sup> GAD-7 Caseness (Post)</b>						
Caseness						
Not at Caseness	12,741	40.99%	6,269	41.21%	6,472	40.78%
	18,342	59.01%	8,943	58.79%	9,399	59.22%
<b>GAD-7 Caseness (Pre)</b>						
Caseness						
Not at Caseness	29,353	94.43%	14,225	93.50%	15,128	99.45%
	1,730	5.57%	987	6.49%	743	4.68%
<b><sup>a</sup> PHQ-9 Caseness (Post)</b>						
Caseness						
Not at Caseness	11,370	36.58%	5,498	36.14%	5,872	37.00%
	19,713	63.42%	9,714	63.86%	9,999	63.00%
<b>PHQ-9 Caseness (Pre)</b>						
Caseness						
Not at Caseness	27,027	86.95%	13,091	86.06%	13,936	87.81%
	4,056	13.05%	2,121	13.94%	1,935	12.19%

**Note.** WSAS does not have a clinical caseness threshold, so it was not included.

CWPT (Coventry and Warwickshire Partnership Trust)

BCHNFT (Black Country Healthcare NHS Foundation Trust)

The treatment label was for individuals who received two or more sessions and were included.

<sup>a</sup> Overall Sample Data Missing: Ethnicity data  $n = 718$ ; Gender Identity data  $n = 63$ ; Religious background  $n = 315$ ; Referral Pathway  $n = 1,044$ ; Type of Treatment Unknown/not specifically stated  $n = 8,060$

<sup>b</sup> Due to the low numbers individually, the other treatments (Behavioural Activation, Psychoeducation, Self-help, Ante/post-natal counselling, Eye movement desensitisation reprocessing, couples therapy for depression and interpersonal psychotherapy) were combined.

Service users' ethnicity was categorised into sub-groups of Black (comprised of: African, Caribbean and any other Black background), Asian (comprised of: Bangladeshi, Indian, Pakistani and any other Asian background), Mixed-heritage (comprised of: Mixed -

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white and Asian (any)/Black (any) and any other mixed background), Other Ethnic Groups, white (comprised of: white – British / white – Irish / white - Any Other) and Not Known (comprised of: Not stated / NULL / Blanks). It is acknowledged that issues arise when aggregating sub-groups of ethnicities into one category, as experiences and beliefs can vary between different ethnicity groups, for example, Black African and Black Caribbean groups or Asian Indian and Asian Pakistani. However, the composition of the sample did not allow for the quantitative exploration and analysis of the individual ethnic groups. The variable ethnicity was thus dichotomised, where 0 = CED ( $n = 5880$ ) and 1 = white ( $n = 24485$ ).

In addition, religious status was grouped into religious (encompassed Buddhist / Christian / Hindu / Muslim / Sikh / Pagan /Other) or non-religious (Not stated / Null / Patient Religion Unknown / Blanks / None) due to the low numbers to have separate categories. Further demographics, such as service users' current employment, were gathered (Employed – full or part-time/ Student full or part-time / Long-term sick or Disabled / Retired / Self-employed / Unemployed [seeking or not seeking work]/ Volunteer/ Not stated), but this was not used in the analysis based on data constraints.

### *7.5.3 Referral Pathways*

Service users accessed the IAPT service through one of seven routes: 1) GP, 2) self-referral, 3) primary health service (excluding GP), 4) secondary services such as other mental health organisations or outpatient programmes, 5) community service for example the justice system, job centre or other government/voluntary services, 6) internal referrals for example being stepped up or down from their treatment, and 7) Other / not mentioned.

### *7.5.4 Type of Treatment Received*

Cognitive Behavioural Therapy was the most frequent treatment administered within the sample, in line with previous evidence (Clark, 2018; NCCMH, 2018). Counselling for Depression is a high intensity treatment that followed in terms of frequency of treatment received. Computerised CBT was the most commonly administered low intensity treatment (NCCMH, 2018).

### *7.5.5 Mental Health Measurements*

In the IAPT service, recovery refers to the process where service users who initially exhibit symptoms above the clinical threshold, as determined by the GAD-7 and PHQ-9 scales, demonstrate a reduction in their symptoms and return to a state of clinical normality by the end of treatment. Whereas 'reliable improvement' is when service users show significant improvements and their symptomology scores for GAD-7 and PHQ-9 decrease after the intervention, regardless of being at clinical caseness at the start of treatment (NCCMH, 2018).

**7.5.5.1 The Generalised Anxiety Disorder (GAD-7):** Measures patients' symptoms of anxiety, including panic or social anxiety and post-traumatic stress, using seven items (Kroenke et al., 2007). Patients answer seven questions on a four-point Likert scale where 0 means "not at all" and 3 means "nearly every day" (See, Appendix 7.a). The questions assess service users on how much they have been bothered by feelings like nervousness or anxiety over the past two weeks. The clinical cut-off point for caseness is 8 or above (with a maximum score being 21). A GAD score of 0-4 indicates 'minimal anxiety', 5-9 'mild anxiety', 10-14 'moderate anxiety' and 15-21 'severe anxiety' (Spitzer et al., 2006). The sensitivity of

the scale is 89% and has a specificity of 82% along with excellent internal consistency (Cronbach  $\alpha = .92$ ; NCCMH, 2018; Spitzer et al., 2006).

**7.5.5.2 The Patient Health Questionnaire (PHQ-9):** Measures depression symptoms with nine questions that service users answered using a four-point scale ranging from 0 "not at all" to 3 "nearly every day". The questions assess service users' feelings over the past two weeks, such as feeling down or hopeless. A score of 10 or higher (out of 27) indicates clinical caseness. A PHQ score 0-4 represents 'minimal depression', 5-9 'mild depression', 10-14 'moderate depression', 15-19 'moderately severe depression' and 20-27 'severe depression' (Kroenke et al., 2001; *See*, Appendix 7.b). The sensitivity and specificity of the scale are both 88%, and an excellent internal consistency (Cronbach  $\alpha = 0.89$ ; Kroenke et al., 2001).

**7.5.5.3 The Work and Social Adjustment Scale (WSAS):** Measures how mental health affects daily functioning at work or home (Mundt et al., 2002). The questionnaire has five items, such as "Because of my [problem], my ability to work is impaired." Participants answer them on a 0 (indicating "low") to 8 ("very severe") Likert scale. For WSAS, there is no clinical caseness cut-off point (*See*, Appendix 7.c). A score of 0-9 signifies 'low impairment', 10-19 is 'moderate impairment', and 20-40 is 'severe impairment' (Mundt et al., 2002).

### *7.5.6 Ethical Approval and Procedure*

Ethical approval was first gained through the researcher's Institutional Ethics Committee in July 2021 (approval reference: Clarke-Jeffers /#9600 /sub1 /R(C) /2021 /Jul /BLSS FAEC). Further ethical approval was required to retrieve the datasets from NHS trusts. The researcher completed a Disclosure and Barring Service and the e-learning Introduction to GCP. The NHS ethics was completed on the IRAS platform in March 2022. Approval by the Health Research Authority and the West Midlands Solihull Research Ethics Committee was secured in May 2022 (IRAS ethics reference: 22/WM/0086). The researcher then

corresponded with IAPT Research & Development (R&D) departments from the West Midlands to retrieve the anonymised datasets. The two NHS TRUSTs sent over the datasets in an encrypted, password-protected file. The e-mails were deleted within 24 hours after the datasets were saved onto the researcher's password-protected university OneDrive account.

### *7.5.7 Data Analysis*

JASP software was used to analyse the data (JASP Team, 2024). To assess recovery, depending on ethnicity (CED vs white), multi-level modelling was used to explore pre- and post-outcome scores on the three well-being measures of IAPT recovery (GAD-7, PHQ-9 and WSAS). As well as exploring clinical caseness outcomes for GAD-7 and PHQ-9. In addition, parallel mediation was used to explore whether the effect of ethnicity on GAD-7 and PHQ-9 (pre-treatment scores) was mediated by WSAS (pre-treatment scores).<sup>13</sup>

## **7.6 Results**

Table 7.2 presents the descriptive statistics of CED and white service users' pre-, post- and change scores (pre-and post-scores) for the well-being measurements of depression, anxiety and functional impairment. Data were normally distributed, although slightly positively skewed for pre-GAD-7/PHQ-9 and slightly negatively skewed for post-GAD-7/PHQ-9.

The mean scores in Table 8.2 displayed that CED groups had higher levels of anxiety, depression and functional impairment for pre- and post-scores, i.e., worse mental health compared to white IAPT service users. The data for the mean change scores (pre/post)

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<sup>13</sup> Post-scores were not used to avoid treatment effect. Thus, the researcher was concerned with pre-scores and the initial disparities.

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across both groups (CED and white) showed a reduction in all mental well-being scores, suggesting better health outcomes for anxiety, depression and functional impairment symptoms after receiving psychological evidence-based treatment in the IAPT service.

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**Table 7.2**

*Descriptive Statistics of the Pre- and Post-treatment Well-being Outcomes Between CED and white Service Users*

Column Label		Well-being Outcomes								
		Pre-GAD	Post-GAD	GAD Change Scores (Pre/Post)	Pre-PHQ	Post-PHQ	PHQ Change Scores (Pre/Post)	Pre-WSAS	Post-WSAS	WSAS Change Scores (Pre/Post)
CED (n=5880)	Mean	15.09	8.38	6.71	16.67	9.36	7.31	21.19	13.97	7.23
	Standard Deviation	4.11	5.82	6.04	5.38	6.72	6.73	9.59	10.48	11.18
	Skewness	-.54	.56	-.17	-.37	.64	-.06	-.06	-.54	-.08
	Kurtosis	-.34	-.77	-.55	-.34	-.48	-.39	-.75	-.75	-.04
white (n=24485)	Mean	14.83	8.06	6.76	15.94	8.68	7.26	19.23	12.03	7.19
	Standard Deviation	4.32	5.59	5.78	5.66	6.35	6.46	9.19	9.71	10.00
	Skewness	-.58	.65	-.10	-.30	.74	.10	.05	.77	.10
	Kurtosis	-.25	-.57	-.51	-.50	-.29	-.33	-.64	-.23	.18
Ethnicity (CED vs. white) Cohen's <i>d</i> Scores		.06	.06	-.01	.13	.11	.01	.21	.20	.01

**Note.** CED = Culturally and Ethnically Diverse Groups, GAD-7 = Generalised Anxiety Disorder, PHQ-9 = Patient Health Questionnaire, WSAS = Work and Social Adjustment Scale. Missing cases due to non-disclosure of ethnicity, n =718.

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To determine if there were statistically significant differences for the pre, post and change scores between the two ethnic groups, a one-way MANOVA was conducted. The data for the separate pre- and post-GAD, PHQ and WSAS scores showed a significant difference ( $<.001$ ) between CED and white participants. The multivariate tests indicated a significant overall effect for CED and white service users when combining the dependent variables (well-being outcomes), Pillai's Trace = .011,  $F(6, 30358) = 54.80$ ,  $p < .001$ , partial  $\eta^2 = .011$ . Also, the intercept was significant, Pillai's Trace = .897,  $F(6, 30358) = 44004.67$ ,  $p < .001$ , partial  $\eta^2 = .89$ .

However, when exclusively observing the change scores (pre/post) for differences between the two ethnicity groups (CED and white) the data was non-significant outcomes: GAD change scores,  $F(1, 30363) = 0.384$ ,  $p = .535$ , partial  $\eta^2 = .000$ . PHQ-9 change scores,  $F(1, 30363) = 0.232$ ,  $p = .630$ , partial  $\eta^2 = .000$ . WSAS change scores,  $F(1, 30363) = 0.044$ ,  $p = .835$ , partial  $\eta^2 = .000$ . The outcomes suggest that the change scores for all three well-being outcomes did not differ between CED and white service users indicating similar levels of improvement within the IAPT program regardless of ethnicity.

The Cohen's  $d$  coefficient captured the effect size for pre- and post-change scores between CED and white participants. The data in Table 8.2 revealed that the effect sizes were negligible or very small ( $d \approx 0.2$ : small effect size), showing there were no meaningful differences between the ethnicity groups. The WSAS pre- and post-outcomes had the biggest effect size in the study ( $d = > .21$  and  $d = > .20$ ), albeit a small effect which may not be clinically meaningful. Also, the Partial Eta Squared showed a small effect for all outcomes ( $\eta^2 < .01$ ).

Table 7.3 below reports the Pearson’s correlation coefficients for GAD, PHQ and WSAS measures. Reporting these correlations helps to examine the relationships between pre- and post-treatment well-being measures. All correlations were positive and significant at the  $p < .001$  level. The pre-intervention correlations ranged from  $.20 < |rs| < .56$ , with a Cohen’s  $d$  range of small to large. In contrast, the correlations among the three post-intervention outcomes were large ( $.68 < |rs| < .88$ ).

**Table 7.3**

*Pearson’s  $r$  Coefficients for the Correlation Between the Well-being Variables*

Well-being	Pre-GAD	Post-GAD	Pre-PHQ	Post-PHQ	Pre-WSAS	Post-WSAS
1. Pre-GAD						
2. Post-GAD	.33					
3. Pre-PHQ	.55	.32				
3. Post-PHQ	.26	.87	.43			
4. Pre-WSAS	.36	.25	.55	.32		
5. Post-WSAS	.21	.69	.35	.74	.44	

**Note.**  $p$ . all correlations were significant at the  $p < .001$  level.

GAD-7 = Generalised Anxiety Disorder, PHQ-9 = Patient Health Question, WSAS = Work and Social Adjustment Scale

A key observation was the stronger associations between the three post-intervention well-being scores in comparison to the pre-intervention measures. This pattern suggests that improvements in one area of well-being (anxiety, depression or functional impairment) are linked to improvements in others post-treatment. Furthermore, the interconnection of the well-being outcomes reinforces the effectiveness of IAPT treatments, aiding positive changes in more than one well-being area, i.e., anxiety, depression or functional impairment.

### *7.6.1 Multilevel Regression Analysis - Pre/post differences on the three well-being measures*

A multilevel regression analysis was run to examine the relative contribution of religious affiliation and IAPT referral pathway to predict recovery outcomes, which were measured as the difference between the pre- and post-treatment scores. For the following analysis, 2,290 participants were removed from the dataset due to not indicating their religious affiliation, referral pathway or those who labelled themselves 'other ethnic group'. For the multilevel analysis, two separate tests were conducted, differing only in how ethnicity was specified as a variable, while all the other factors remained unchanged. In the first analysis, ethnicity was inserted as a dichotomous variable (white vs CED). 0 = white ( $n = 23,568$ , baseline category) and 1 = CED group which encompassed Black, Asian, Mixed ( $n = 5,225$ ).

In the second analysis, the researcher aimed to obtain a further breakdown for each specific ethnicity group (depending on whether the results were significant) rather than the dichotomous variable split (white vs CED). Therefore, ethnicity was dummy coded. 0 = white ( $n = 23,568$ , baseline category), 1 = Black ( $n = 979$ ), 2 = Asian ( $n = 3,308$ ) and 3 = Mixed ( $n = 938$ ). Participants labelled as 'other ethnic group' ( $n = 402$ ) were excluded from the analysis due to the small sample size. To explore the effect of the referral pathway, the variable was also dummy-coded. Self-referral ( $n = 20,233$ ) was set as the baseline dummy variable (0) against the dummy variables (1) GP referral ( $n = 5,700$ ) and (2) other routes ( $n = 2,860$ ). The referral pathway category labelled 'other' included participants who selected from the following: primary health service (excluding GP), secondary services, community service, and internal referrals.

A separate linear mixed model was used to examine the effect of referral pathway and religion on the three well-being outcomes (GAD, PHQ and WSAS). All the results showed that ethnicity was not a significant ( $ps > .05$ ) predictor for GAD, PHQ or WSAS scores. The non-significant effect was also supported by the Type III ANOVA, with all scores were  $ps > .05$ . Also, the random effects estimates indicated some significant variation in the intercepts for religious affiliation across all three well-being outcomes. However, the random slopes for ethnicity were negligible across all levels, suggesting that there was little variation in the effect of ethnicity across the random effect variables for referral pathways and religious affiliation.

### *7.6.2 Logistic Regression Analysis - Clinical Caseness Outcome*

Clinical caseness outcomes (binary – ‘at clinical caseness’, i.e., not recovered or ‘not at clinical caseness’, i.e., recovered) at the end of treatment outcomes were assessed. Clinical caseness was only assessed for the measures GAD and PHQ (anxiety and depression) in relation to ethnicity and referral pathway (GP, self or other referral pathways) and being religious or not. Firstly, a cross-tabulation was run to provide descriptive information on the recovery percentage within each ethnic group (See, Table 7.4).

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**Table 7.4**

Recovery Caseness Rates And Percentages Across Ethnicity Groups for Anxiety and Depression

Caseness

Well-being Outcomes of Clinical Caseness	Ethnicity Group			
	n (%)			
	Black	Asian	Mixed	white
Anxiety: Recovered	526 (53.73)	1,964 (59.37)	522 (55.65)	13,947 (59.18)
Anxiety: Not Recovered	453 (46.27)	1,344 (40.63)	416 (44.35)	9,621 (40.82)
<i>p</i>	<.001	.558	.040	.042
Depression: Recovered	586 (59.86)	2013 (60.85)	544 (58.00)	15,147 (64.27)
Depression: Not Recovered	393 (40.14)	1295 (39.15)	394 (42.00)	8,421 (35.73)
<i>p</i>	.015	<.001	<.001	<.001

**Note:** n is the number of participants, and the value in parentheses indicates the percentage (%) of participants within that specific ethnicity group.

Table 7.4 results show that the recovery rates for anxiety were highest among Asian service users (59.37%), though this was non-significant, and for depression, it was highest amongst white service users (64.27%), which was significant. Whereas Black service users had the lowest recovery rate for anxiety (53.73%), and for depression, it was Mixed service users with the lowest recovery rate (58.00%), which were both significant. The *p* values indicate there are statistically significant differences (besides anxiety for Asian service users) in recovery rates for both anxiety and depression among the various ethnic groups. This means that the likelihood of recovering (or not recovering) from anxiety or depression is significantly related to a person's ethnicity.

Additionally, a cross-tabulation was completed for the factor variables of the referral pathway types and religious affiliation (See, Table 7.5).

**Table 7.5**

Recovery Caseness Rates Across Referral Pathway and Religious Affiliation

Well-being Outcomes of Clinical Caseness	Factor Variables				
	n (%)			Religious	Not
	GP	Self	Other		
Referral Pathway			Religious Affiliation		
Anxiety: Recovered	3,492 (61.26)	12,005 (59.33)	1,462 (51.12)	6,351 (60.04)	10,608 (58.27)
Anxiety: Not Recovered	2,208 (38.74)	8,228 (40.67)	1,398 (48.88)	4,227 (39.96)	7,607 (41.76)
<i>p</i>	<.001	.021	<.001	.003	.003
Depression: Recovered	3,711 (65.11)	12,994 (64.22)	1,585 (55.42)	6,856 (64.81)	11,434 (62.77)
Depression: Not Recovered	1,989 (34.89)	7,239 (35.78)	1,275 (44.58)	3,722 (35.18)	6,781 (37.23)
<i>p</i>	.006	<.001	<.001	<.001	<.001

Table 7.5 results found that individuals referred to the IAPT service through ‘other’ referral pathways are 48.88% found to be at clinical caseness for anxiety ( $p < .001$ ), thus suggesting that these individuals may have more severe cases of clinical anxiety that has made recovery more challenging in comparison to being referred by a GP or self-referral (38.74% and 40.67% respectively). For depression clinical caseness, participants referred by the ‘other’ types of pathways were 44.58% found to be at not recovered in comparison to those referred by a GP (38.89% and 35.78% respectively), a difference which was all statistically significant. The results suggest that GP and self-referral may be useful pathways to aid depression recovery, whereas the ‘other’ pathway types may be considered more challenging. For the variable of being religious for both anxiety and depression, individuals who stated they were religious were 60.04% (anxiety) and 64.81% (depression), and were found to be at recovery (i.e., not labelled as clinical caseness). In comparison, for individuals

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who stated they did not affiliate with religion, the anxiety recovery was 58.27%, and for depression, the recovery was 62.77%. The association between religion and both anxiety and depression recovery were statistically significant ( $p = <.05$ ), with the results suggesting that religion may play a protective role in recovery for anxiety and depression.

Further to the cross-tabulation outputs, logistic regression analyses were conducted (See, Tables 7.6 and 7.7 below) to explore clinical caseness for anxiety and depression when considering the referral pathways and religious affiliation across different ethnicity groups.

**Table 7.6**

Coefficients For The Outcomes Of Anxiety Clinical Caseness

	Estimate	Standard Error	Standardized <sup>+</sup>	Odds Ratio	z	Wald Test			95% Confidence interval	
						Wald Statistic	df	p	Lower Bound	Upper Bound
Intercept	-0.457	0.024	-0.457	0.633	-18.880	356.459	1	< .001	-0.505	-0.410
Black	0.248	0.066	0.248	1.281	3.731	13.922	1	< .001	0.118	0.378
Asian	0.039	0.040	0.039	1.040	0.987	0.974	1	.324	-0.039	0.118
Mixed	0.167	0.067	0.167	1.181	2.477	6.138	1	.013	0.035	0.298
Not Religious	0.096	0.026	0.096	1.101	3.640	13.251	1	< .001	0.045	0.148
GP	-0.083	0.031	-0.083	0.921	-2.679	7.178	1	.007	-0.143	-0.022
Other Referral	0.333	0.040	0.333	1.396	8.306	68.992	1	< .001	0.255	0.412

**Note.** Model Summary BIC value = 38956.126,  $p < .001$ . The model was saturated, with high BIC values (Delattre et al., 2014). It is typical for multicollinearity to occur due to the similarity between the well-being measures.

Table 7.6 displays clinical caseness for anxiety, which focuses on the different ethnicity groups along with the referral pathway and religious affiliation. The findings show that Black and Mixed service users were significantly more likely to be found and remain at clinical caseness for anxiety (28.1% and 18.1%, respectively) in comparison to white service users. Black service users’ odds ratio of 1.281 ( $p < .001$ ), whereas for Mixed service users, the odds ratio was 1.181 ( $p = .013$ ). However, Black service users showed a stronger association with experiencing higher levels of clinical levels of anxiety. For Asian service users, the odds ratio of being found at clinical caseness compared to

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white service users (baseline category) were 1.040 ( $p = .324$ ), indicating a 4.0% higher likelihood of remaining at clinical caseness. However, the result was not statistically significant, thus no strong evidence that Asian service users differ from white service users in their likelihood of being at clinical caseness after treatment. When observing the referral routes, individuals who were referred by their GP were 7.9% less likely to remain in clinical caseness, with an odds ratio of 0.921 ( $p = .007$ ) compared to self-referrals (baseline category), indicating that GP referrals were associated with a higher chance of recovery. For the Other types of referral pathways, they had a significantly higher likelihood of not recovering, odds ratio = 1.396 ( $p < .001$ ), which was 39.6% in comparison to the self-referral route. Furthermore, for service users who classified themselves as not belonging to a religious background, these individuals were 10.1%, odds ratio = 1.101 ( $p = <.001$ ) more likely to be found at clinical caseness (i.e., not recovering) for anxiety compared to those who stated a religious affiliation.

Furthermore, a logistic regression for the clinical caseness for depression was conducted that also focuses on the different ethnicity groups, referral pathway and religious affiliation (See, Table 7.7).

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**Table 7.7**

Coefficients for Depression Clinical Caseness

	Estimate	Standard Error	Standardized <sup>+</sup>	Odds Ratio	z	Wald Test			95% Confidence interval	
						Wald Statistic	df	p	Lower Bound	Upper Bound
Intercept	-0.718	0.025	-0.718	0.488	-28.732	825.531	1	< .001	-0.767	-0.669
Black	0.230	0.068	0.230	1.259	3.399	11.555	1	< .001	0.097	0.363
Asian	0.214	0.040	0.214	1.238	5.286	27.939	1	< .001	0.134	0.293
Mixed	0.287	0.068	0.287	1.333	4.240	17.981	1	< .001	0.155	0.420
Not Religious	0.146	0.027	0.146	1.157	5.366	28.799	1	< .001	0.093	0.199
GP	-0.051	0.032	-0.051	0.950	-1.619	2.620	1	.106	-0.113	0.011
Other Referral	0.366	0.040	0.366	1.442	9.046	81.831	1	< .001	0.287	0.445

**Note.** Model Summary BIC value = 37702.934,  $p < .001$ . The model was saturated, with high BIC values.

Table 7.7 shows that Mixed service users had a stronger association with experiencing higher levels of clinical caseness of depression. The odds ratio for Mixed service users was 1.333 ( $p = <.001$ ), and they were 33.3% more likely to remain at clinical caseness compared to white service users (baseline category, consistent with the findings displayed on Table 7.7). Similarly, Black service users' odds ratio was 1.259, ( $p = <.001$ ), and Asian service users' odds ratio was 1.238 ( $p = <.001$ ), and were 25.9% and 23.8%, respectively, more likely to remain at clinical caseness (i.e., not recovered). For the referral pathways, the GP referral route has a 5% lower likelihood of remaining at clinical caseness for depression (odd ratio 0.950) compared to the self-referral group; however, there were no differences ( $p = .106$ ). For the other referral pathway, they were 44.2% more likely to remain at clinical caseness compared to the self-referral pathway (baseline category), with an odds ratio of 1.442 ( $p = .001$ ). Additionally, individuals who referred to themselves as not being religious were 15.7%, odds ratio = 1.157 ( $p = <.001$ ) more likely to be at clinical caseness for depression than those who referred to themselves as being religious.

### 7.6.3 Parallel Mediation Analysis

A parallel mediation analysis was conducted to examine whether the effect of ethnicity on functional impairment was mediated by anxiety and depression (See Figure 8.2). Results revealed a partial mediation for ethnicity (predictor variable), functional impairment (outcome variable) and experiencing mental health problems of anxiety and depression (mediators). The results for the standardised path coefficients were significant across all paths (See, Table 8.8).

**Table 7.8**

Well-being Path Coefficients

Well-being Paths	Estimate	Std. Error	z-value	p	95% Confidence Interval	
					Lower	Upper
GAD_FirstScore → WSASFirstScore	0.095	0.006	16.223	< .001	0.084	0.107
PHQ_FirstScore → WSASFirstScore	0.485	0.006	82.555	< .001	0.474	0.497
Ethnicity (CED Group) → WSASFirstScore	0.146	0.013	11.388	< .001	0.121	0.171
Ethnicity (CED Group) → GAD_FirstScore	0.086	0.015	5.606	< .001	0.056	0.116
Ethnicity (CED Group) → PHQ_FirstScore	0.131	0.015	8.551	< .001	0.101	0.161

**Note.** Delta method standard errors, normal theory confidence intervals, ML estimator.

Table 7.8 shows that both anxiety and depression are associated with functional impairment. Higher GAD scores predict greater functional impairment ( $\beta = 0.095$ ,  $p < .001$ ), while PHQ-9 scores have a stronger effect ( $\beta = 0.485$ ,  $p < .001$ ), suggesting that depression plays a more substantial role in daily difficulties.

Ethnicity also significantly predicts functional impairment ( $\beta = 0.146$ ,  $p < .001$ ), with its effect being partially explained by anxiety and depression. Additionally, ethnicity is significantly associated with both GAD ( $\beta = 0.086$ ,  $p < .001$ ) and PHQ-9 scores ( $\beta = 0.131$ ,  $p < .001$ ), indicating that CED individuals report higher levels of anxiety and depression compared to white service users.

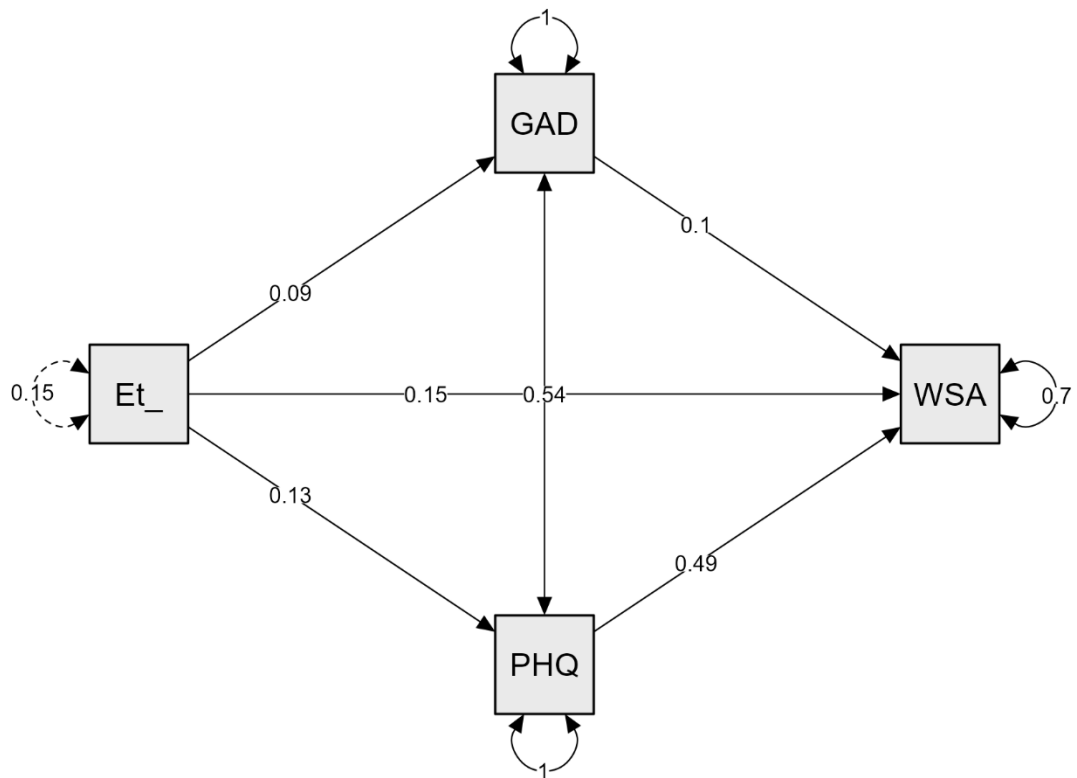
Figure 7.2 below shows the standardised path coefficients that are represented by the arrows that show the direction of the relationships between variables.<sup>14</sup> In summary, the model shows that CED groups experience lower functional impairment, which is partially due to their higher levels of anxiety and depression.

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<sup>14</sup> The curved-dotted double loop on the exogenous variable CED, has a value of 0.15 that indicates the variance of the variable CED is not explained by other variables in the model. Whereas the curved-double loop for the endogenous variables (GAD, PHQ, and WSAS) represent the proportion of variance that is not explained by the predictors in the model or show the measurement error of this variable. The GAD and PHQ double arrow loop both have a value of 1 (residual variance) that show that 100% of the variance in GAD and PHQ is unexplained by the model. The WSAS double arrow loop has a value of 0.70 that indicates that 70% of the variance in WSAS is unexplained by the model.

Figure 7.2

Parallel Mediation of anxiety and depression first scores and the path standardised coefficients on functional impairment between binary ethnic groups (CED vs white).



**Note.** Et\_ = Ethnicity (binary coded, i.e., CED vs white, both included), GAD = Generalised Anxiety Disorder first scores, PHQ = Patient Health Questionnaire first scores and WSA = Work and Social Adjustment Scale first scores

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The model showed a significant effect of anxiety and depression on functional impairment prior to the start of therapy. Table 8.9 below shows that both anxiety and depression are partially mediated by the effect of ethnicity (CED and white) on functional impairment (measured by WSAS), with all being significant. The mediation was stronger for depression, accounting for 29.3% (i.e., .063 / .217) of the total effect, compared to anxiety, which accounted for 3.7% (i.e., .008 / .217) of the total effect. These findings suggest that the effect of ethnicity on functional impairment is partially due to high levels of depression and anxiety.

**Table 7.9**

A combination of the different effects on well-being outcomes

Effect Type	Pathway	Estimate	Std. Error	z-value	p-value	95% CI Lower	95% CI Upper
Direct Effect	Ethnicity → WSAS_FirstScore	0.146	0.013	11.388	< .001	0.121	0.171
Indirect Effect	Ethnicity → GAD_FirstScore → WSAS_FirstScore	0.008	0.002	5.299	< .001	0.005	0.011
Indirect Effect	Ethnicity → PHQ_FirstScore → WSAS_FirstScore	0.063	0.007	8.506	< .001	0.049	0.078
Total Effect	Ethnicity → WSAS_FirstScore	0.217	0.015	14.260	< .001	0.187	0.247

**Note.** Ethnicity = CED vs white

## 7.7 Discussion

The study utilised two anonymised secondary datasets from the IAPT service sites in the Midlands to explore factors influencing recovery outcomes amongst IAPT service users. There was a particular focus on observing referral pathways, religious affiliation and ethnic disparities to help explain the differences in recovery rates between CED and white service users. The results showed that white service users were typically more likely to recover compared to CED service users (supporting H1), with CED service users displaying higher levels of functional impairment, anxiety and depression pre- and post-treatment (supporting H1.a). Similarly, CED service users were more likely to be at clinical caseness for anxiety and depression, in contrast to white service users (supported by H4). These findings are in line with previous research that has shown higher symptom severity amongst CED service users (Stochl et al., 2022; Tuffour et al., 2019). Previous research suggests that the higher severity of symptomology amongst CED groups is typically due to systemic factors such as racism and discrimination, as well as cultural or religious barriers that can inhibit accessing or maintaining within the mental health setting (Edge, 2013; Grey et al., 2013; Hackett et al., 2020). Although the results indicated that CED service users began with higher levels across all three well-being outcomes, they still did experience a reduction in all well-being outcomes at the end of treatment. Supporting hypotheses 1.b and 4. a, the findings provide evidence that the IAPT service is beneficial across ethnicity groups in decreasing the severity of anxiety, depression and functional impairment (reliable improvement). Also, reducing the number of CED groups remaining at clinical caseness, even though this study found that CED individuals had greater symptom severity at the beginning and end of treatment (Amati et

al., 2023; Moller et al., 2019). Hence, the findings suggest that CED groups can benefit from evidence-based psychological therapy.

Additionally, the findings of this study incorporated the variables of referral pathway and religious affiliation. For the change scores (pre- and post-outcome) GAD, PHQ and WSAS linear mixed model results showed no significant differences when including referral pathway, religious affiliation and ethnicity (binary - CED and white service users). However, when assessing GAD and PHQ clinical caseness outcomes (rather than the change scores) when including referral pathway, religious affiliation and ethnicity, there was a significant difference. Thus, when observing religious affiliation, hypothesis 2 can be partly supported. This study found that when assessing the clinical caseness outcomes (not the change score outcomes), individuals who had a religious affiliation showed better recovery outcomes, i.e., not remaining at clinical caseness for both anxiety and depression. The findings suggest that religious affiliation may serve as a mental health protective factor to aid service users' treatment trajectory (Bradshaw et al., 2015; Ward et al., 2014). Religion can help individuals with a sense of purpose, cultivate positive emotions, provide additional coping mechanisms and have supportive social networks that align with their beliefs and values (Freire et al., 2019; Jonas & Jonas, 2019; Koenig et al., 2020). Being Black, Asian or from a Mixed background suggests that one's religious affiliation and beliefs may play a part in their engagement in treatment (Murwasuminar et al., 2023; Nurasikin et al., 2013).

The findings for the referral pathways highlight that they act as a predictor in treatment outcomes for anxiety and depression clinical caseness (however, this was non-significant for all three of the change scores linear mixed model), which partly supported hypothesis 3. The type of referral route could reflect differences in engagement and motivation for the treatment, as well as the severity of the mental health conditions at the

time of referral. Service users who were referred to the IAPT service by their GP showed a higher likelihood of better recovery outcomes than those referred by 'other' referral routes. When comparing GP and self-referral routes, this difference was significant only for anxiety. Seeking support from a GP can be beneficial, especially for individuals who may lack the knowledge and familiarity of what the IAPT service is or generally about mental health (Brown, 2018). Thus, the GP can be a useful navigation tool to get access to retrieve appropriate help. Also, GP-referred individuals may receive additional clinical support before going to seek IAPT psychological support, which may be useful in reducing individuals' clinical caseness outcomes. In comparison, service users referred by 'other' routes such as through the criminal justice system, community service or from being inpatient-users in compulsory detention (Department of Health, 2005) are more likely to have severe/complex mental health issues in which this study showed difficulty in reaching recovery (i.e., remaining at clinical caseness more challenging) compared to the other referral pathways. Individuals who are GP or self-referred may have been more proactive in seeking and wanting support (that aids with an earlier detection of symptoms), so may have been more willing to engage in psychological interventions in order to enhance their functional impairment (Barnett et al., 2019; Dixon et al., 2016; Gajwani et al., 2016). Therefore, it is suggested that service users entering IAPT through 'other' routes may require additional support to address specific challenges to help them through the treatment process to reach recovery.

The results of this study revealed some discrepancies in the significance between change scores and clinical caseness analyses. The change scores assess the improvement of symptoms on a continuous scale. The changes may be small increments, but they produce meaningful data for shifts in symptom severity. Oppositely, clinical caseness is based on

individuals meeting a specific threshold; thus, nuanced data may be overlooked. This study's discrepancy in the significance of change scores and clinical caseness analyses does suggest that there is a unique interplay between referral pathway, religious affiliation and ethnicity. Thus, reinforcing the need for targeted support mechanisms in the IAPT service to address these disparities and to further understand the influence on well-being scores.

Furthermore, the mediation analysis indicated that the effect of ethnicity on functional impairment (WSAS) was partially mediated by depression (PHQ) and anxiety (GAD), which partly supports hypothesis 5. In addition, the mediation explained by depression was 29.3%, in contrast, for anxiety it was 3.7%. The data suggest that targeted interventions that address depression symptoms for CED service users would be useful to improve daily functioning. The findings underscore the complex interplay between ethnicity and psychological factors that further reflect the longstanding historical disparities (Edge, 2013; Holley et al., 2016; Stochl et al., 2022). These factors can exacerbate depression and anxiety symptoms before CED service users enter a health service like the IAPT service, consequently resulting in worse levels of functional impairment, in contrast to white service users. The mediation findings reinforce the idea that mental health symptom severity (anxiety and depression) is a key determinant of worse functional impairment (Aderka et al., 2011; Stochl et al., 2022; McKnight et al., 2016).

### **7.8 Strengths, Limitations, Future Research and Recommendations**

A strength of this study was distinguishing between symptom improvement (change scores) and clinical caseness. Though the change scores showed non-significant differences between ethnic groups when considering the referral pathway and religious affiliation, clinical caseness findings revealed significant effects. The study showed that therapy works equally well for CED and white service users; however, it provides insight that therapy does

not reduce inequalities. The inequalities are present during pre- and post-outcomes, as CED groups had a higher severity of depression and anxiety. In addition, including and analysing religious affiliation is beneficial to extend upon the growing literature on the importance of considering cultural and social influences on mental health outcomes.

Another strength is the inclusion of the mediation analysis that uncovered the indirect role of depression and anxiety in functional impairment. The finding emphasised that depression largely accounts for a significant portion of the relationship between ethnicity and functional impairment. The findings help to suggest the importance of targeted depression interventions to reduce depressive symptomology in CED groups.

A number of additional factors were absent from our analyses, such as whether English was the service users' first language, whether an interpreter was included and whether adaptations were incorporated into the treatment to assess if these factors enhanced or inhibited recovery. The aforementioned variables would have been beneficial to further intersect the contributions towards recovery. Hence, future research should include and investigate these other variables to delve deeper into explaining reasons why some of the data showed a significant difference, whilst other results did not, when observing the ethnic disparity on recovery change scores and clinical caseness.

Another key limitation is the lack of specificity for the variable religious affiliation. Religion was a binary variable where service users stated whether they followed any religious belief or not. Future studies could benefit from understanding how much they practice their religion (rather than belonging to a religious group or not). As well as religious practices such as prayer/meditation or community involvement, to explore its specific impact on recovery outcomes. Knowing further information on an individual's frequency of

their religious practices could aid in predicting or better explaining how their religious affiliation could aid in reducing symptom severity.

Furthermore, this study did not include service users' stigma/cultural attitudes towards mental health and the barriers to accessing support at IAPT services. Therefore, future research may use qualitative methods to further investigate service users lived experiences to get a deeper understanding of what factors are involved.

Lastly, it is important to note that whilst the sample size for this study was large, which ensured sufficient statistical power, the small effect sizes should be treated with caution when referring to it being clinically meaningful.

## **7.9 Conclusion**

In conclusion, the study explored the ethnic health inequalities in recovery outcomes within the IAPT service. Though there was a discrepancy in the change scores and clinical caseness, the data revealed that receiving IAPT psychological treatment was comparable for both CED and white service users. However, CED groups had a higher severity of anxiety, depression and functional impairment symptoms pre- and post-outcomes. Furthermore, the findings emphasise that service users labelled as having 'other' referral routes had poorer recovery rates, whereas GP referrals (particularly for anxiety) showed to aid recovery. Additionally, the role of religious affiliation appeared to be a protective factor for better recovery outcomes. Also, the study's mediation analysis indicated that CED groups experience a poorer functional impairment partly because of higher levels of depression and, to a lesser extent, anxiety. These findings underscore that IAPT policymakers may want to consider greater attention to referral-based barriers that may impact equitable recovery. Similarly, the importance of embedding religious aspects into therapy, as this study

provided insight, that it may be a protective barrier to help ensure a continual drive in equitable psychological treatment is being provided.

### **7.10 Chapter Summary**

This study utilised anonymised secondary data from IAPT services to examine ethnic disparities in mental health recovery, for anxiety, depression, and functional impairment. The study specifically explored the roles of ethnicity (CED and white service users), referral pathways and religious affiliation in influencing recovery outcomes. The findings revealed no significant differences in change scores for anxiety, depression, or functional impairment were observed between CED and white service users (though CED did have elevated pre- and post-scores). The determinants of the referral pathway type or religious affiliation when observing the change scores for GAD, PHQ, and WSAS showed a non-significant effect, indicating that both CED and white service users experienced similar levels of symptom improvement. Although when the same determinants were observed for the GAD and PHQ clinical caseness, the data were statistically significant when the regression analyses were conducted. This suggests that, although CED individuals improve at a comparable rate to white individuals for anxiety, depression and functional impairment, CED groups tend to present with more severe symptoms at the start of treatment, which are still persistent at the end of treatment. The significant clinical caseness findings indicate that CED individuals may be less likely to reach a subclinical level of symptoms post-treatment, highlighting potential disparities in achieving full recovery despite equal relative improvement. Though mixed findings occurred when adding in the determinants of the referral pathway and religious affiliation between ethnicity groups, there remains a consensus that CED service users have higher levels of pre- and post-scores across all three outcomes. Furthermore, the parallel mediation analysis revealed that higher depression and, to a lesser extent, anxiety

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were associated with increased functional impairment for CED service users. Therefore, continued efforts are needed to address the health inequalities within the IAPT services to ensure equitable and culturally appropriate systems are in place to aid CED service users with their recovery trajectory.

## **Chapter 8. Overall Discussion**

### **8.1 Chapter Overview**

The overall discussion chapter encapsulates the key findings from all five studies reported in this thesis. The aim of the overall discussion is to gather a holistic understanding by synthesising the findings and offering discussion points from each study. The comprehensive overview outlines the key insights and their implications for future research (Thompson Coon et al., 2019). Also, the integrated discussion provides a coherent understanding of the factors contributing towards the health inequality gap for recovery amongst IAPT service users. The mixed-methods research questions were as follows:

1) How do clinicians perceive diversity, representation, and cultural competency in the IAPT service, and what strategies do they suggest to improve recovery outcomes for CED groups? (Study One)

2) What are the experiences and satisfaction of CED individuals with receiving treatment in the IAPT service? (Study Two).

Additionally, the quantitative research questions were as follows:

1) How do cultural and psychological factors of autonomy contribute to mental health disparities between CED and white service users who have been treated for 3-12 months? (Study Three).

2) How do religious affiliation and referral pathway type impact mental health outcomes between CED and white individuals in the IAPT service? (Study Four)

Overall, the research highlights the interconnected nature of accessibility, treatment experiences, cultural competency, and personal agency in shaping mental health outcomes

for CED individuals. Similarly, the research also highlights the importance of recognising a sense of identity that includes cultural, religious affiliation and ethnic diversity in mental health services.

This chapter focuses on conceptualising the studies as well as discussing the novel contributions. The novel contributions will consider aspects such as clinical practice and policy, education and research that embed the main findings of the research on the recovery challenges amongst CED service users in the IAPT service.

## **8.2 The Findings Conceptualised**

Across the studies, such as clinicians' experiences (study one), CED service users' accounts (study two), autonomy and wellbeing outcomes (study three), and ethnicity with other determinants impacting recovery (study four), this thesis has revealed the multi-layered influence of clinical knowledge, therapeutic conditions, identity/culture and structural conditions (such as; accessibility, awareness of IAPT services, stigma and representation within the service). The findings show an interlocking influence across systems, individuals (their background and knowledge), psychological and service levels that are working simultaneously.

From studies one and two, the findings created a narrative that when clinicians felt unconfident making adaptations and having a lack of cultural awareness, this had implications for service users. Being ethnically matched can be advantageous; however, it was important for clinicians to be culturally knowledgeable so that service users could feel more understood and represented in the IAPT service. Thus, cultural competency is a system-wide responsibility that needs to be governed. Allowing all IAPT staff to have the time to get involved in culturally competent activities and discussions to develop their CPD,

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without feeling burned out, in order for them to feel knowledgeable and increase their confidence. Increasing IAPT health professionals' confidence can enhance the therapeutic alliance in the sessions to contribute towards service users having better recovery outcomes. And although study two did not measure psychological outcomes, as the service users were currently using the IAPT service, the study provided insight into service users being satisfied when they felt understood by their clinician (including when being ethnically matched or not) due to the clinician having cultural awareness, trust, and building a rapport. Furthermore, study two underlines how GP referrals were the most likely referral pathway amongst the participants in that study. Participants emphasised that community outreach is necessary for people to be aware of who and how to access the IAPT service, as study four showed that individuals referred by 'other' means (besides GP or self-referral) had worse psychological outcomes. Thus, it shows the salience of understanding how a referral pathway can inhibit recovery outcomes, as access inequality could be driving worse outcomes rather than treatment ineffectiveness. Furthermore, researchers and clinicians could consider making religion a focal part of the assessment process as well as incorporating it into the psychological sessions. Including religion in the assessment and treatment may aid recovery outcomes, as study four found that being religious can act as a protective factor.

In addition, the thesis (study three) identified how autonomy, namely SA and CNS, were useful predictors of recovery outcomes, which were particularly stronger for CED service users. The results revealed that there is a need for future research to understand the influence of ethnicity intersecting with autonomy (especially SA and CNS) processors that can mediate engagement, improvement and symptom reduction. This thesis has been able to identify the potential of autonomy as a useful indicator in recovery that could allow

clinicians to assess individuals' autonomy as part of their assessment to create a clearer understanding of their autonomy that could aid in the treatment process.

Study four provided mixed findings showing that the IAPT service is effective at treating both CED and white service users for anxiety, depression and functional impairment. However, when observing clinical caseness scores for anxiety and depression, it was revealed that CED service users' symptom severity was higher pre- and post-treatment. Thus, displays a difficulty in CED groups reaching a sub-clinical level post-treatment, suggesting disparities are still evident. Throughout studies one to four, a coherent narrative shows that there is not one single point to explain the ethnic disparities, but rather a combination of autonomous, structural and service level processes contributing to the disparity.

The thesis has synthesised that disparities are likely produced before the individual starts psychological therapy, which are then reinforced when receiving evidence-based therapy, and are reflected in the outcomes. When interpreting the findings through an intersectionality lens (Crenshaw, 1988; 1990; 2013a), again, it highlights how service users' experiences are not shaped through a single factor. Instead, there is an interlocking of individuals' identity (background and experiences – study two, autonomy – study three, and religious beliefs – study four) and wider structural systems (representation and cultural competency – study one, and referral pathways – study four). The theoretical lens of intersectionality helps to understand the nuanced challenges that can make it difficult to reduce the findings to one explanatory influence due to individuals' experiences being multifaceted and overlapping (hence intersectionality). Intersectionality theory postulates why solutions simply cannot be singly targeted at one layer of the system, such as only focusing on the referral pathway, when improvements in cultural competency training and

representation in the service are also required. The intersectionality approach allows for a concentrated multilayer perspective of the individual and broader social structures that should be tackled in conjunction in order to maintain the effectiveness of the IAPT treatment and reduce treatment severity for CED service users. In summary, the combination of the studies shows a relevant insight into recovery and the nuances involved. There is a particular focus on cultural competency and versatility in practice, a supportive environment for staff that will filter down to their clients, identity/culture awareness, the importance of religious beliefs and informed referral pathways to help reduce disparities in the IAPT service.

### **8.3 Novel Contributions**

This thesis makes several novel contributions to the field of mental health practice, policy and research. There is a particular understanding towards the intersection of ethnicity (being from a CED group or white), religious affiliation, and referral pathways in shaping mental health recovery outcomes within the IAPT service. A mixed methods approach was utilised to gather a comprehensive understanding of factors influencing recovery.

#### **8.3.1 Terminology Transition**

Terminology was a salient element towards this thesis. The researcher's positionality (See, Chapter 1), paired with the clinician interviews (See, Chapter 4) and the supplementary study (See, Chapter 10.1), helped strengthen the change from using the term BAME (Aspinall, 2020) to CED when referring to Black, Asian and Mixed/Dual-Heritage individuals. The term BAME can undermine the systemic experiences of individual ethnicity groups (Milner & Jumbe, 2020). Participants involved in the supplementary study chose which of the six terms they preferred to be referred to. Participants denoted that the terms that

contained the adjectives 'minority', 'marginalised' and 'minoritised' were not favourable.

Participants viewed these terms as harmful, degrading and less than in society.

This chapter highlights that one does not need to be seen as being 'politically neutral' (Boakye, 2019). Instead, there should be a focus on adopting appropriate language to suit the needs of the participants involved in the research, as well as shifting the language in other fields such as education, health, policy, research and clinical (Aspinall, 2021; Bosworth et al., 2023; GOV.UK, 2020; Williams, 2021). Transitioning the language used can maximise the voices of Black, Asian and Mixed/Dual-Heritage individuals (Islam et al., 2021). Thus, it was important for this thesis to ensure that CED groups' voices were actively being listened to, especially as this whole thesis is focused on Black, Asian and Mixed/Dual-Heritage individuals.

### **8.3.2 Challenging Assumptions Of CED Groups Recovery**

Vast literature consistently shows that CED groups are less likely to recover in the IAPT service (Baker, 2020; Moller et al., 2019). Research has typically attributed stigma, cultural differences, systemic and systematic barriers as factors contributing to the ineffectiveness of psychological interventions or CED groups being less likely to recover in mental health services (Alang et al., 2020; Grey et al., 2013; Hackett et al., 2020). However, an element within the findings from study four challenged the recovery assumption. Study four found no significant differences in pre-/post-treatment (change scores) between CED and white individuals. The findings demonstrate that both groups recovered at a comparable rate for symptom reduction across the three well-being outcomes. The findings show that the IAPT service is effective at providing evidence-based treatment to reduce symptom severity regardless of one's ethnicity. Though study four results did underline that

CED individuals do have higher severity symptomology at the start and end of treatment, in contrast to white individuals. Therefore, additional support could still be embedded to reduce CED groups' symptom severity, especially as study four showed the mediation of anxiety and depression with functional impairment (Flory & Yehuda, 2015). Thus, reducing CED groups' symptom severity could allow them to have better daily functioning when they have finished treatment in the IAPT service (McKnight et al., 2016).

### **8.3.3 Innovated Interviews In Real-Time**

The thesis provided a novel aspect by conducting interviews with service users while they were actively receiving psychological treatment (See, Study Two). Typically, qualitative research in this field has relied on retrospective accounts from participants (i.e., service users interviewed after completing their treatment) (Axinn et al., 2020; Van den Bergh, & Walentynowicz, 2016). A limitation with retrospective accounts is recall bias (Colombo et al., 2020). Whilst beneficial to get insights from participants, recalling past events/situations can result in individuals forgetting to recollect aspects of their experiences (Axinn et al., 2020; Compton & Lopez, 2014). Therefore, in study two, interviews were conducted in real-time for service users to reflect on immediate experiences of their treatment trajectory.

Surprisingly, the majority of participants in study two were satisfied with how their sessions were going. In contrast, there is a consensus in previous research amongst CED groups receiving psychological support that tends to be a negative experience or not being satisfied with the treatment (Arundell et al., 2024; Alam et al., 2024). Arundell et al. (2024) explained that the participants in their study had challenges with treatment access, engaging in the therapy and what treatment was available. Similarly, other research pertains to the negative experiences of stigma, systematic and systemic barriers that CED individuals experience (Memon et al., 2016). The systematic and systemic barriers could

explain why study four (See, Chapter 7) results showed a higher symptom severity across CED groups. Nevertheless, study four findings outline that the IAPT model offers tangible resources that are advantageous for CED groups to access and receive valuable support that they are satisfied with.

#### **8.3.4 Attention Towards Autonomy In The Recovery Process**

Another novel insight from this thesis is the role of autonomy in the recovery process. Study three findings revealed that both sub-scales, SA and CNS, were associated with lowering anxiety, depression and functional impairment scores regardless of one's ethnicity. Furthermore, SA showed stronger effects on reducing both anxiety and depression, particularly for CED groups. The findings underline that autonomy may serve as a protective barrier against mental health challenges.

The findings suggest that incorporating an assessment of an individual's autonomy could be beneficial to gather more information, such as an individual's level of independency (SA), resilience (CNS) and empathy (SO) (Bekker & Belt, 2006; Maas et al., 2019a). Gathering autonomy-related information could then inform the researcher/clinician on the type and how a particular psychological intervention may need to be adapted and tailored. By having the information on autonomy could aid in reducing symptom severity and ensure that recovery benchmarks are being met (NCCMH, 2018).

#### **8.3.5 Novel Contribution Summary**

This thesis firstly contributes to the field by suggesting alternative terminology that should be used when referring to Black, Asian and Dual/Mixed Heritage individuals to empower their voices in research and practice (See, Chapter 1,4 and 10.1). Specifically, pertaining to the IAPT service, throughout this thesis, novel contributions have been added.

Study four challenges the effectiveness of the IAPT service for CED groups. Study four distinguishes between symptom improvement and clinical caseness scores, which challenges pre-existing research when explaining treatment efficacy and recovery (See, Chapter 7). Furthermore, it emphasises the importance of autonomy in recovery (See, Chapter 6). Additionally, the thesis incorporated real-time interviews with current IAPT service users to get an insight into their IAPT experiences (See, Chapter 5). Similarly, interviews with clinicians and the implications of cultural competency training gaps and burnout (See, Chapter 4). In summary, the thesis highlights the need for research to have a multidisciplinary approach to encapsulate the vast factors to explain recovery, whilst offering improvements for policymakers within the IAPT service.

#### **8.4 Importance of a Multidisciplinary Approach And Contributing To The Field**

The focus now turns to the benefits of the thesis having a multidisciplinary approach. Section 8.3.1 outlines the methodological approach, whilst Section 8.3.2 makes references to the wider fields.

##### **8.4.1 Multidisciplinary Methodological Approach**

Conducting multidisciplinary methodological research by employing interviews, questionnaires and secondary data allowed the researcher to get a holistic understanding to evaluate and contextualise the impact of the IAPT service and why previous research (Baker, 2020; Moller et al., 2019) has shown a disparity in the recovery of CED groups. The qualitative methods of the one-to-one interviews with clinicians (See, Chapter 4) and with service users (See, Chapter 5) allowed the research to explore the subjective experiences from these two contrasting groups (delivered treatment vs received treatment). Participants from both studies were able to draw on themes relating to culture/diversity, stigma and

accessibility. The themes drawn from the participants' experience were able to provide an insight into how the IAPT service operates from both perspectives (clinician and service user) that allows the researcher to go deeper than just the empirical metrics of recovery (Kahlke et al., 2024; Watson et al., 2023).

The quantitative approach of primary and secondary data was useful to examine anxiety, depression and functional impairment outcomes between ethnicity groups, but also to explore what other factors could be influencing the mental health outcomes. The primary data incorporated the element of autonomy (See, Chapter 6). Primary data allowed for flexibility, for the researcher to define and include new variables in their research rather than being bound and restricted by pre-existing datasets (Banerjee, 2019). Being able to have full control over the design of the study was salient, as instead of only focusing on one's ethnicity, study three explored autonomy that is influenced by an individual's cultural background, which enabled an understanding of what factors could further help increase recovery. Additionally, the thesis comprised two large secondary datasets (See, Chapter 7). The large sample size allowed for complex analysis to be conducted where pre- and post-scores as well as clinical caseness outcomes were assessed whilst embedding other determinants such as the type of referral pathway and religious affiliation (Smith et al., 2011).

### ***8.4.2 Multidisciplinary Fields And Perspectives***

This thesis draws on several different fields, such as psychology, healthcare and social care, sociology and public health to evaluate the IAPT service. At its core is psychology, where the thesis examines mental health recovery outcomes according to pre- and post-treatment scores alongside clinical caseness. The data provided a robust evaluation of how the IAPT service is effective at reducing symptom severity to aid recovery.

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

In addition, the research included clinician and service users' experiences delivering or receiving evidence-based psychological interventions. The findings contribute to the importance of patient-centred care and satisfaction (Balharith et al., 2024; Wang et al., 2023), burnout (Owen et al., 2021), accessibility (Brown, 2018; Harwood et al., 2021) and cultural competency (Gone, 2015; Kirmayer, 2012) within the mental health sector.

Moreover, these findings are linked to health and social care. For instance, a sub-theme from study one, clinicians expressed the high caseload demands, pressure to reach the recovery benchmarks and burnout, which are factors directly related to service quality (Delgadillo et al., 2018; Morse et al., 2012). Also, participants denoted that cultural competency training needed to be improved to increase their understanding of making adaptations and feeling confident to support all service users within the IAPT service. Thus, it would be beneficial for IAPT service providers to increase staff recruitment and develop content that includes a variety of intersectional identities to aid when completing cultural competency training.

Another area the research considers is the sociological perspective. The thesis emphasises that broader cultural and social factors can contribute towards mental health recovery. In study four, autonomy was assessed and showed that SA and CNS reduced symptom severity across all three well-being indices. Similarly, study five included religious affiliation, which acted as a protective barrier for recovery. Religious affiliation is considered an element of an individual's cultural background and how they may navigate and handle mental health challenges (Acevedo et al., 2022; Malinakova et al., 2020). Lastly, studies two and three conveyed that diversity, representation, and culture are important aspects that should be considered in therapy. This thesis adds to the growing sociological discourse on

systemic inequalities and the challenges that can arise in mental health (McAllister et al., 2018; Mezzina et al., 2022).

Public health is another field that this research encapsulates. Studies two and three discussed the importance of accessibility to ensure CED groups, in particular, know how and where they can seek psychological support. Additionally, study five included the variable referral pathways. The data showed that individuals referred by 'other routes' were less likely to recover compared to GP and self-referral routes. Individuals who were GP-referred showed significant improvement in recovery for anxiety, though non-significant effects were shown for depression. There are policy implications suggesting that outreach programs need to be enhanced to ensure that the IAPT service awareness is publicly promoted. Creating awareness can aid with early detection, thus reducing symptom severity (Corrigan et al., 2014; Stochl et al., 2022)

Overall, this thesis provided a more nuanced perspective to evaluate the IAPT service for CED groups. The thesis incorporated more than a single-discipline perspective, which has allowed for a comprehensive evaluation of the IAPT service and recovery rates. The combination of cultural, structural and social influences that can impact recovery and treatment experiences was salient to capture in the thesis. Additionally, the information gathered throughout this thesis has real-world application that can inform clinical practice, policy, education and future research to support CED individuals within mental health services and more specifically the IAPT service (*See*, section 8.6 for further information).

### **8.5 Wider Strengths, Challenges and Future Considerations**

The strengths, limitations and future research/considerations have been outlined in each relevant chapter. Thus, to avoid repetition, the researcher addresses additional points, as well as emphasising a holistic discussion pertaining to the overall thesis.

Firstly, this thesis conceptually explored autonomy-connectedness rather than empirically using autonomy as a measurement. Using autonomy as a theoretical concept provides a valuable catalyst for future empirical research. Future studies could examine how the dimensions of the Autonomy-Connectedness Scale (ACS-30), i.e., SA, SO and CNS, manifest empirically across different cultural groups (independence and interdependence). By testing the sub-scales of autonomy, future research could clarify the cultural contingency of the psychological components. Furthermore, this would aid in understanding how autonomy operates within diverse cultural settings that could inform the development of culturally sensitive assessments and how to effectively implement psychological support for individuals within health settings like the IAPT service.

Another significant avenue for future research is the intersecting factor of religious affiliation influencing psychological treatment outcomes. While this thesis included whether individuals labelled themselves as belonging to a religious background or not, a specific measure of religiosity was not used. This current research showed mixed results regarding the change scores and religious affiliation, which was non-significant, whereas clinical caseness scores suggested religious affiliation could be a protective barrier. Future studies could use these insights as a foundation to embed religiosity measurements to explore the effectiveness of being religious on psychological outcomes. Also, to investigate to what extent religious awareness is embedded in staff cultural competency training. Having culturally competent IAPT staff could further enhance the therapeutic rapport, assessment accuracy, and inclusivity if particular intersecting variables such as religiosity are understood within the service. Thus, it could contribute towards developing more equitable and culturally responsive mental health care.

In addition to intersecting variables, it is important to note that this thesis did not incorporate service users' English proficiency, particularly in relation to the secondary data study (See, Study Four). Although due to data availability, it was not possible to collect data on English proficiency. The absence of English proficiency in the study offers an important area for future research to consider. English proficiency as an intersectional factor could be instrumental in understanding the role of language in shaping the effectiveness of psychological treatment. Previous research has found that when English is not an individual's first language, they can face difficulties articulating their experiences to their therapist when they undergo psychological therapy (Bauer et al., 2010; Memon et al., 2016; Mohammadifirouzeh et al., 2023). Furthermore, challenges can arise when translating culturally specific terms, especially when some words might not have a clear translation in the service user's native language. Thus, impacting service users' ability to accurately converse and complete the anxiety and depression questionnaires (Cork et al., 2019; Raghavan et al., 2022). Even with the use of an interpreter, the triadic dynamic can make it difficult to build a rapport and for the therapist to comprehend the patients' wants and needs (Mofrad & Webster, 2012). While this research lacked sufficient data to analyse English proficiency as a variable, the researcher suggests that future research could use this as a springboard to explore how cultural background and linguistic factors intersect to influence assessment accuracy, engagement and recovery outcomes. The additional intersecting factors could contribute to developing more suitable psychological care and to understanding further nuances in recovery rates in the pre-existing literature (Miteva et al., 2022).

### *8.5.1 Methodological Considerations*

Mental health services and, in this instance, the IAPT service, due to its clinical nature, the service tend to possess a positivist stance (Chilisa & Kawulich, 2012; Ryan, 2018). Within the clinical setting, the IAPT service relies on empirical data such as the clinical caseness scores to measure improvements or declines in an individual's mental health (Kroenke et al., 200; Mundt et al., 2002; Spitzer et al., 2006). The data-driven outcomes provide the IAPT service with an indication if they are achieving their 50% recovery benchmark, which helps provide suggestions on the effectiveness of the interventions (NCCMH, 2018). Conversely, having a reductionist approach by only focusing on the empirical evidence does not allow for the consideration of the individual's perspectives within the social context (See studies one and two). Therefore, a critical realism stance was undertaken in this thesis to address the limitations of a positivist epistemology (Bryman, 2016; Fryer, 2020).

Previous research has highlighted that CED individuals have worse recovery rates compared to white service users (Amati et al., 2023; Moller et al., 2019). This thesis extended on this by quantitatively exploring clinical outcomes combined with the effects of autonomy (See, Study Three), and determinants such as religious affiliation and referral pathway (See, Study Four). Also, qualitative factors contributing towards the recovery disparity. In particular, the qualitative findings allowed for a richer insight into aspects such as representation, session dynamics, IAPT knowledge (See, Study Two), diversity, cultural competency, representation and accessibility (See, Study One). Embedding a qualitative approach provided a rich insight into the complexities contributing to the recovery. Intentionally allowing for an exploratory narrative (from both clinicians' and service users) for a holistic understanding, as well as the complexities of what factors can be suggested to

contribute towards the recovery disparity. Thus, a mixed method was an advantageous methodological approach to aid with suggestions for clinical practice and future research.

## **8.6 Clinical Considerations**

Considerations and implications across all study findings are denoted below, especially with reference to clinical practice and policy, education and research relating to the IAPT service.

### **8.6.1 Clinical Practice and Policy**

**8.6.1.1 Workforce Representation and Diversity:** It is important to continuously foster staff diversity without it feeling ‘tokenistic’. Two participants in study two stated they ‘felt like a diversity hire’ due to them being the only Black person. Having representation and diversity helps staff feel a sense of belonging that enables them to feel valued in the workplace (Clarke, 2024; Shaikh & Haider, 2024). Also, having diverse staff members helps service users feel represented in the service (Vukic et al., 2016). Even if they are not assigned or request to be ethnically matched, the presence or the ‘visibility’ (See, Study Two) of diversity helps with accessing and allows them to feel welcomed (Simms, 2013). Study two also explains that diversity within the IAPT service can help CED service users feel ‘at home’ and ‘accepted’ to help increase treatment trajectory in the service. Therefore, policymakers should ensure that diversity is reflected in the recruitment process and in managerial positions.

**8.6.1.2 Reducing Systemic Inequities:** It is important to note that whilst promoting diversity and having representation is beneficial, it is crucial not to automatically assign CED clinicians with subsequently larger caseloads of service users from a CED background. Participants in study two explained that it is a ‘danger’ to increase diversity but

only make CED work with CED service users, thus calling for a 'commitment to diversity' to be required within the IAPT service. Some participants explained that they are not confident in cultural competency and delivering psychological adaptations (See, Study One). Although, it would be unjust, especially when service users have not specifically requested, they want to be ethnically matched, to assign caseloads in that manner (purely based on one's ethnic background). IAPT policies must reinforce regular training so that it is everyone's responsibility to support any CED service user. Further supporting, in study two, CED service users spoke about not being ethnically matched, which was not an issue as their clinician were culturally competent. Evidence from both chapters in this thesis highlights that it should be all clinicians' responsibility to be given and accept caseloads pertaining to CED service users and being confident in using their cultural competency skills and making adaptations where needed.

**8.6.1.3 Awareness and Outreach:** To help bridge the recovery gap, policymakers should increase funding and resources for community-based outreach programs by expanding and creating awareness of what the IAPT service is, particularly within highly populated CED areas, to communicate about mental health and the support they offer. In particular, through community outreach and trusted sources like faith-based groups and GPs, they can disseminate information and encourage early intervention. Early intervention, i.e., less likely to have elevated levels of anxiety and depression, can lead to better functional impairment (as seen in Study three), thus reducing symptomology severity upon entering the IAPT service, which can aid with recovery (Islam et al., 2015; Stochl et al., 2022). The findings in study four showed that GP referrals were more effective in supporting recovery for anxiety compared to other types of referral sources, which were linked to poorer outcomes, similarly, aligning with previous research (Harwood et al., 2021). Hence,

policies may need to be put in place that emphasise early intervention and additional support for individuals who are referred by alternative routes, such as secondary or community services, due to study five findings showing higher symptom severity.

Furthermore, the thesis findings suggest that strengthening referral care pathways can allow for equitable access to mental health services, which is important to put into practice to reduce structural and systemic inequalities.

Supporting the salience of GP referrals in study two, there were eight out of twelve participants who stated they were GP-referred to the IAPT service. Participants emphasised that a GP was a reliable resource from whom they could gather information on what the IAPT service was, accessing and the treatment they could receive. Although in study one, some participants in this study suggested that GPs have a lack of knowledge when it comes to understanding what the IAPT service provides and can almost be seen as 'being gatekeepers.' Thus, study one findings suggest that policies and IAPT best practices should ensure that GPs are knowledgeable about the IAPT service and aid individuals in engaging in the service, which can help bridge the gap in the referral process to help recovery. Especially as studies two and three underlined the importance of GPs being a useful resource to aid in reducing symptom severity, leading to better chances of recovery.

Additionally, using faith-based groups may be of interest within policies and practice to aid with the recovery, as evident in study five, religious affiliation was associated with better well-being outcomes. To have a trustworthy faith leader who can conceptualise the individual's mental health experiences and align the psychological treatment offered by the IAPT service can help with the individual's engagement and trajectory (Jonas & Jonas, 2019; Levin, 2016). Moreover, ensuring policymakers collaborate with faith-based groups as religion can be a protective barrier for recovery (Koenig et al., 2012; Nguyen, 2020). Thus,

incorporating religion into therapy, especially for individuals who state they have a religious affiliation, can be advantageous for their well-being outcomes.

## **8.6.2 Clinical Education**

**8.6.2.1 Crucial Cultural Competency Training:** It is essential to enhance the cultural competency training amongst IAPT health practitioners. Evidence from study one of the thesis demonstrated that the majority of service users did not feel that the training was up to the 'right standard', whereby participants felt that the training was 'short,' 'surface learning' and a 'tick box exercise'. Health professionals who have limited culturally competent knowledge lack confidence in making cultural adaptations to suit their clients' needs and are inadequately supporting them, which can lead to drop-outs, disengagement and poorer treatment outcomes (Schwartz et al., 2022). Being able to provide appropriate training to upskill, boost clinicians' skillset and provide them with worldwide views is salient in order to aid the therapeutic process to help their clients (Caldwell & Galiardi, 2014). For instance, participants in study two revealed that the cultural competency training should include teaching 'nuances,' 'shadowing opportunity, or role play'. Evidence in nursing and counselling research emphasises how shadowing can be beneficial for the learner to pick up new techniques and practices of real-life situations that often can be complex or unique in order to learn how to adapt to different cases (Salinda et al., 2024; Zhai & Prescod, 2024). Additionally, it is noted in study two that health professionals who are culturally competent (the example in study two was a CED service user and a white clinician) are sufficient in providing supportive treatment for CED. Participants highlighted that their therapist was 'very accommodating' and talked about their 'race and identity'. Although the service users were sceptical due to the contrasting ethnic backgrounds, due to the clinician being culturally competent, it enhanced the therapeutic alliance as they were able to build a

rapport and a safe environment to discuss identity, culture and their experiences without fear of being judged or not understood (Naz et al., 2019; Galán et al., 2023). Hence, the findings from study three emphasise that it is critical to address topics such as racism directly to foster an inclusive therapeutic environment (Drustrup, 2020). Naidoo et al's (2024) research underlines that white clinicians need to ensure they actively engage in conversations about race, ethnicity and culture to build trust and open communication. Thus, to improve clinical effectiveness and improve the recovery process for CED groups, the IAPT service must ensure that comprehensive cultural competency training is provided to all clinicians.

### **8.6.3 Clinical Research**

**8.6.3.1 Drop-outs:** Future research should consider individuals who dropped out.

This thesis did not include participants who dropped out or did not engage with the IAPT intervention due to wanting individuals with both pre- and post-scores to calculate their recovery (See, Study Four). Experiences of the challenges to access and/or engagement remained underexplored by not considering those who have dropped out. Thus, interviewing individuals who have dropped out could provide a useful exploration into structural and systemic issues, accessibility and whether a lack of culturally competent care has deterred them from dropping out. Also, quantitatively assessing dropout rates could provide trends on which specific ethnicity groups this is more likely to happen to, so that provisions are put in place to support them through their IAPT trajectory.

**8.6.3.2 Cultural Research:** Future research should expand upon this thesis, in particular towards the cross-cultural element. Exploring autonomy, i.e., the ACS-30 (Bekker & Belt, 2006), would be beneficial to investigate further. The findings in study three

highlight that SA and CNS were linked to improved outcomes for anxiety, depression and functional impairment. Specifically, SA was a useful indicator in lowering both anxiety and depression amongst CED groups, suggesting its potential as a predictive factor for mental health outcomes. Providing a deeper insight into how autonomy and connectedness function across different cultural groups should be considered further in future research, in particular during the assessment and formulation stage, whereby researchers incorporate an individual's cultural background to aid with aligning effective and tailored interventions to support recovery outcomes (Edwards & Young, 2013). In addition to this, future researchers should also consider bi-cultural identities (Benet-Martínez et al., 2021; West et al., 2017), which are indicative and relevant to the CED service users within the UK IAPT service. For example, an individual of a Black Caribbean heritage who is UK-born may integrate values and beliefs about mental health from both cultures, leading to unique perspectives on treatment and recovery compared to the westernised standard (Bhui et al., 2002; Karasz et al., 2019; Walsh & Cross, 2013). This highlights the importance of conducting in-depth assessments using quantitative and qualitative methods to understand the specific individual needs. A 'one size suits all' approach can be detrimental towards one's recovery (Bennett et al., 2007) as it fails to consider cultural nuances in mental health perception and treatment approaches (Ma-Kellams, 2014; Mooney et al., 2016; Williams et al., 2015). Hence, future research should emphasise the importance of cultural identity and the interaction of multiple cultures intertwining, particularly in the context of the UK. Carrying out research that embeds these concepts would support mental health services to develop more effective and inclusive evidence-based psychological treatment to help address the diverse groups of CED individuals in the UK.

## **Chapter 9 Conclusion**

The current thesis examined the challenges and disparities experienced by individuals from CED backgrounds in relation to the UK's IAPT service. There were four studies that were integrated to explore the challenges that CED groups experience, along with the mental health inequality issues resulting in recovery differences. This thesis has been beneficial in emphasising and adding on to previous research on the importance of increasing diversity and representation within mental health services. As well as increasing accessibility, tailoring/making adaptations for CED groups and how crucial it is for health professions to be culturally competent (studies one and two). Moreover, there was evidence that showed that higher levels of depression and, to a lesser extent, anxiety correlated with increased functional impairment among CED individuals (study four). Hence, reinforcing the salience of understanding and addressing health inequalities within IAPT services to support CED service users effectively.

Interestingly, this study has provided a novel contribution by firstly including autonomy (more specifically, the importance of SA and CNS) to explain mental health disparities across ethnicity groups (study three). The connection between an individual's agency, which is influenced by their cultural and social background, showed that better well-being outcomes can be achieved when these factors are considered. Additionally, these findings tied in with other determinants influencing recovery outcomes (study four). The determinants included religious affiliation, which served as a protective factor in aiding recovery. Similarly, GP referrals positively impacted anxiety recovery, whereas 'other' referral routes were associated with poorer outcomes.

Overall, the thesis highlighted the importance of recognising the multilayered factors that hinder mental health recovery for CED groups. This thesis was geared particularly

towards the IAPT service, in order to aid suggestions on helping CED groups reach the 50% recovery benchmark (NCCMH, 2018). Though the findings in study four did expose that CED service users were reliably improving at a similar extent to white service users. There was an emphasis on a higher amount of CED groups remaining at clinical caseness (not recovered) and higher severity of pre- and post-symptoms compared to white service users. Thus, the thesis underscored that a 'one size suits all' approach (Bennett et al., 2007) is insufficient within the IAPT service as shown throughout the mixed methods of this thesis, due to complexities and barriers that CED groups are more likely to experience (Alang et al., 2020; Grey et al., 2013; Nazroo et al., 2020). Based on the thesis findings, future research, as well as IAPT policymakers, need to continue addressing systemic barriers and to consider increasing representation and concrete cultural competency examples in training for health professionals that include the importance of religious values. Furthermore, to consider the importance of GP referrals to help with accessibility and detecting symptoms earlier to support CED groups' trajectory in the IAPT service to aid recovery. Lastly, a collaborative approach is required between policymakers, clinicians, community groups and researchers to make positive and meaningful changes to close the health inequality gap to make equitable mental health for all within the IAPT service.

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## Appendices

### Appendices Study Two – Clinicians IAPT Experience


#### 4.a Study Poster

## Clinicians Wanted For An Online Interview On Their Experiences In The IAPT Service


### Study Information

A study exploring **clinicians experiences** of working and delivering psychological therapy to service-users in the **Improving Access to Psychological Therapies (IAPT)** service.

QR Code: Scan Me!



[https://blss.eu.qualtrics.com/jfe/form/SV\\_d4osO5pckfiUh\\_hQ](https://blss.eu.qualtrics.com/jfe/form/SV_d4osO5pckfiUh_hQ)



### What does the study involve?

Filling out a **5 min online questionnaire** then participating in a **one-to-one interview** or a **focus group** via Microsoft Teams or Zoom for **60-120 minutes**.

### Eligibility Criteria

- **Currently** working in the **IAPT** service, **minimum of 6 months**
- Working as either a **Clinician/Therapist/Psychological Wellbeing Practitioner**
- Delivered either or both **low** and/or **high intensity treatment**
- Able to speak and understand English to converse in the interview

### Interested in Participating?

Scan the **QR code** or use the **link** to fill out the questionnaire and to arrange the interview.  
If you have further questions please e-mail:  
**Paige.Clarke-Jeffers@mail.bcu.ac.uk**


**Ethical Approval Granted by Birmingham City University**

## 4.b Study Poster

### Black, Asian, Minority Ethnic (BAME) Clinicians Wanted For An Online Interview On Their Experiences In The IAPT Service

#### Study Information

A study exploring **BAME clinicians experiences** of working and delivering psychological therapy to service-users in the **Improving Access to Psychological Therapies (IAPT)** service.




#### Eligibility Criteria

- Identify as **BAME**
- **Currently** working in the **IAPT** service, **minimum of 6 months**
- Working as either a **Clinician/Therapist/Psychological Wellbeing Practitioner**
- Delivered either or both **low** and/or **high intensity treatment**
- Able to speak English

**Ethical Approval Granted by  
Birmingham City University**

**QR Code: Scan Me!**



[https://blss.eu.gu.altrics.com/jfe/room/SV\\_d4osO5pc\\_kfiUhhQ](https://blss.eu.gu.altrics.com/jfe/room/SV_d4osO5pc_kfiUhhQ)

#### What does the study involve?

Filling out a **5 min** online **questionnaire** then participating in a **one-to-one interview** via Microsoft Teams or Zoom for **60-75 minutes**.

#### Interested in Participating?

Scan the **QR code** or use the **link** to fill out the questionnaire and to arrange the interview.  
If you have further questions please e-mail:  
**Paige.Clarke-Jeffers@mail.bcu.ac.uk**

## **4.c Interview Schedule**

### **A Study Exploring the Experiences of Clinicians Working and Delivering Therapy in the Improving Access to Psychological Therapies (IAPT) Service**

#### **One-to-one Interview Guide**

### **Pre- Interview Checklist**

- Ensure that participants are sent a calendar invitation with an MS Teams link
- Check that Screen Cast-O-Matic is set up correctly and it ready to record.
- Ensure participant has read the participant information sheet and has signed the consent form before the interview begins.

### **Interviewer Introduction and Purpose of Study**

#### **START RECORDING**

Hello, my name is Paige Clarke-Jeffers and I am the lead researcher conducting the interview today. So, I would like to firstly double check that you have read the participant information sheet and you are happy to consent to take part in this study?

I would like to start by thanking you for taking time to participate today. The aim of the interview is to gather your experiences working and delivering treatment to service users in the Improving Access to Psychological Therapy (IAPT) Service. On average, this study should take around 60-75 minutes to complete.

I also would like to remind you that this interview will be recorded. Your identity will remain confidential and the data we collect will be used anonymously. I would like to remind you that you can stop the interview at any time without giving me reasons why you want to stop.

**Are there any questions before we get started?**

### **Interview Schedule**

#### **Section 1: Psychosocial Factors and Identity**

- 1) What drew you to work in the IAPT service?
- 2) What do you think are the characteristics/hallmarks of a good clinical therapist?
- 3) Given two equally experienced therapists, how does one become an expert whereas the other remains mediocre?
- 4) How do you know when you are doing a good job with a client?
- 5) Do you feel that you have a sense of belonging working in the IAPT service?
  - a) How/why not?
- 6) Do you feel like the workforce represents your identity?
- 7) Do you feel like the service users you deliver treatment to represent your identity?

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

- 8) Do you use the term BAME? (new question)
- 9) What is your preference towards the term BAME?
  - a) Do you like or not like it?

### Section 2: Delivering Treatment - Diversity and Inclusion

- 1) How do you establish a therapeutic rapport with your clients?
- 2) Do you take different approaches in how you build a rapport if your client is from a different ethnic/cultural background from yourself? How so?
- 3) Do you find it easier or harder making a bond with clients who are from a different ethnic/cultural background as yourself?
  - a) How can you overcome this?
- 4) If they say yes: Please could you rate this from 1 to 10. 1 being extremely hard and 10 being easy/confident... if it has ever been difficult to discuss issues around ethnicity/ culture with clients? Please explain why?
  - a) If no: what makes this process easy for you to do this?
- 5) Do you feel that the use of your language in therapy is inclusive? E.g., Making sure you use the right terminology when addressing your clients?
  - a) Do you feel like this could be improved in any way?
- 6) Do you feel like you have the knowledge to deliver treatment to any service users regardless of their ethnic, cultural background?
- 7) Have you noticed any similarities or differences between ethnic minority groups and white service users when they deal with mental health? E.g.: participation/engagement, accessing the service etc.
- 8) Do you feel like there are any differences in whether ethnic minorities and white service users receive high or low intensity treatment?
- 9) Do you feel like there any differences in the number of sessions offered to ethnic minorities and white service users?
- 10) Do you feel like there any differences in the types of psychological therapy offered to ethnic minorities and white service users?
- 11) Can you think of anything that may hinder progression ethnic groups and white service users? E.g. interacting with the session, drop-outs, cultural challenges etc.
- 12) Do you ever set homework for your clients?

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

- a) (if answered yes to question 16) Have you noticed any differences between clients who can and cannot complete work? Any particular factors e.g., minority ethnic groups, technology deprivation?
- b) (if answered no to question 16) Any reasons you don't set homework?

### Section 3: Cultural Competency

- 1) Please could you rate from 1 to 10. 1 being extremely not useful to 10 being extremely useful, how important do you think it is for all clinicians to be aware of e.g.: ethnicity, cultural values while providing therapy? Please explain why?
- 2) In the demographic form you stated that you have/have not received cultural competency training in the IAPT service. → (if yes) how useful was that training?  
(if no) Why do you think you have not received the training?
  - a) (if no) Does the IAPT service you work at deliver cultural competency training?
  - b) (if no to question Do you think the IAPT service you work in will work towards implementing cultural competency interventions? Why/why not?
  - a) (yes, only ask if they have done the training) What would you say are the main things you have learnt from cultural competency training?
  - b) (yes, only ask if they have done the training) How confident do you feel that you are able to implement what was learnt in training into practice? – could take out (only ask if ppts don't answer in previous questions)
- 3) How regularly would you say cultural competency training is implemented in your IAPT service? e.g.: Was the cultural training a one off or do you receive continuous training/updating?
- 4) Do you think cultural competency training needs to be imbedded within IAPT service?
- 5) Are there any barriers in providing therapy to BAME groups?
- 6) Do you think psychological therapy needs adapting for BAME groups?
- 7) Do you deliver culturally adapted therapies?  
What tools do you include such as changing the terminology, inc values e.g. prays
  - c) (if yes to question 9) what has your experience been like delivering cultural adapted therapy?
  - d) (if yes to question 9) Have you found any parts/concepts of delivering cultural adaptations challenging? – Anything specific?

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

- e) (If answered no to question 9) How confident would you feel in delivering cultural adapted for example CBT in the future? - Why/why not?
- f) (if no to question 9) What do you think some of the challenges might be?

### Section 4: Quality of the Service

- 1) How accessible do you think the IAPT service is for service users, in particular for ethnic minorities?
- 2) How do you think the IAPT service can reach out to individuals from BAME communities?
- 3) How can the IAPT service help with the retention of BAME service users?
- 4) Added if they mention burnout → do you feel like burnout has any impact on delivering treatment to service users? What ways has/would burnout impact you? Does burnout stop you for doing things you would want to do eg: learning cultural competency training etc.
- 5) What ways do you think clinicians or policyholders in IAPT can help close the recovery gap between ethnic minorities/white service users?
  - a) Anything specific?, If so, what would this look like?

### Section 5: Closing up

- 1) Do you feel supported in the IAPT service? Why/Why not
- 2) You stated in the demographic questionnaire that you are currently ? working in the IAPT service – what are your reasons for this?
- 3) Are there any gaps in your knowledge or areas of improvements that you could learn that would be beneficial to help your client?
- 4) Do you have anything to add (positive and/or negative) that could improve the IAPT service from a clinician's point of view?
- 5) Is there anything that we have not covered today that you would like to mention?

### Ending of the Interview

Thank you for taking time to participate in the interview today about your experience working and delivering psychological treatment in the IAPT service.

I would like to remind you that participation is voluntary, in line with the regulations outlined by the British Psychological Society. You can stop being a part of the study at any time without explanation. If you wish to withdraw after this interview, please e-mail myself (my details are on the debrief form which I will send you), you have 10 working days from today's interview which will be the on ??/??/????

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

After sending you the debrief form I will be deleting all e-mail conversations as well as the MS links so that I will no longer have your contact details.

Are there any questions before I stop the recording?

Thank you for taking part, I will now end the recording?

### **Post- Interview Checklist**

- Stop and SAVE the focus group recording on Screen Cast-O-Matic
- Upload the recording to OneDrive within 24 hours and delete from Screen Cast-O-Matic
- Ensure to send the debrief sheet with participants unique withdrawal data
- Ensure to delete participants e-mail/MS Teams link after I have sent the debrief form

## **4.d Participant Information Sheet**

### ***A Study Exploring the Experiences of Clinicians Working and Delivering Therapy in the Improving Access to Psychological Therapies (IAPT) Service***

#### **STUDY BACKGROUND**

You are being invited to take part in a research study exploring the experiences of clinician's working and providing treatment in the Improving Access to Psychological Therapies (IAPT) to service users. This study has been given approval by Business, Law and Social Science Ethics Committee.

#### **WHAT WILL YOU NEED TO DO?**

In this study, you will be asked to firstly fill out an online demographic questionnaire (e.g., general questions about yourself) then to contact the lead researcher ([Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)) first to arrange the interview data. When the interview has been arranged you will then be taking part in a semi-structured interview that will be one-to-one. You are able to pick which format you would like to be in. The interview will explore your experience working and delivering psychological treatment in the IAPT service such the approaches in providing high/low intensity treatment, the type of psychological therapy offered, the number of sessions offered, different and similarities in delivering treatment to different service users and cultural competency. The semi-structured interviews will be conducted via Microsoft Teams or Zoom and will be recorded via Screencast-O-Matic.

#### **HOW LONG WILL THE STUDY LAST?**

On average, the online questionnaire should take 5 minutes then the online interview should take around 60-75 minutes to complete.

#### **WHAT IS THE INCLUSION CRITERIA?**

- Participants can be clinicians/therapist/Psychological Well-being Practitioner (PWP).
- Currently working in an IAPT service for a minimum of six months
- Can identify as any ethnic group for example white, Black, Asian, mixed or any other ethnic background.
- Deliver either or both low and high intensity psychological treatment in the IAPT service.
- Speak a good level of English

#### **ARE THERE ANY RISKS OF TAKING PART?**

There is a minimal risk of taking part in this study. Due to the nature of the research, you may feel distressed or uncomfortable at times. Anytime throughout the interview you can choose not to answer and skip any questions. You can also stop the interview at any time.

You will be provided with details of mental health support services and helplines at the end of the study, so you are aware of the support available, should you require it.

### **ARE THERE ANY BENEFITS OF TAKING PART?**

Although there are no direct benefits from taking part, it is hoped that through this research will allow a deeper understanding of clinician's experience of working and delivering treatment in the IAPT service.

### **YOUR RIGHT TO WITHDRAW AND WITHHOLD INFORMATION**

Participation in this study is entirely voluntary and there is no obligation to take part. In line with the regulations outlined by the British Psychological Society, you can stop being a part of the study at any time without explanation. You are still entitled to the same benefits as an individual who completes the study.

If after completing the study, you decide you would like to withdraw, please contact the researcher within *10 working days* from taking part in the study. During the study, you also have the right to omit or refuse to answer or respond to any question that is asked of you.

Please contact Paige [Clarke-Jeffers@mail.bcu.ac.uk](mailto:Clarke-Jeffers@mail.bcu.ac.uk) if you require any further information or wish to withdraw. Remember, you will need to provide your pseudonym if you would like to withdraw your data.

Please note, however, (only applies if taking part in the focus group) due to the nature of focus group data it will not be possible to withdraw your individual data from the transcript. However, all necessary steps will be taken to remove individual data from analysis and final project output. You will be asked to provide a pseudonym on the demographic form, which will be used in circumstances where the participant wishes to withdraw from the study.

### **YOUR RIGHT TO CONFIDENTIALITY/ANONYMITY**

The study will not involve the collection of any personal information about you except your age, gender, ethnicity and other demographic information. Any personal information given will be unidentifiable to an external party – Your data will be stored confidentially, using a personalised anonymous pseudonym that you will create (you will be given instructions on how to produce this at the beginning of the study on the demographic sheet).

Your data will be stored on a password-protected laptop, on a password-protected University OneDrive folder, which will only be accessible to those within the research team. All identifiable features will be removed from the transcripts and audio recordings prior to publication or presentation at conferences.

### **FURTHER GUIDANCE**

If you feel distressed as a result of taking part in this study you can ring the Samaritans who offer 24-hour emotional support for individuals experiencing distress. They can be called on **116 123** or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org).

Also, you can search for mental health services in your local area on the NHS site by providing your post code using the link below:

<https://www.nhs.uk/service-search/other-services/Mental-health-information-and-support/LocationSearch/330>

**WHO IS ORGANISING THE RESEARCH?**

The study is part of the researchers PhD project.

Department of Psychology  
School of Social Sciences  
Birmingham City University  
The Curzon Building  
4 Cardigan Street  
Birmingham B4 7BD

The primary research team are Paige Clarke-Jeffers, Dr Athfah Akhtar, Dr Panos Rentzelas, and Dr Silvio Aldrovandi.

**Lead Researcher:** Paige Clarke-Jeffers PhD Psychology Student (Lead Researcher)

**Contact:** [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

If you are unhappy at any point in the study, or if there is a problem, please contact the Business, Law & Social Sciences faculty ethics committee directly.

#### **4.e Consent Form**

##### ***A Study Exploring the Experiences of Clinicians Working and Delivering Therapy in the Improving Access to Psychological Therapies (IAPT)***

#### **BRIEF SUMMARY OF PROJECT**

You are being invited to take part in a research study exploring clinicians experiences of working in the IAPT service as well as clinicians' experiences delivering psychological therapy to service users in the IAPT service. This study has been given approval by Birmingham City University Ethics Committee.

**In order to participate in this study, we need to ensure that you understand the nature of the research, as outlined on the Participant Information page.**

**Please tick the boxes to indicate that you understand and agree to the following conditions.**

- I confirm that I have read the participant information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that in order to take part in this study, I should be at least 18 years old.
- I understand that I will need to complete a demographic form (before participating in the interview). The demographic form will contain personal data about yourself that will be collected for the purposes of the research study including gender, ethnicity, and age, and that these will be processed in accordance with the information sheet.
- I understand that I need to be able to read and speak English in order to converse in the interview.
- I understand that I must be currently working with a minimum of six months in an IAPT service in England.
- I understand that I can be a Clinician/Therapist/Psychological Well-being Practitioner working in the IAPT service to participate in this study.
- I understand that I need to have delivered either or both low/high intensity psychological treatment.
- I understand that I need to complete the online demographic questionnaire then e-mail the lead researcher first to arrange an interview data.

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

- I understand that I can pick to be in a one-to-one interview or be in a focus group which can be stated when e-mailing the lead researcher when arranging the interview data.
- I understand that my participation is voluntary and that I am free to withdraw up to 10 working days after the focus group without giving any reason, without my legal rights being affected.
- I understand that my data is anonymous and will be stored on secure university servers.
- I understand that the audio from this interview will be recorded via Screen-Cast-O-Matic and transcribed.
- I understand that the researcher's screen will be recording the discussion via Screen-Cast-O-Matic and I have the option to have my camera turned off during the focus group discussion if I wish to.
- I understand that the study findings (including anonymised data extracts) from this project will be presented at academic conferences and research articles, published in peer reviewed journals.
- I agree to take part in this study

**Participant Name (Pseudonym) :** Click or tap here to enter text.

**Date:** Click or tap here to enter text.

## **4.f Demographic Questionnaire**

*A Study Exploring the Experiences of Clinicians working and delivering therapy in the  
Improving Access to Psychological Therapies (IAPT) Service*

*Participant Study Information (located here when participants open Qualtrics)*

*Consent form (located here when participants go to the next page after reading the participant study information).*

<b>Section 1: Participant Identification</b>
<p><b>Please provide a Pseudonym</b> (a fictitious name used to conceal your real name, e.g., Samantha or Sammy), which can be used to identify your data if you wish to withdraw from the study within 10 working days after you have completed the interview.</p> <p><i>Click or tap here to enter text.</i></p> <p><i>Please keep a note of the name you have provided.</i></p>
<b>Section 2: Participant Information</b> (please tick the box that most applies)
<p><b>1. What is your gender identity?</b></p> <ul style="list-style-type: none"><li>• Female</li><li>• Male</li><li>• Prefer not to say</li><li>• Non-binary</li><li>• Prefer to self-describe: _____</li></ul>
<p><b>2. What is your sexual orientation?</b></p> <ul style="list-style-type: none"><li>• Bisexual</li><li>• Gay Woman/Lesbian</li><li>• Gay Man</li><li>• Heterosexual/Straight</li><li>• Prefer not to say</li><li>• Prefer to self-describe: _____</li></ul>
<p><b>3. What is your age?</b></p> <ul style="list-style-type: none"><li>• Please state: _____</li></ul>

4. **What is your Ethnic Group?** *(Choose one option that best describes your ethnic group or background)*

- **Asian/Asian British** *Click here to choose an item.*

*If you have selected 'Other' (please describe) Click or tap here to enter text.*

- **Black/ African/ Caribbean/ Black British** *Click here to choose an item*

*If you have selected 'Other' (please describe) Click or tap here to enter text.*

- **Mixed/ Multiple Ethic Group** *Click here to choose an item*

*If you have selected 'Other' (please describe) Click or tap here to enter text*

- **White** *Click here to choose an item*

*If you have selected 'Other' (please describe) Click or tap here to enter text*

- **Other Ethnic Group**

*Other (please describe) Click or tap here to enter text*

- **Prefer not to say**

5. **What is your religious background?**

- *Christian (Catholic protestant or any other Christian denominations)*
- *Buddhist*
- *Hindu*
- *Muslim*
- *Jewish*
- *Sikh*
- *Agnosticism (uncertain of a religion)*
- *Atheist (No Religion)*
- *Other please, state: \_\_\_\_\_*

**Section 3: IAPT Service** *(please tick the box that most applies)*

6. **What is your current role in the IAPT service?**

- *Clinician/Therapist*
- *Psychological Well-being Practitioner*

<p><b>7. How long have you been working in mental health?</b></p> <ul style="list-style-type: none"><li>• <i>Please, state: _____</i></li></ul>
<p><b>8. How long have you currently been working in the IAPT service?</b></p> <p><i>Please, state: _____</i></p>
<p><b>9. What type of intensity psychological treatment have you delivered in the IAPT service?</b></p> <ul style="list-style-type: none"><li>• <i>Low Intensity Treatment</i></li><li>• <i>High Intensity Treatment</i></li><li>• <i>Both levels of Intensity Treatment</i></li></ul>
<p><b>10. What type of psychological treatment have you delivered? Can choose multiple answers:</b></p> <ul style="list-style-type: none"><li>• <i>Computerised Cognitive Behaviour Therapy</i></li><li>• <i>Cognitive Behaviour Therapy</i></li><li>• <i>Behavioural Activation</i></li><li>• <i>Psycho-Educational Groups</i></li><li>• <i>Counselling for Depression</i></li><li>• <i>Mindfulness-based Cognitive Therapy</i></li><li>• <i>Brief Psychodynamic Therapy</i></li><li>• <i>Interpersonal Psychotherapy</i></li><li>• <i>Couple Therapy</i></li><li>• <i>Any other, please state what this was (write below)</i></li><li>• _____</li></ul>
<p><b>11. What type of delivery style have you provided in the IAPT service? Can choose multiple answers:</b></p> <ul style="list-style-type: none"><li>• <i>Individual, face-to-face</i></li><li>• <i>Telephone</i></li><li>• <i>Computer</i></li><li>• <i>Group, Online</i></li><li>• <i>Group, face-to-face</i></li><li>• <i>Any other, please state what this was (write below)</i></li><li>• _____</li></ul>

<p><b>12. What is your outcode of your postcode of the IAPT service you work out? Max 3 digits/letters</b> e.g.: B8 = Washwood Heath, Ward End, Saltley, WR9 = Droitwich, Ombersley, Wychbold, Rushock, CV1 = Coventry, B80 = Redditch etc</p> <p>Please, state: _____ (will only allow participants to write a total of 3 numbers/letters to know their area code, this will prevent participants writing their full post code to ensure confidentiality).</p>
<p><b>13. How confident would you feel delivering cultural adapted/sensitive psychological therapy?</b></p> <ul style="list-style-type: none"><li>• <i>Very Confident</i></li><li>• <i>Confident</i></li><li>• <i>Unsure</i></li><li>• <i>Unconfident</i></li><li>• <i>Very Unconfident</i></li><li>• <i>I already deliver this</i></li></ul>
<p><b>14. Have you received cultural competence training whilst in the IAPT service?</b></p> <ul style="list-style-type: none"><li>• <i>Yes</i></li><li>• <i>No</i></li><li>• <i>Not sure</i></li></ul>
<p><b>15. Do you feel that you and other clinicians would benefit from regular (e.g., every year/few years) cultural competence training in the IAPT service?</b></p> <ul style="list-style-type: none"><li>• <i>Yes</i></li><li>• <i>No</i></li><li>• <i>Not sure</i></li></ul>
<p><b>16. Do you feel like there are any differences in delivering treatment to BAME and non-BAME service users?</b></p> <ul style="list-style-type: none"><li>• <i>Yes</i></li><li>• <i>No</i></li><li>• <i>Some differences</i></li><li>• <i>Not sure</i></li></ul>
<p><b>17. Do you ever find it difficult delivering psychological treatment to service users who are a different ethnic, cultural, sexual, religious background from yourself?</b></p> <ul style="list-style-type: none"><li>• <i>Yes</i></li><li>• <i>No</i></li><li>• <i>Sometimes</i></li><li>• <i>Not sure</i></li></ul>
<p><b>18. How would you rate your performance as a Therapist/Clinician/Psychological Well-being Practitioner?</b></p> <ul style="list-style-type: none"><li>• <i>Excellent</i></li></ul>

- *Very Good*
- *Good*
- *Satisfactory*
- *Poor*

**19. How would you currently rate your experience working in the IAPT service?**

- *Very Satisfied*
- *Satisfied*
- *Neither Satisfied nor Dissatisfied*
- *Dissatisfied*
- *Very Dissatisfied*

**Section 4: Interview Set-up**

**20. Do you understand that you need to contact the researcher first to set up your interview time and date?** (*When e-mailing please state a few different times and dates from **Monday-Sunday between 9am-7pm** along with your **pseudonym name***)

- **Yes** *Click here to choose an item*
- **No** *Click here to choose an item* (if participants click 'no' then Qualtrics will go to another page stating: "Please e-mail the lead researcher: [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk) and state your pseudonym name along with your availability to arrange an interview data. You will need to be the first one to contact the researcher as the researcher has **not obtained** your e-mail address to arrange the interview. Thank you").

Then participants can go to the next page to finish the study.

Researcher's e-mail address: [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

**Section 5: Study Completion**

*Thank you for spending the time to complete the demographic form.*

*Please do not forget that you have to e-mail the researcher (Paige) to arrange the interview.*

*If you do have any questions in the meantime please contact the lead researcher Paige Clarke-Jeffers [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)*

*In the meantime feel free to e-mail the researcher if you have any questions about the study ([Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)) or if you are need to seek any emotional support you can contact the Samaritans on 116 123 or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org)*

## **4.g Debrief Sheet**

### ***A Study Exploring the Experiences of Clinicians Working and Delivering Therapy in the Improving Access to Psychological Therapies (IAPT) Service***

#### **SUMMARY OF PROJECT**

The aim of the research was to explore clinicians' perspectives of what it is like working and delivering psychological treatment in the IAPT service to BAME and non-BAME service users. The researcher wanted to understand if there were different approaches in how clinicians assess and deliver treatment.

In addition, the researcher wanted to know clinicians' thoughts on how the IAPT service could be improve the recovery gap between to BAME and non-BAME service users. Also, an insight into what clinicians thought about cultural competency training and how much this is imbedded during practice.

#### **FURTHER GUIDANCE**

If you feel distressed as a result of taking part in this study you can ring the Samaritans who offer 24-hour emotional support for individuals experiencing distress. They can be called on **116 123** or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org).

Also, you can search for mental health services in your local area on the NHS site by providing your post code using the link below:

<https://www.nhs.uk/service-search/other-services/Mental-health-information-and-support/LocationSearch/330>

#### **YOUR RIGHT TO WITHDRAW AND WITHHOLD INFORMATION**

Participation in this study is entirely voluntary and there is no obligation to take part. In line with the regulations outlined by the British Psychological Society, you can stop being a part of the study at any time without explanation. You are still entitled to the same benefits as an individual who completes the study.

If after completing the study, you decide you would like to withdraw, please e-mail the researcher (myself- Paige) and simply state 'Withdraw from study' along with the pseudonym that you created. You can withdraw up to 10 working days after you have completed the interview. Your unique withdrawal data is at the bottom of this page.

#### **WHO IS ORGANISING THE RESEARCH?**

Department of Psychology  
School of Social Sciences  
Birmingham City University  
The Curzon Building  
4 Cardigan Street  
Birmingham B4 7BD

The primary research team are Paige Clarke-Jeffers, Dr Athfah Akhtar, Dr Panos Rentzelas, and Dr Silvio Aldrovandi.

Paige Clarke-Jeffers PhD Psychology student (Lead Researcher)

[Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

**KEEPING IN TOUCH**

The findings from the study will be submitted as part of a PhD thesis and written up for publication. The following study may also be used to present at conferences and other journals.

Once the study has been completed in February 2024 you can request a copy of the findings by e-mailing the lead researcher using the contact details below.

**ANY MORE QUESTIONS?**

We hope that you enjoyed participating in this study. If you have any further questions, please feel free to contact the researchers at the address below.

Paige Clarke-Jeffers PhD Psychology student (Lead Researcher)

[Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

If you are unhappy at any point in the study, or if there is a problem, please contact the Business, Law and Social Science Ethics Committee directly at [blssethics@bcu.ac.uk](mailto:blssethics@bcu.ac.uk)

**Withdrawal date: ??? (unique for each participant)**

## 4.h Interview Script Extract Example

45 **Interviewer**  
 46 Thank you for explaining that. So what do you think the characteristics or hallmarks are of a good  
 47 clinical therapist?  
 48  
 49 **Aleya**  
 50 So I do, I do think experience plays an important part, it doesn't necessarily mean that you have to have  
 51 experienced IAPT yourself or mental health issues. But I do think that you need to be familiar with the  
 52 symptoms and the nuances of mental health because it isn't very linear. It's not as to quote textbook.  
 53 So for you to just go to school and learn psychology, and then think that you can apply that in real life,  
 54 you will be shocked because it is nothing of the sort. So I think one of the main characteristics is that  
 55 familiarity of the topic and of psychology, I think, being open minded, because there is going to be a lot  
 56 of examples where you're not gonna be able to fit your client into an intervention, or you're not going to  
 57 be able to demonstrate all the stages of an intervention for a client because it just doesn't work or it  
 58 needs adapting. And I also think, because of everything that's been going on within the last sort of few  
 59 years with COVID, with Black Lives Matter with the dam war on the Ukraine. I think that there's an  
 60 element of erm I want to be like multicultural and like cultural sensitivity, like, unfortunately, it's  
 61 something that is very much advocated by people of colour, but we actually need more white people to  
 62 step up and actually learn and read and even if you don't necessarily live in somebody's shoes, you  
 63 need to understand where they're coming from. So a part of IAPT no matter where you are in the UK is  
 64 that you don't know what client you getting and you don't know their background. But what you can do  
 65 is be open minded to the prospect of learning something new. And even if it is just being culturally  
 66 sensitive by not being racist, for example, or like [not] displaying microaggressions, for example, and  
 67 just knowing what you can and can't say, is a step in the right direction. And also, I do think empathy,  
 68 empathy is probably one of the most important as well, I think, sometimes we forget. And we think that  
 69 sympathy is, I guess, the same characteristic, and I don't believe that it is. Empathy is a really hard trait  
 70 to kind of explain or demonstrate. But I do think it's an important characteristic for the job.

76 **Aleya**  
 77 Maybe time, I think, when you're more exposed to the job, and you're practiced in that field for an  
 78 extended period of time, I think that does add to expertise. I think an uncomfortable, comfortableness in  
 79 uncomfotableness, if that makes sense. So maybe not necessarily knowing what's going to happen. But  
 80 being comfortable sitting in that unknown. I think somebody who is a mediocre practitioner wouldn't feel  
 81 comfortable with that and may be stressed out a lot more and might kind of run the risk of burnout, and  
 82 then maybe just be put off the job all together. Whereas I think somebody who's more experienced  
 83 might understand that there's going to be like peaks and troughs, there's going to be difficult times, but  
 84 it's just about sitting in that uncomfotableness. And I do think that independent learning is probably a  
 85 big factor as well. I do think you need to kind of do your own research and reading, because then you  
 86 can be more flexible in your day to day job. And I think maybe just tailoring your interventions and your  
 87 delivery of treatment to each practitioner each each patient sorry. Because if you're trying to generalise  
 88 and treat them all the same, then you are you aren't going to be an expert, I think you're gonna run the

89 risk of therapeutic resistance because the patient's just not going to, I guess, warrant what you're  
 90 saying.  
 91

PC Paige Clarke-Jeffers ...

Clinicians needing to be educated and experienced to pick up mental health.

@mention or reply

---

PC Paige Clarke-Jeffers ...

Negative social situation can bring a light the changes that need to be made. Advocating that white HP are aware of different ethnicities and cultures so they can understand ppts beliefs and values to bring this into practice. 08 July 2022, 11:12

@mention or reply

---

PC Paige Clarke-Jeffers ...

Open-minded, learning, culture sensitive, training

@mention or reply

---

PC Paige Clarke-Jeffers ...

Empathy

@mention or reply

@mention or reply

PC Paige Clarke-Jeffers ...

Independent, knowledge, gaining skills to become better.

@mention or reply

---

PC Paige Clarke-Jeffers ...

Cultural awareness, tailoring interventions, increase risk of resistance that could decrease recovery especially amongst ethnic groups.

@mention or reply

# Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

138 it's kind of like, I would say, I wouldn't don't feel necessarily part of the service that I belong to. And I  
 139 think in IAPT as a whole. So the actual programme itself erm yeah, kind of, yeah, sort of (laughs).  
 140  
 141 **Interviewer**  
 142 Okay, thank you. Do you feel like the workforce represents your identity?  
 143  
 144 **Aleya**  
 145 No.  
 146  
 147 **Interviewer**  
 148 Could you explain that, please?  
 149  
 150 **Aleya**  
 151 And I guess that's probably one of the reasons why I also joined, IAPT is because of the lack of  
 152 representation being a mixed race person. I advocate a lot in my spare time for people of colour. And I  
 153 do that by taking my own experience and making it into my passion, which is obviously the job that I'm  
 154 in. And what I notice is there is a lot more white, middle class women that are in the role of IAPT. And  
 155 unfortunately, in the Black community, specifically, there is a preference to speak to people that are of  
 156 the same ethnicity or the same background as you because there's a lot of cultural stereotypes that  
 157 people who are not from your background may apply when they are treating you. And there's a lot of  
 158 stigma. So I would say that the workforce as a whole is not racially representative of the UK, specifically  
 159 [says city name], because that's where I'm based, in terms of, I guess, they are trying. So there's a lot  
 160 of like, you know, if English is not your first language, there's a lot of people that are employed that  
 161 might speak multiple languages, so that that kind of bridges the gap with sort of any language problems  
 162 or barriers or anything like that. But again, I just don't think that it's as equal representation. And I think  
 163 when you look higher up the the chain of command, there is no one who looks like anybody [me] in the  
 164 workforce. Yeah, don't think there's any people have colour really that I can think of, maybe like one or  
 165 two but the fact that I'm trying to think (laughs) so it's easy they don't reflect it. So no, I wouldn't. I'd say

PC Paige Clarke-Jeffers ...   
 Representation matters, lack of diversity

PC Paige Clarke-Jeffers ...   
 Stereotypes, preference towards having some  
 from the same ethnic group.  
 Representation, diversity.

PC Paige Clarke-Jeffers ...   
 Stigma, mis or pre conceptions when treating  
 SU's from a different background  
 Lack of representation

PC Paige Clarke-Jeffers ...   
 Translators / other HP that speak multi language  
 can help SU's.

178 nave, because it was part of their, I guess, mental health difficulties, but in terms of like say somebody  
 179 is expressing their anxieties and things like that they would never sort of, say, I mixed race or this is my  
 180 background or anything. So I guess it's difficult with maybe in telephone based, maybe that would  
 181 change if I was face to face. But I guess in the service that I work in, and the demographic of [says city  
 182 name] that we cover is predominantly white.  
 183  
 184 **Interviewer**  
 185 Okay, and so you mentioned that people, people of colour are less likely to use the service. Do you  
 186 have any reasons why you think that is the case?  
 187  
 188 **Aleya**  
 189 I had loads of reasons why. One of the main reasons why is because the framework of the NHS is very  
 190 Eurocentric, so it's very much fit for white people. An example of that is obviously, if a Black man was  
 191 struggling with his mental health, they would, somebody would call the police and get them  
 192 institutionalised rather than that, signposting them to a mental health service for support. So, but if it  
 193 was a white man, irrespective of their background, they probably would get that signposting of mental  
 194 health services first, in terms of my specific service that I work for, I don't think they do enough to  
 195 promote that we are inclusive and that we can support people of colour, I think. They love to do BAME,  
 196 which I'm not a fan of the word, but they love to group, everybody that is brown together, and then tick a  
 197 box to say, 'Yay, everybody, well, we're inclusive'. And that's just not the case. It doesn't cover all the,  
 198 like intersectionalities of a person. So. And I also believe that mental health treatment for people of  
 199 colour is very different to people who are white, just from a cultural background, just from a religious  
 200 background. There's certain things that, you know, people of colour will instil in their upbringing that  
 201 then affects their mental health that a white person won't necessarily be able to understand. So I think,  
 202 you know, they should probably do some research in how to kind of deliver CBT that's a bit more  
 203 multicultural, to be honest. But no, I don't I don't think they do a lot.  
 204  
 205 **Interviewer**  
 206 Thank you. So we're gonna move on to Section two, there's five sections. Section two is delivering

PC Paige Clarke-Jeffers ...   
 Large uptake of white SU using iapt.

PC Paige Clarke-Jeffers ...   
 Westernised the iapt framework  
 Importance of tailoring interventions

PC Paige Clarke-Jeffers ...   
 Service needing to do more

PC Paige Clarke-Jeffers ...   
 Lack of inclusivity  
 Grouping ind.v's

# Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

235 **Aleya**  
 236 So just somebody who might just be a bit working class and just might, might not be as literate as  
 237 somebody who may have gone to university, for example, then I know that I need to code switch, and I  
 238 need to use terminology that isn't like cognitive restructuring or, you know, behavioural activation, those  
 239 terms, those terms don't mean anything. But in terms of if it's somebody that's from, like, say, a Jewish  
 240 background, or you know, I don't know Farsi background, then yes, I think also, whilst the terms are not  
 241 necessarily changed, the way that I explain the techniques or the interventions might be so for  
 242 example, I might try to include, you know, the practice of religion and going to church or going to the  
 243 mosque as a as a behavioural exercise that I wouldn't necessarily incorporate into somebody who  
 244 didn't, wasn't brought up in that background.

245  
 246 **Interviewer**  
 247 Thank you. So do you find it easier or harder building a bond with a client that's from a different ethnic  
 248 or cultural background from yourself?

249  
 250 **Aleya**  
 251 I think it's easier because erm there's a differ... there's many differences, but there's a shared similarity  
 252 of the fact that we're not the majority. And it takes a level of courage and confidence in order to reach  
 253 out to a mental health service from a person of colours perspective than it is from anybody else. And so  
 254 already, I'm already rooting for the underdog. And I'm like, okay, I'm totally on board as a, what do you  
 255 want me to do? And I think I'm a bit more sensitive to it. And the same still applies, but I just knew that if  
 256 a white person was not necessarily able to get the support from an IAPT service, there's many other  
 257 avenues that they could access, that might not necessarily be the case, from a person of colour.

258  
 259 **Interviewer**  
 260 Okay, so if you could, rate, so one been extremely hard to 10 been extremely easy, confident, has it  
 261 ever been difficult to discuss anything around ethnicity or culture with the client?

262

PC Paige Clarke-Jeffers ...  
 Modifying the intervention to the client  
 @mention or reply

PC Paige Clarke-Jeffers ...  
 Modifying the intervention to the client  
 @mention or reply

PC Paige Clarke-Jeffers ...  
 Easier to building a rapport with ethnic minorities  
 @mention or reply

PC Paige Clarke-Jeffers ...  
 Courage for ethnic clients  
 @mention or reply

546 **Aleya**  
 547 Yeah, there's loads of barriers. I don't think there's, it's specific to ethnicities, but there is barriers. So  
 548 the fact that most people that access therapy from a ethnic racial background may be judged based on  
 549 the colour of their skin, there's systemic racism left, right and center. So they're not necessarily going to  
 550 walk into the NHS and ask for support, when we've had documentaries throughout the pandemic telling  
 551 us that we're not, we're not cared for, and people don't consider us at all in terms of our well being. So  
 552 that, that alone is a reason for them not to access support. But also, you know, predominantly, a lot of  
 553 the workforce don't look like you, if you want to make the preference of speaking to somebody that's  
 554 from your ethnic background, where are you going to get that, especially in you know, in the, in the  
 555 PWP up world, I'm not too sure of the percentages at the moment. But it'd be interesting to see how  
 556 many people of colour are practitioners and where they're based. Erm and how accessible they are?  
 557 Because that is one of the main barriers that I see, you know, if you wanted to gain access to the NHS,  
 558 and you said, 'Actually, can I have a therapist that's Black?' I don't think they're going to bend over  
 559 backwards to make that happen. They'll probably be like, 'Okay, well, the waiting is about is about six  
 560 months. So probably this first come first serve, isn't it?' So that's a barrier in itself.

561  
 562 **Interviewer**  
 563 Okay, and do you think psychological therapy needs adapting for ethnic minority groups?

PC Paige Clarke-Jeffers ...  
 Their thoughts on the difficulty of ethnic minorities accessing the service  
 Racism  
 Systemic  
 Lack of care  
 15 August 2022, 16:11  
 @mention or reply

PC Paige Clarke-Jeffers ...  
 Ethnic matching clients to therapist  
 Long wait times  
 @mention or reply

## 4.i Similar Codes To Be Grouped Into A Meaningful Theme Or Sub-Theme


(lack of) sense of belonging, external, outcast, different, representation, lack of diversity (lack of) sense of belonging, external, outcast, different, representation, lack of diversity	hiring more staff that represent different minorities, by making the knowledge and upscale of people of colours, backgrounds and differences, part of the competency training or part of the curriculum, and part and then therefore embedded in all the services. But as a person of colour, I don't think so. Because, you know, there's a lot of concentration on what you need to do to kind of pass and what is required within the therapy room, but there isn't anything about my own background. So what I mean by that is, if I'm in I'm treating a patient, and that patient has, all withholds racial stereotypes, and they might say it in passing and again, they can't see me so they don't know who I am, they don't know where come from, that's triggering. [...] Now, if I wanted to speak to somebody about my experience, and say, I was triggered by that, like that really upset me, do I feel like there's anybody in my service that would understand and be able to support me? No, and that's not because they're all white, so they don't know. It's because there's no demonstration in the service of cultural competency. There's, who do I go to, to speak to about that my, my automatic thought is, okay, somebody that looks like me, but there isn't any Black or mixed race people in the service. So there's nobody that I can access support to. And again, if I was to speak to somebody who is Asian or Indian, they don't have the same, theirs is like, theirs might be Islamophobia. And that's completely different to somebody making a comment about a Black person. Yes, it's still racist, but it's different. It's a different like thing. So I don't feel supported on that, on that level. I'm just very fortunate that I'm surrounded by people that I can speak to outside of service that understand me
Building a rapport. Supporting clients. Similarities and differences in MH Building a rapport. Supporting clients. Similarities and differences in MH	sometimes people just want to offload and don't necessarily want you to reassure or normalise what they're going through. They just want a space to be heard. So I think if you are sensitive to that, and you respect that, then yeah, you can build a rapport. reminding people that, you know, whilst they're doing the right steps in the right direction for their mental health, there's an element of commitment and responsibility that they too have to present. It isn't just about picking up the phone or attending therapy, or ticking a box, it's actually about doing some of the [home]work as well, which is difficult, but it's about try, just giving it a go and perseverance really.
Burnout / boundary setting Burnout / boundary setting	there's a lot of burnout, and there's a lot of people that drop out I'm seeing a lot of, a lot of dropout. So because there's not many qualified staff, I'm feeling a lot more pressure as a trainee, and I'm not competent enough to even deliver treatment. Erm, if that make sense? Like I'm still learning. And I think I, whilst I am passionate and satisfied in the career that I'm going down and the trajectory of where I want to see myself, erm I feel like the IAPT programme, whilst it maybe started off with good intentions, I don't think it's really understood the magnitude of supply and demand. There is way more demand than there is practitioners.
Burnout / boundary setting Burnout / boundary setting	what I'm finding out is because of case management, so you know, managing the amount of patients that you have in treatment, sometimes I'm noticing that people are signposted away, because physically as a practitioner, you shouldn't have so many people in treatment. And I would argue that that's probably not patient centered a lot of funding, they need more money in the service as a whole Time! [...] And what I mean by that is the training itself feels like a crash course for practitioners. It feels very much like I'm learning my driving license in 10 days
Cultural adaption/tailoring, the term BAME	tailoring your interventions and your delivery of treatment to each practitioner each each patient sorry. Because if you're trying to generalise and treat them all the same, then you are you aren't going to be an expert, I think you're gonna run the risk of therapeutic resistance because the patient's just not going to, I guess, warrant what you're saying.
Cultural adaption/tailoring, the term BAME	the way that I explain the techniques or the interventions might be so for example, I might try to include, you know, the practice of religion and going to church or going to the mosque as a as a behavioural exercise that I wouldn't necessarily incorporate into somebody who didn't, wasn't brought up in that background.
Cultural adaption/tailoring, the term BAME	somebody who might just be a bit working class and just might, might not be as literate as somebody who may have gone to university, for example, then I know that I need to code switch, and I need to use terminology that isn't like cognitive restructuring or, you know, behavioural activation, those terms, those terms don't mean anything
Cultural adaption/tailoring, the term BAME.	And I also believe that mental health treatment for people of colour is very different to people who are white, just from a cultural background, just from a religious background. There's certain things that, you know, people of colour will instil in their upbringing that then affects their mental health that a white person won't necessarily be able to understand. So I think, you know, they should probably do some research in how to kind of deliver CBT that's a bit more multicultural, to be honest
Cultural adaption/tailoring, the term BAME.	. So I do think that there should be more done, like differences in the delivery of interventions. Obviously, I'm not, I'm not saying oh, there should be BA for Black people or BA for Asian people. I'm not saying that. I'm just saying that the generic BA that we get taught, for example, is very universally structured, but it's not cross culturally sensitive. So you have to be mindful of that when you're delivering it.
Cultural/system change to IAPT	do I think 30 minutes is a long enough therapy session? No? Do I think six sessions is long enough? No! Because step two, is no longer mild symptoms of mental health, your seeing and people that have mild to moderate aren't you? Because of the pandemic, that, what I mean by that is, we've change as a culture. So 10 years ago, it might have been mild. But now people are anxious because of what's been going on in society. And a lot of people have never accessed therapy before. So they wouldn't have straight to high intensity, you have to do low intensity work with

culture sensitive/awareness, training, Advocating that white HP are aware of different ethnicities and cultures, learning (self research), promoting inclusivity, not grouping ind.v's, proactive to support clients	having honest conversations with your colleagues about is there anything more that I can do to show that I am an ally? [...] And it's like just unpacking that and being honest, instead of being silent and not doing anything or not saying anything about it. I don't think you're very progressive if you're just silent, I think you need to speak up a bit more.
culture sensitive/awareness, training, Advocating that white HP are aware of different ethnicities and cultures, learning (self research), promoting inclusivity, not grouping ind.v's, proactive to support clients	cultural competency isn't something that we need to tick when we speak to every patient in treatment as like a competency requirement
Difficulties of telephone contacts	a lot of my clients are telephone based. So I don't have that body language, I don't have the response, I can't see that they are taking on board what I'm saying or smiling or laughing at my jokes, I can't see that. So I really have to kind of listen attentively as to what they're saying
reasons for the low uptake, low recovery, difficulties accessing the service, barriers, improving access and recovery	most people that access therapy from an ethnic racial background may be judged based on the colour of their skin, there's systemic racism left, right and center. So they're not necessarily going to walk into the NHS and ask for support, when we've had documentaries throughout the pandemic telling us that we're not, we're not cared for, and people don't consider us at all in terms of our well being. So that, that alone is a reason for them not to access support
reasons for the low uptake, low recovery, difficulties accessing the service, barriers, improving access and recovery	predominantly, a lot of the workforce don't look like you, if you want to make the preference of speaking to somebody that's from your ethnic background, where are you going to get that [...] and how accessible they are? Because that is one of the main barriers that I see, you know, if you wanted to gain access to the NHS, and you said, 'Actually, can I have a therapist that's Black?' I don't think they're going to bend over backwards to make that happen. They'll probably be like, 'Okay, well, the waiting is about is about six months. So probably this first come first serve, isn't it?' So that's a barrier in itself.
reasons for the low uptake, low recovery, difficulties accessing the service, barriers, improving access and recovery	there's been a lot of work in the last 10 years in terms of promoting mental health support. So I wouldn't be ignorant to sit here and say that there's, there's no accessibility because there is, if you Google mental health services, or mental health support, you know, it will pull up NHS recommended services in your local area. But in terms of, for example, like ethnic matched therapists, no. And that's, and that is a barrier to treatment, and also can prevent somebody from accessing it.
reasons for the low uptake, low recovery, difficulties accessing the service, barriers, improving access and recovery	,language for example, I know that in my service, they have dedicated practitioners that might speak Polish, or Farsi or Punjabi, but there isn't anybody that speaks Yoruba, or like, you know, I guess, predominantly, like Congolese Black, African oriented languages, there isn't. And that's because there isn't any Black practitioners in the service, let alone as a practitioner across the UK. And I think that there should be more racially exclusive groups or services, because you probably would get a lot more access to those groups.
reasons for the low uptake, low recovery, difficulties accessing the service, barriers, improving access and recovery	behalf of my experience with working for safe spaces for Black women. That is, specifically for Black women, you cannot join if you're not a Black woman. Now, that doesn't mean that when you come, we're like, 'Are you Black?' No, it's if you identify as a Black woman, then you're accepted. And that's, you know, this is where we hold you, because a lot of the conversation is about the Black experience. So I think that, because I've seen how powerful and empowering that is, I think there should be more groups like that, I think there should be more services that are specifically for that. And then that would hopefully gain a bit more access to those elements of IAPT from those, like people of colour backgrounds
reasons for the low uptake, low recovery, difficulties accessing the service, barriers, improving access and recovery	I could say somewhat cliché and say, you know, there should be more promotion of it. And whether that's on billboards, or you know, on the TV, I think there should be more promotion of and I think there should be more people of colour behind the adverts. Because if I see somebody that looks like me, I'm probably going to be more inclined to access that support.
reasons for the low uptake, low recovery, difficulties accessing the service, barriers, improving access and recovery	asking somebody about their racial identity should be a requirement.
Support from IAPT	In general, yes, I think, you know, you're given a lot of sort of access to supervision, and clinical skills, development. You know, if I struggle with my case, management, I've got a line manager that I can talk to, and they can support me, I've got a mentor that I can go to for any problems. But also, if I come across anything that's extremely risky, or I need to escalate, or I need to debrief, I can ring a duty officer or you know, somebody that is more experienced than me and gain a different perspective, but also access that support. So I would say that in terms of the role itself, there is a lot of support, you know

## Appendices: Study Two – CED Service Users Experiences

### 5.a Study Poster

V4: 13.03.2023



**Are You Currently Using The Improving Access to Psychological Therapies (IAPT) Service?**

Ethical Approval Granted by Birmingham City University and West Midlands-Solihull Research Ethics Committee.


**Do You Identify as being Black, Asian, Or From A Ethnic Minority Group?**

**Receive a £20 Love2Shop Voucher When Completed!!!**

**Participants Wanted For An Interview!**

**Study Information**

A study exploring **Black, Asian, Minority Ethnic (BAME)** groups experiences of the **Improving Access to Psychological Therapies (IAPT)** service.



The aim of the study is to gain an insight into the perspectives of **current IAPT users** who identify as an ethnic minority to understand how they are finding the IAPT service and the treatment offered. The main goal is to help improve inclusivity within the IAPT service.

**What does the study involve?**

Filling out a **10-15 min questionnaire** then participating in a **one-to-one** via Microsoft Teams or Zoom **interview for 60-75 minutes.**


**Eligibility Criteria**

- **18 years** or older
- Speak good English for the interview
- **Currently receiving treatment** in a UK, IAPT service
- Identify as **Black, Asian or Dual-Heritage**
- Have a common mental health disorder e.g. **Depression/Anxiety**

**Interested in Participating?**

Please contact the researcher by e-mail to take part: [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

Paige will then send over the information sheet, consent and demographic form before arranging the interview.



## **5.b Participant Information Sheet**

### **A Study Exploring the Experiences of Black, Asian and Minority Ethnic (BAME) Service users Using The Improving Access to Psychological Therapy (IAPT) Service**

**Please feel free to take a screenshot/picture of this information sheet for your safe keepings.**

#### **NOTICE**

When reading the information of the study, when you see any reference to ‘we’ this means the research team which include researchers from Birmingham City University who are: Paige Clarke-Jeffers, Dr Athfah Akhtar, Dr Panos Rentzelas and Dr Silvio Aldrovandi.

#### **STUDY BACKGROUND**

You are being invited to take part in a research study exploring the experiences of Black, Asian and Minority Ethnic (BAME) service users currently using the Improving Access to Psychological Therapies (IAPT) service. This study has been given approval by Business, Law and Social Science Ethics Committee.

#### **NHS COMMITTEE CONSIDERATION**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and granted a favourable opinion by West Midlands- Solihull Research Ethics Committee.

#### **SUMMARY OF THE PARTICIPANT INFORMATION SHEET**

In this research study we will use information from [you]. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study, we will save some of the data [in case we need to check it] **AND** [for future research]. We will make sure no-one can work out who you are from the reports we write.

The information below tells you more about the study.

#### **WHAT WILL YOU NEED TO DO?**

In this study, you will be asked to fill out a demographic questionnaire (e.g., general questions about yourself) then [you] will e-mail the lead researcher [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk) to arrange the interview date.

It will be a one-to-one interview about your experience in the IAPT service such as the process entering the IAPT service, the quality of the treatment, your therapist at IAPT, positives and barriers experienced at IAPT. The interview will be on Microsoft Teams or Zoom and will be recorded on Screencast-O-Matic.

#### **HOW LONG WILL THE STUDY LAST?**

On average, the questionnaire should take 10-15 minutes then the online interview should take around 60-75 minutes to complete.

### **WHAT IS THE INCLUSION CRITERIA?**

- You must be 18 years old or older.
- Speak good English.
- Identify as Black, Asian, mixed, ethnic minority group.
- You must be currently still receiving treatment within the IAPT service.
- You must have one of the following common mental health disorder(s):
  - Depression
  - Anxiety
  - Generalised Anxiety Disorder (GAD)
  - Panic Disorder
  - Obsessive-Compulsive Disorder (OCD)
  - Post-Traumatic Stress Disorder (PTSD)
  - Social Anxiety Disorder
  - Agoraphobia
  - Specific Phobias (such as heights or small animals)
  - Health Anxiety
  - Body Dysmorphic Disorder Mixed Depression And Anxiety
- You cannot take part if you have a severe mental health condition e.g.: Bipolar disorder, Psychosis and Schizophrenia.

### **ARE THERE ANY RISKS OF TAKING PART?**

There is a minimal risk of taking part in this study. You may feel uncomfortable at times. In the interview you can choose not to answer and skip any questions you feel uncomfortable with. You can also stop the interview at any time.

### **ARE THERE ANY BENEFITS OF TAKING PART?**

You will receive a £20 Love2Shop voucher between 1-3 working days after finishing the 1-2-1 interview with the researcher. This will be sent to the e-mail address that you contacted the researcher with.

Also, it is hoped that this research will help the researcher understand what the experiences of the BAME community using the IAPT service.

### **HOW WILL WE USE INFORMATION ABOUT YOU?**

We will need to use information from [you] for this research project.

This information will include your:

- Gender identity
- Sexual Orientation
- Age
- Ethnicity
- Religion
- Occupation
- The specific IAPT service you use

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

We will use these identifiers to do the research study.

We will keep all information about you safe and secure.

People who do not need to know who you are will not be able to as you will create your own pseudonym (fake name) that we will use to hide your identity.

However, there are certain situation when confidentiality will have to be broken if you mention **risk of harm to yourself or others**. If risk does occur then the researcher will contact [your specific IAPT site/general enquiry e-mail to let them know the situation]. The researcher will pass on your e-mail to the enquiry team, and you may be required to provide the researcher with your full name and contact details if this is what the service requests. Then, the researcher will follow the rules set by the IAPT service.

### **DATA PROTECTION/ CONFIDENTIALITY**

If you have not mentioned any risk of harm to yourself or others then when the interview has finished the researcher will delete e-mail conversations as well as the Microsoft Teams/Zoom link for confidentiality. This means the researcher will no longer have your contact details.

Also, the researcher will be using a software called Audacity which is a voice changing software. The Audacity software will change the pitch of your voice for confidentiality so nobody other the lead researcher (Paige) can identify you.

### **STORING DATA**

Once we have finished the study, we will keep some of the data so we can check the results. The original recording will be deleted as soon as the researcher has transcribed the data. The pitch/voice changing recording will be deleted after one year. The transcribed data will be kept for 10 years.

We will write our reports in a way that no-one can work out that you took part in the study as [you] will create your unique pseudonym (fake name) (this will be on the demographic questionnaire).

Your data will be stored on a password-protected laptop, on a password-protected University OneDrive folder, that only the research team can access. Any identifiable information will be removed from the transcripts before publication or presentations at conferences.

### **WHAT ARE YOUR CHOICES ABOUT HOW YOUR INFORMATION IS USED?**

You can stop being part of the study at any time, without giving a reason, as well as refusing to answer or respond to any questions but we will keep information about you that we already have.

If after completing the study, you decide you would like to withdraw, we would like you to contact us 'within 10 working days' from taking part in the study.

Contact [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk) if you need more information about withdrawing. Make sure to provide your pseudonym (fake name) if you would like to withdraw your data.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

If data will be used for future research: If you agree to take part in this study, you will have the option to take part in future research using your data saved from this study.

### WHERE CAN YOU FIND OUT MORE ABOUT HOW YOUR INFORMATION IS USED?

You can find out more about how we use your information

- by asking one of the research team by e-mail - [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)
- at [www.hra.nhs.uk/information-about-patients/](http://www.hra.nhs.uk/information-about-patients/)

### FURTHER GUIDANCE

If you feel distressed due to taking part in this study there are some services available to help you:

- 'Find a local NHS urgent mental health helpline' – Click the link below, then enter your age and postcode to a local mental health number. This service is 24/7 to get support from a mental health professional.  
<https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline>
- 'NHS, non-emergency number medical helpline' – Call **111**. The service is 24/7 and can help for your symptoms if you're not sure what to do and find general health information and advice.
- Samaritans' - You can call on 116 123 or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org). The Samaritans offer 24-hour emotional support if you are experiencing distress.
- 'Mental health services' – To find NHS mental health sites in your local area using the link below: <https://www.nhs.uk/service-search/other-services/Mental-health-information-and-support/LocationSearch/330>

### WHO IS ORGANISING THE RESEARCH?

Department of Psychology  
School of Social Sciences  
Birmingham City University  
The Curzon Building  
4 Cardigan Street  
Birmingham B4 7BD

The study is part of the researchers PhD project.

**Lead Researcher:** Paige Clarke-Jeffers PhD Psychology Student (Lead Researcher)

**Contact:** [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

The main research team are Paige Clarke-Jeffers, Dr Athfah Akhtar, Dr Panos Rentzelas and Dr Silvio Aldrovandi

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

If you are unhappy at any point in the study, or if there is a problem, please contact the Business, Law & Social Sciences faculty ethics committee directly at [blssethics@bcu.ac.uk](mailto:blssethics@bcu.ac.uk)

### **SPONSOR DATA PROTECTION OFFICER'S DETAILS**

**Sponsors Name:** Professor Maxine Lintern

**Contact:** [Maxine.Lintern@bcu.ac.uk](mailto:Maxine.Lintern@bcu.ac.uk)

Birmingham City University

Westbourne Road

Birmingham

United Kingdom

B15 3TN

Faculty of Health, Education and Life Sciences.

Seacole Building, Edgbaston Campus

## **5.c Consent Form**

### ***A Study Exploring the Experiences of Black, Asian and Minority Ethnic (BAME) Service users Using The Improving Access to Psychological Therapy (IAPT) Service***

#### **BRIEF SUMMARY OF PROJECT**

You are being invited to take part in a research study exploring the experiences of BAME service users in the IAPT service. This study has been given approval by Birmingham City University Ethics Committee.

Please take a screenshot on your consent form for your safe keepings. In addition, the researcher will send you a copy of your consent form when organising the interview.

**In order to participate in this study, we need to ensure that you understand the nature of the research, as outlined on the Participant Information page.**

**Please tick the boxes to indicate that you understand and agree to the following conditions.**

- I confirm that I have read the participant information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand I should be at least 18 years old to take part in this study
- I understand that I will need to complete the demographic form (before participating in the interview). The demographic form will contain personal data about myself that will be collected for the purposes of the research study including gender, ethnicity, and age, and that these will be processed in accordance with the information sheet.
- I understand that I need to be able to read and speak English in order to complete the questionnaire and the interview.
- I understand that I must be currently using the IAPT service in England.
- I understand that I need to complete the online demographic questionnaire then e-mail the lead researcher (Paige) first to arrange an interview data.
- I understand that my participation is voluntary and that I am free to withdraw up to 10 working days after the interview without giving any reason, without my legal rights being affected.

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

- I understand that my data is anonymous and will be stored on secure university server via OneDrive.
- I will have to provide written consent to the researcher to be able to make a complaint on my behalf if I discuss poor practice in the IAPT service then the researcher (Paige) can report it.
- I understand that confidentiality will have to be broken if I mention risk of harm to myself or others.
- I understand that the audio from this interview will be recorded via Screen-Cast-O-Matic.
- I understand that the researcher's screen will be recording the discussion via Screen-Cast-O-Matic and I have the option to have my camera turned off during the interview if I wish to.
- I understand that the original recording will be deleted as soon as the researcher has transcribed the data.
- I understand that the software called Audacity, a voice changing will be used to change the pitch of my voice for confidentiality so nobody other the lead researcher (Paige) can identify me.
- I understand that the researcher will delete the pitch/voice changing recording one year after the interview has taken place. This is to help the researcher to fully understand the interview data.
- I understand that the study findings (including anonymised data extracts) for this project will be presented at academic conferences and research articles, published in peer reviewed journals.
- I agree to take part in this study

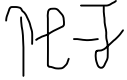

**Participant (Pseudonym/Fake )** code- please use the following to create your pseudonym - initials of your name and last 4 digits of your phone number eg: AB1234 which can be used to identify your data if you wish to withdraw from the study within 10 working days after you have completed the interview.

**Click or tap here to enter text.**

Please keep a note of the name you have provided.

**Date:** Click or tap here to enter text.

Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

Lead Researcher Name: Paige Clarke-Jeffers	Lead Researcher Signature: 
Supervisor's Name: Athfah Akhtar	Supervisors' Signature: 

## **5.d Demographic Questionnaire**

### ***A Study Exploring the Experiences of Culturally and Ethnically Diverse (CED) Service users Using The Improving Access to Psychological Therapy (IAPT) Service***

*Participant Study Information (located here when participants open Qualtrics)*

*Consent form (located here when participants go to the next page after reading the participant study information). - (forced response, otherwise they cannot proceed but participants are made aware that participant is voluntary and do not have to start, proceed or finish the study but also the researcher will get oral consent at the start of the interview).*

#### **Section 1: Participant Information (please tick the box that most applies)**

##### **2. What is your gender identity?**

- *Female*
- *Male*
- *Prefer not to say*
- *Non-binary*
- *Prefer to self-describe: \_\_\_\_\_*

##### **21. What is your sexual orientation?**

- *Bisexual*
- *Gay Woman/Lesbian*
- *Gay Man*
- *Heterosexual/Straight*
- *Prefer not to say*
- *Prefer to self-describe: \_\_\_\_\_*

##### **22. What is your age?**

- *Please state: \_\_\_\_\_*

23. **What is your Ethnic Group?** (Choose one option that best describes your ethnic group or background)

- **Asian/Asian British** *Click here to choose an item.*

*If you have selected 'Other' (please describe) Click or tap here to enter text.*

- **Black/ African/ Caribbean/ Black British** *Click here to choose an item*

*If you have selected 'Other' (please describe) Click or tap here to enter text.*

- **Mixed/ Multiple Ethic Group** *Click here to choose an item*

*If you have selected 'Other' (please describe) Click or tap here to enter*

*text*

- **Other Ethnic Group**

*Other (please describe) Click or tap here to enter text*

- **Prefer not to say**

24. What is your relationship status?

- *Single* *Click here to choose an item*
- *Married* *Click here to choose an item*
- *Divorced* *Click here to choose an item*
- *Civil Partnership* *Click here to choose an item*
- *Widow* *Click here to choose an item*
- *Other* *Click or tap here to enter text*

25. **What is your occupation (this includes education or unemployed)?**

- *Please state:* *Click or tap here to enter text*

**26. What is your religious background?**

- *Christian (Catholic protestant or any other Christian denominations)*
- *Buddhist*
- *Hindu*
- *Muslim*
- *Jewish*
- *Sikh*
- *Agnosticism (uncertain of a religion)*
- *Atheist (No Religion)*
- *Other please, state: \_\_\_\_\_*

**Section 3: Mental Health and the IAPT Service** (please tick the box that most applies)

**27. How did you access the IAPT service?**

- *Self-referral*
  - *General Practitioner (GP)*
  - *Other, please state what this was (write below)*
- \_\_\_\_\_

**28. What is the name of the specific IAPT service you use? E.g.: Birmingham Healthy Minds, Worcestershire Healthy Minds, Wolverhampton Healthy Minds etc.**

- *Please state (write below)*
- \_\_\_\_\_

**29. What type of mental health disorder do you currently have?**

- *Anxiety Click here to choose an item*
- *Generalized Anxiety Disorder Click here to choose an item*
- *Obsessive-Compulsive Disorder (OCD) Click here to choose an item*
- *Panic Disorder Click here to choose an item*
- *Post-Traumatic Stress Disorder (PTSD) Click here to choose an item*
- *Social Anxiety Disorder Click here to choose an item*
- *Agoraphobia Click here to choose an item*
- *Specific Phobias (such as heights or small animals) Click here to choose an item*
- *Health Anxiety Click here to choose an item*
- *Body Dysmorphic Disorder Mixed Depression And Anxiety. Click here to choose an item*
- *Depression Click here to choose an item*
- *Prefer not to say Click or tap here to enter text*
- *Other, please state: Click or tap here to enter text*

**30. How many IAPT sessions have you currently had?**

- *Please state (write below)*

\_\_\_\_\_

**31. What intensity of psychological treatment have you received in the IAPT service?**

- *Low Intensity Treatment*
- *High Intensity Treatment*
- *Both levels of Intensity Treatment*
- *Not sure*

**32. What type of psychological treatment have you received in the IAPT service? Can choose multiple answers:**

- *Self-help*
- *Computerised Cognitive Behaviour Therapy*
- *Cognitive Behaviour Therapy*
- *Behavioural Activation*
- *Psycho-Educational Groups*
- *Counselling for Depression*
- *Mindfulness-based Cognitive Therapy*
- *Brief Psychodynamic Therapy*
- *Interpersonal Psychotherapy*
- *Couple Therapy*
- *Any other, please state what this was (write below)*
- \_\_\_\_\_

**33. What type of delivery style have you received for the psychological treatment in the IAPT service? Can choose multiple answers:**

- *Individual, face-to-face*
- *Telephone*
- *Computer*
- *Group, Online*
- *Group, face-to-face*
- *Other, please state:*

**34. How currently satisfied are you by the type of psychological treatment you are receiving in the IAPT service?**

- *Very Satisfied*
- *Partly Satisfied*

- *Neither Satisfied nor Dissatisfied*
- *Partly Dissatisfied*
- *Very Dissatisfied*

**35. How currently satisfied are you with your therapist in the IAPT service?**

- *Very Satisfied*
- *Partly Satisfied*
- *Neither Satisfied nor Dissatisfied*
- *Partly Dissatisfied*
- *Very Dissatisfied*

**36. How would you currently rate your experience so far in the IAPT service?**

- *Very Satisfied*
- *Satisfied*
- *Neither Satisfied nor Dissatisfied*
- *Dissatisfied*
- *Very Dissatisfied*

**Section 4: Interview Set-up**

**37. Do you understand that you need to contact the researcher first to set up your interview time and date?** (*When e-mailing please state a few different times and dates from **Monday-Sunday between 9am-7pm** along with your **pseudonym name***)

- **Yes** *Click here to choose an item*
- **No** *Click here to choose an item* (if participants click 'no' then Qualtrics will go to another page stating: "Please e-mail the lead researcher: [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk) and state your pseudonym name along with your availability to arrange an interview data. You will need to be the first one to contact the researcher as the researcher has **not obtained** your e-mail address to arrange the interview. Thank you").

Then participants can go to the next page to finish the study.

Researcher's e-mail address: [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

**Section 5: Study Completion**

*Thank you for spending the time to complete the demographic form.*

*Please do not forget that you have to e-mail the researcher (Paige) to arrange the interview.*

*If you do have any questions in the meantime please contact the lead researcher Paige Clarke-Jeffers [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)*

*If you need to seek any emotional support you can contact the Samaritans on 116 123 or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org)*

## **5.e Interview Schedule**

### **A Study Exploring the Experiences of Culturally Ethnically Diverse (CED) Service users Utilising The Improving Access to Psychological Therapy (IAPT) Service**

#### **Pre- Interview Checklist**

- Ensure that participants are sent a calendar invitation with an MS Teams link
- Check that Screen Cast-O-Matic is set up correctly and it ready to record.
- Ensure participant has read the participant information sheet and has signed the consent form before the interview begins.

#### **Interviewer Introduction and Purpose of Study**

##### **START RECORDING**

Hello, my name is Paige Clarke-Jeffers and I am the lead researcher conducting the interview today. So, I would like to firstly double check that you have read the participant information sheet and you are happy to consent to take part in this study?

I would like to start by thanking you for taking time to participate today. The aim of the interview is to gather your opinions and experiences of using the Improving Access to Psychological Therapy (IAPT) Service. On average, this study should take around 60-75 minutes to complete.

I also would like to remind you that this interview will be recorded. Your identity will remain confidential and the data we collect will be used anonymously. I would like to remind you that you can stop the interview at any time without giving me reasons why you want to stop.

I would like to remind you that if you mention an issue such as poor practice or harm to yourself or others then I will be required to break confidentiality and to get in contact with the IAPT team for further support.

**Are there any questions before we get started?**

#### **Interview Schedule**

##### **Section 1: Perception of mental health**

**Change the code name?**

**What is your age?**

**So are you currently in the IAPT service?**

1. Tell me what mental health means to you?
2. Do you feel like your views about mental health have been influenced by your culture/ethnic background?
3. How do you think people cope with mental health in your community? For instance, get support from family, friends, the community, religious leaders, doctors, counsellor etc.

4. What is your perspective on mental health therapy/counselling?
  - a. Do people in your culture/ethnic background have similar or different views?
5. How might people from different ethnicities deal with seeking mental health support?
  - A. Why do you think this is the case?
6. What are some of the things that might prevent someone from seeking help when experiencing difficult emotions or thoughts?
  - B. Please could you explain that a bit more, why might this be?

### **Section 2: Accessibility and entering the IAPT service**

1. Before seeking support from the IAPT service, did you seek any other type of support? E.g., family, friends, religious group, community any other
  - A. How did you find this support? / Did (the above) help or hinder your mental health?
2. You mentioned that you found out about the IAPT service by ‘?’? eg: GP/self-referral.
  - A) Did you face any barriers during the process?
3. How accessible (being able to reach people, being known) do you think the IAPT service is?
  - A. Do you feel like there is enough information about the IAPT service?
  - B. How welcoming/accessible do you feel that the IAPT service is for Black/Asian/Dual Heritage people?
4. When you entered the IAPT service were there any barriers or challenges to attending IAPT sessions etc?
5. Are you able to fulfil any work set by your therapist e.g., online work or preparing things for a session/homework?
  - A. Do you find this easy or challenging to do?

### **Section 3: Being in the IAPT service?**

1. In the demographic questionnaire you mentioned that you are currently diagnosed with (anxiety/depression), how was it getting that diagnosis?
  - A. How did you feel in that present moment?
  - B. Did you tell anybody about your diagnosis? Why or why not?

2. You mentioned that you are receiving '?' treatment (e.g.: CBT, Behaviour activations, Mindfulness etc)?
  - A. How are you finding the psychological treatment your receiving?
  - B. Is it what you expected from the treatment?
  - C. How satisfied are you with the current treatment?
  - D. Do you feel like this treatment is beneficial for you?
  - E. Why/why not?
  - F. Can you think of any other psychological treatment in the IAPT service that you think you would find useful? à Why is that?
3. In the demographic questionnaire you mentioned that you've had (?) number of sessions.
  - 3.A. How have you found these sessions so far?
    - . Is there anything you've liked?
    - . Is there anything you've disliked?
4. In the demographic questionnaire you mentioned that your sessions are delivered by '?' (e.g., phone, groups, online or in person)?
  - A. How are you finding the format of delivery, e.g.: in person, online, groups?
  - B. Are there any aspects that you like or dislike?
  - C. (If they mention group treatment - How have you found contributing to group discussions?)
  - D. Are there any other ways in which you would like your psychological treatment to be delivered? Why?
  - E. (Only if they have had multi format of delivery). Could you rank the order of what deliver style you like the most to the least? Please provide your reasons?
5. What has been the hardest or most challenging aspects you've dealt with in the IAPT service? (e.g., entering the service, the diagnosis, the treatment etc).

#### **Section 4: Therapist and inclusion**

1. What was it like meeting your therapist for the first time?
2. What is the bond/relationship like between you and your therapist?

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

- A. How quickly did you gain that bond?
- B. Why don't you think have gained that bond?
- 3. In the demographic questionnaire you mentioned that you were '?' with your therapist in the IAPT service?
  - a) Could you explain your reason for this? / What could make it better?
- 4. Is your therapist from the same ethnic or culture background as yourself?
  - A. Has this been positive or negative that they are from the same/different background?
  - B. Do you think you would prefer a therapist of the same/different ethnic or cultural background as you? Why/why not?
  - C. Has it ever been difficult to discuss certain issues with them, especially if it relates to your ethnicity, culture, religion, gender identity?
- 5. Is there anything that the therapist could do to better your experience in the IAPT service?

### **Section 5: Identity and the environment of the IAPT service**

- 1. Do you feel a sense of belonging being the IAPT service?
- 2. Do you feel like the IAPT service represents someone like yourself? (E.g.: in terms of your ethnicity/culture).
  - A. What changes would you like to see made, if any?
- 3. Do you feel your cultural/ethnic identity has ever affected your experience in the IAPT service?
- 4. Have you ever felt you have been stereotyped whilst at the IAPT service by staff/the service etc?
- 6. Have you experienced discrimination or racism, directly or indirectly in the IAPT service?
  - A. Were you able to speak with someone in IAPT about this?
- 7. Do you think there are any reasons that may impact recovery/improving mental health levels for ethnic minorities in the IAPT service?

### **Drawing To A Close**

- 1) What would you say is the main things that you gained from having psychological therapy so far?
- 2) Is there anything that you feel could support you more whilst being in the IAPT service?
- 3) How can mental health services like IAPT make it easier for ethnic minorities to get psychological support?
  - A. You rated ? for recommending to someone else, could you give me your reasons Why/why not?
- 4) Are there any suggestions positive and/or negative that you would like to see being made in the IAPT service?
- 5) If you rank for me 1-10 your experience been so far?
- 6) If you could summarise your experience so far in the IAPT service in a short sentence, what would it be?
- 7) Is there anything that we have not covered today that you would like to mention?

### **Ending of the Interview**

Thank you for taking time to participate in the interview today about your experience using the IAPT service.

I would like to remind you that participation is voluntary, in line with the regulations outlined by the British Psychological Society. You can stop being a part of the study at any time without explanation. If you wish to withdraw after this interview, please e-mail myself (my details on the debrief form which I will send you), you have 10 working days from today's interview which will be the on ??/??/????

Are there any questions before I stop the recording?

Thank you for taking part, I will now end the recording?

### **Post- Interview Checklist**

- Stop and SAVE the focus group recording on Screen Cast-O-Matic
- Upload the recording to OneDrive within 24 hours and delete from Screen Cast-O-Matic
- Ensure to send the debrief sheet with participants unique withdrawal data
- Ensure to delete participants e-mail/MS Teams link after I have sent the debrief form

## **5.f Debrief Sheet**

### **A Study Exploring the Experiences of Culturally and Ethnically Diverse (CED) Service users Using The Improving Access to Psychological Therapy (IAPT) Service**

#### **SUMMARY OF PROJECT**

The aim of the research was to gain detailed information from Black, Asian and Dual/Mixed Heritage service users experience within the Improving Access to Psychological Therapy (IAPT) Service. The study explored the factors that could help suggest why the recovery of BAME groups from mental health disorders is lower than service users from a white background. Also, the study wanted to understand BAME service users experiences of mental health in terms of diversity, inclusion, accessibility and representation in the IAPT service.

The researcher used other demographic variables such as age, socio-economic background, religion etc to understand if any other factors influenced service users experience in the IAPT service.

#### **FURTHER GUIDANCE**

If you feel distressed due to taking part in this study there are some services available to help you:

- **'Find a local NHS urgent mental health helpline'** – Click the link below, then enter your age and postcode to a local mental health number. This service is 24/7 to get support from a mental health professional.  
<https://www.nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline>
- **'NHS, non-emergency number medical helpline'** – Call **111**. The service is 24/7 and can help for your symptoms if you're not sure what to do and find general health information and advice.
- **Samaritans'** - You can call on 116 123 or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org). The Samaritans offer 24-hour emotional support if you are experiencing distress.
- **'Mental health services'** – To find NHS mental health sites in your local area using the link below: <https://www.nhs.uk/service-search/other-services/Mental-health-information-and-support/LocationSearch/330>

#### **WHAT ARE YOUR CHOICES ABOUT HOW YOUR INFORMATION IS USED?**

You can stop being part of the study at any time, without giving a reason, as well as refusing to answer or respond to any questions but we will keep information about you that we already have.

If after completing the study, you decide you would like to withdraw, we would like you to contact us 'within 10 working days' from taking part in the study.

Your unique withdrawal data is at the bottom of this page.

Contact [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk) if you need more information about withdrawing. Make sure to provide your pseudonym (fake name) if you would like to withdraw your data.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

#### **WHERE CAN YOU FIND OUT MORE ABOUT HOW YOUR INFORMATION IS USED?**

You can find out more about how we use your information

- by asking one of the research team by e-mail - [Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)
- at [www.hra.nhs.uk/information-about-patients/](http://www.hra.nhs.uk/information-about-patients/)

#### **NHS COMMITTEE CONSIDERATION**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and granted a favourable opinion by West Midlands- Solihull Research Ethics Committee.

#### **WHO IS ORGANISING THE RESEARCH?**

Department of Psychology  
School of Social Sciences  
Birmingham City University  
The Curzon Building  
4 Cardigan Street  
Birmingham B4 7BD

The study is part of the researchers PhD project and ethics were approved by Birmingham City University.

**Lead Researcher:** Paige Clarke-Jeffers PhD Psychology Student (Lead Researcher)

**Contact:** [Paige Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

The main research team are Paige Clarke-Jeffers, Dr Athfah Akhtar, Dr Panos Rentzelas and Dr Silvio Aldrovandi

#### **KEEPING IN TOUCH**

The findings from the study are part of the researcher (Paige's) PhD to be used for publication. The following study may also be used to present at conferences and other journals.

Once the study has been completed in February 2024 you can e-mail [Paige Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk) to ask for details of the study. The researcher will be deleted e-mail conversations and the Microsoft Teams/Zoom link from the calendar so the researcher will

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

no longer have your details to send you the findings. So if you are interested please e-mail the lead researcher (Paige).

### **ANY MORE QUESTIONS?**

We hope that you enjoyed participating in this study. If you have any further questions, please feel free to contact the researchers at the address below.

Paige Clarke-Jeffers PhD Psychology student (Lead Researcher)

[Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

If you are unhappy at any point in the study, or if there is a problem, please contact the Business, Law and Social Science Ethics Committee directly at [blssethics@bcu.ac.uk](mailto:blssethics@bcu.ac.uk)

You will receive a £20 Love2Shop voucher between 1-3 working days after finishing the 1-2-1 interview with the researcher. This will be sent to the e-mail address that you contacted the researcher with.

**Withdrawal date: ??? (unique for each participant)**

### 5.g Logbook Extract Example

ensure the participants that this is okay

||

Surprisingly, participants are finding the IAPT service useful, rating it as partly / satisfied with it. Based on the previous literature I read I thought the participants may have had a more negative or dissatisfied perception. I did not make my pre-conceived ideas interject with the interviews. I asked further why they rated their answer that is to ask for examples.

||

I had to use prompts when I got onto the ethnically matching questions. I felt like participants just assumed that because I am from a CED background I could relate to their experience. Which I did but I needed them to verbally explain it so that it was not

log

me simply agreeing or filling in the spaces for them. This ensured that I was also getting the correct path from them.

It is also becoming regular that the participants would say "because you know", "you know what I mean", "you get it / understand". I made sure I asked participants to expand on their answers due to that I have previously mentioned.

||

Due to being from a CED background I do feel that asked me then participants were speaking about being with a therapist from an opposing background. I felt like they felt comfortable talking to me about why they are glad to prefer being with a therapist from a CED background & the reasons why.

Similarly, participants' thoughts on a white

This made them a cover was And here relate to Perhaps

||

These think about those are culturally And can then stimulate their

## 5.h Interview Script Extract Example

43 Yeah, I feel they've been influenced. So my culture and background has influenced my my  
 44 perception about mental health. So I was just saying that my cultural background, and my  
 45 ethnicity have actually contributed to my perception of mental health.

46 **Interviewer**  
 47 Okay, and how so, how did it contribute, or anything in particular?

48 **GH0420**  
 49 I think basically, because of my background, my perception towards mental health was not  
 50 quite serious at the time, it was not something that was really considered as a serious  
 51 problem coming from my ethnicity. And I think because I spent a lot of time with my Black  
 52 crowd, you know, and I think it was really a challenge, or something we actually quite quoted  
 53 as problems.

54 **Interviewer**  
 55 Okay, so how do you think people within your background deal with mental health? Do they  
 56 go to their friends, families, community, religious group, doctors or any other?

57 **GH0420**  
 58 I think first off most people [Black] to me do not really or are aware of the mental health  
 59 problems. I don't think they are even at that point where they think they have a problem with  
 60 their mental health. That's the first one for me and those that do I think the first time is they  
 61 try to reach out to family members, and, you know, share with them.

62 **Interviewer**  
 63 So what are your perspectives about seeking counselling and therapy?

64 **GH0420**  
 65 I think is quite important. At one point in time, it was really not something that I'll consider as  
 66 something very important but at this point in time now, I understand that it's quite important.  
 67 And then my perception about it is it should be taught as wellness necessary. Mental health  
 68 is an important part of the whole body, the whole wellness. And then if that's not in check, I  
 69 think it really is going to affect a whole lot of other things. So I feel like it's important that it  
 70 should be checked, in check.

71 **Interviewer**  
 72 Okay, so how might people from different ethnicities such as those from an Asian  
 73 background or white background, how do you think they might seek mental health support?

74 **GH0420**  
 75 I think, I understand that actually, seeking mental support is quite frequent, is quite normal  
 76 for all the backgrounds, from the white perspective, I don't know how Asians will relate to  
 77 issues of mental health. But the point that I know of as to why, and I know that they're very  
 78 proactive when it comes to seeking mental health support, they very, very much take it  
 79 serious then people from Black backgrounds or coloured backgrounds to.

80 **Interviewer**

128 know, and you know taking the time to go through searching for the service, I wouldn't come  
 129 across it. And I think that it needs to be out there, it needs to be in the face of people.

130 **Interviewer**  
 131 Okay, so what specifically do you think that IAPT service can do to make it more accessible?

132 **GH0420**  
 133 I think first off, it should be able to reach out to it's target audience. And I think the first would  
 134 be mental health service users, existent service users at this point in time, if that's the way  
 135 that each can help to integrate those existing users in to the system, I think that's going to  
 136 work. And then the second thing is, and I think the information about IAPT services needs to  
 137 go out there into the communities, it needs to be heard in the communities, local  
 138 pharmacies, the local community centres, local council, they have a lot of job there, to put  
 139 the word out there for the community members. So I think these two things could get the  
 140 IAPT services out there.

141 **Interviewer**  
 142 And do you think that will help people from minority backgrounds such as Black and Asian  
 143 people be more aware of what the IAPT service is?

144 **GH0420**  
 145 Yeah, I think that will help because that would enable them to understand the service to  
 146 make the service reasonable and realistic to them.

147 **Interviewer**  
 148 Okay, so when you entered the IAPT service, did you experience any barriers or  
 149 challenges?

150 **GH0420**  
 151 I didn't experience any barrier but that's not the expectation for the general person, I didn't  
 152 expect barriers because I was used to doing things virtually, because I actually was working  
 153 remotely at some point in time. So I was used to navigating through the service, you know,  
 154 using the IAPT, you know, booking appointments you know, setting up appointments, and all  
 155 those, I was quite used to them. But then I think it's something that, it's not something that  
 156 everybody would be used to, I think it depends on the level of digital literacy you have in  
 157 people, that's going to determine the way they are able to use the service.

158 **Interviewer**  
 159 Thank you for that. And so, so far, in your case, I know you've only had two sessions so far.  
 160 So when you entered and had these two sessions, did you find any of the homework or any  
 161 other tasks that you were set, have you found them difficult?

PC Paige Clarke-Jeffers Family influenced MH views Culture

PC Paige Clarke-Jeffers Family influenced MH views Culture

PC Paige Clarke-Jeffers Culture Lack of understanding

PC Paige Clarke-Jeffers Family is important for MH

PC Paige Clarke-Jeffers Change of perspective Importance of MH eg: getting therapy etc and awareness of what MH is

PC Paige Clarke-Jeffers Importance of MH eg: getting therapy etc and awareness of what MH is

PC Paige Clarke-Jeffers Integrating current SU to promote iapt

PC Paige Clarke-Jeffers Improving accessibility

PC Paige Clarke-Jeffers Relatability, knowing what iapt does so people will use the service. Familiarity

PC Paige Clarke-Jeffers Flexibility of online using, enjoyed this mode

PC Paige Clarke-Jeffers Barriers impacting how other progress

# Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

266 telephone, computer, group online and group face to face if you could put them in an order  
267 for me, that would be great.

268 **GH0420**  
269 I think group online as the first one. Then individual face to face comes next. And I think  
270 online face to face also comes next. Then group face to face would follow.

271 **Interviewer**  
272 So if you could give me a bit more information about why you liked the group online  
273 sessions?

274 **GH0420**  
275 Yeah, why I like the group online sessions. I think it's flexible for everybody. So a lot of  
276 people, it's very easy for you, for the attendance to be high than it would be for attending a  
277 face to face group session, and attending the face to face group session, I think it's quite  
278 sensitive. And there is a way that people are actually easy to live with themselves online  
279 then meeting strangers face to face. I think that was interesting. And the fact that we were  
280 not together so everybody's able to also share on diluted experiences. And everybody is  
281 also able to make objections, and also bring up the opinions about something they don't feel  
282 right about. That's the interesting thing about group online.

283 **Interviewer**  
284 Okay, and then you said that second you would say you would prefer individual face to face  
285 compared to individual online?

286 **GH0420**  
287 I think it actually individual online as being the one that I've used more. And the reason why I  
288 was to prefer individual face to face is based on the fact that when I have the time, when it's  
289 flexible, and it's available when the timing is available, I would like to be able to have a one  
290 on one discussion with a therapist or psychologist or service provider, I want to talk to them  
291 understand the perception or understand the body language and the things I say to them  
292 you understand and also how they react to the things that they ask about me. You know, I  
293 also want to understand that point that that they ask me so that's why I'm able to that's why  
294 I'm able to, you know to really like it when it's face to face. Yeah.

295 **Interviewer**  
296 And then what are some of the hardest or challenging things you've had to deal with in IAPT  
297 so far, so this could be from just accessing the service, entering it, the assessment, the  
298 diagnosis, the treatment, whatever?

299 **GH0420**  
300 I think the first thing is remembering the services.

301 **Interviewer**  
302 Remembering the services, what do you mean by that?

The screenshot shows a vertical list of five posts, each by a user named 'Paige Clarke-Jeffers' (PC). Each post includes a title, a short text snippet, and a reply field with a placeholder '@mention or reply'. The posts are:

- 1. Title: Preference of delivery format
- 2. Title: Gain more with online groups as more people will attend to be able to learn from them
- 3. Title: Hid ones anonymity when talking about MH in the group setting
- 4. Title: You can hide your identity online so able to talk more about an issue
- 5. Title: Able to make objections when online rather than face to face

Below the fifth post, the start of another post is visible with the title 'Enjoys 1-2-1 discussions, can get more from your therapist, more in depth'.

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

350 **GH0420**  
351 I think it was an interesting meeting them for the first time was really a challenge. Because  
352 we were really new at that point, even though the therapist tried to make me understand the  
353 whole process. But then for me, it was not just at that point where I felt like I could really talk  
354 a lot. And I could really show a lot. So took a couple of meetings for me to really be that  
355 much comfortable.

356 **Interviewer**  
357 Okay, and so do you feel like you have a bond now with your therapist?

358 **GH0420**  
359 Yeah, I feel like we have a bond now. There's this whole relationship which we established  
360 and it's quite good.

361 **Interviewer**  
362 Okay, and how quickly did you think it took to, for you both to gain that kind of bond?

363 **GH0420**  
364 I think it was about some meetings two, three or four, five meetings and we started finally  
365 rising, and then I started feeling understood as I feeling comfortable and then from then on  
366 just is very easy to do that.

367 **Interviewer**  
368 Okay, and can I ask, what gender is your therapist?

369 **GH0420**  
370 Male.

371 **Interviewer**  
372 Okay, how important, do you think it is, as a male yourself to have another male therapist?

373 **GH0420**  
374 Well, I didn't consider gender. I didn't know. I don't know if that would have been a  
375 consideration. Maybe if I had a female gender, maybe I would have thought about it  
376 differently, at the point, at the start now, I didn't consider that. I did not.

377 **Interviewer**  
378 So how has it been then talking to a male therapist then for you?

379 **GH0420** |  
380 Well, it was just straightforward. And I felt like it's maybe just because the (inaudible) is new  
381 to copy those down so we could get to the point where I'm able to share personal things. |  
382 And then I think it was quite straightforward because it's business at the start, and then we  
383 built the rapport.

384 **Interviewer**  
385 And do you think building that rapport would have been easier with a woman therapist  
386 maybe?



**PC Paige Clarke-Jeffers** ...   
Comfortability  
Need this to create a bond to move through the sessions effectively  
@mention or reply

**PC Paige Clarke-Jeffers** ...   
Good bond with therapist  
@mention or reply

**PC Paige Clarke-Jeffers** ...   
A few meetings in to feel that bond  
@mention or reply

**PC Paige Clarke-Jeffers** ...   
Did not consider what is would have been like if they had a women therapist. Gender was not a factor  
@mention or reply

**PC Paige Clarke-Jeffers** ...   
Building a rapport  
@mention or reply

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

393 **GH0420**  
 394 |My current therapist is Black|

395 **Interviewer**  
 396 Black. So you've had another therapist before this?

397 **GH0420**  
 398 My therapist is Black. That's what I said. I've never had any other before that.

399 **Interviewer**  
 400 Okay, so how's it been then, having a Black therapist?

401 **GH0420**  
 402 I think that was quite, that [was quite interesting. And then it really helped me also], I would  
 403 say.

404 **Interviewer**  
 405 Okay, so what are the benefits of having somebody from a similar ethnic background from  
 406 yourself?

407 **GH0420**  
 408 |I think you feel that you're able to be understood quite earlier. You're, this person is able to  
 409 relate with you realities, and also relate with your background. |

410 **Interviewer**  
 411 Okay, and what are your thoughts maybe if you had a white therapist, maybe how do you  
 412 think that would have been?

413 **GH0420**  
 414 |If I had a white therapists, I think it will depend on the conversations that we have before  
 415 maybe to, you know, feel understood, you get me, maybe I would have a perception of,  
 416 okay, maybe it's experience and is going to understand me, that's just a perception, but I  
 417 wouldn't be quite sure.

418 **Interviewer**  
 419 Okay. So has it ever been difficult to talk about issues such as race, ethnicity, culture,  
 420 religion with your therapist?

421 **GH0420**  
 422 |It's been quite easy. And I think that's because we're from the same race. So there's a way  
 423 we share that common ground. |

424 **Interviewer**  
 425 Okay, and in the demographic questionnaire, you stated that you're very satisfied with your  
 426 therapist. Could you give me my reasons why?

PC Paige Clarke-Jeffers Same ethnic background  
 @mention or reply

PC Paige Clarke-Jeffers Having a therapist of the same ethnic background was good  
 @mention or reply

PC Paige Clarke-Jeffers Reliability, trust, understood  
 @mention or reply

PC Paige Clarke-Jeffers Unsure about an ethnically different therapist  
 @mention or reply

PC Paige Clarke-Jeffers Talking about culture/race was easy  
 @mention or reply

486 service are not able to relate with their background and the realities, so it's not about telling  
 487 me this and that it's about telling me what I can relate with and what I can understand as a  
 488 Black person, if you don't come into things that I'm able to relate with in my day to day life  
 489 and your just coming up with things and telling me things from your profession, and I might  
 490 not really see the impact of it all. So I think that's one of the reasons why people, Black,  
 491 colour, did not really easily get get get get treated or kind of go after therapists and all,

492 **Interviewer**  
 493 Okay, thank you. So last few questions now. So what are some of the main things you've  
 494 gained from having therapy so far?

495 **GH0420**  
 496 |I think I've gained recognition of myself, I've also gained understanding that things are  
 497 allowed to go south. And it's not just about me, I think it's a way, most natural way of getting  
 498 to understand yourself and weaknesses. And I've also been able to understand that we're  
 499 allowed to fail as humans and then failures are an important aspect of humans and also is  
 500 able to understand the fact that it means a lot to have somebody you can talk to.

501 **Interviewer**  
 502 Yeah, okay. And is there anything more that the IAPT service could do to enhance your  
 503 experience as obviously you've still got more sessions to go?

504 **GH0420**  
 505 So if the IAPT service can, like I said a form flexibility that will be nice.

506 **Interviewer**  
 507 And is there anything more that you can add about what would make it easier for ethnic  
 508 minorities to get support within IAPT?

509 **GH0420**

PC Paige Clarke-Jeffers Reliability  
 Understanding  
 Inclusivity  
 @mention or reply

PC Paige Clarke-Jeffers Learnt a lot about themselves and how to handle situations  
 @mention or reply

510 Well, |I think we make it easier would be inclusion, including people from ethnic minority  
 511 background in design of this, of the process and design of the programme and now having  
 512 public people from coloured background involved in the whole process. |

PC Paige Clarke-Jeffers Increasing accessibility by inclusion and diversity being embedded throughout

## 5.i Similar Codes To Be Grouped Into A Meaningful Theme Or Sub-Theme

Understand/Knowledge	it's about telling me what I can relate with and what I can understand as a Black person, if you don't come into things that I'm able to relate with in my day to day life and your just coming up with things and telling me things from your profession, and I might not really see the impact of it all. So I think that's one of the reasons why people, Black, colour, did not really easily get get get treated or kind of go after therapists and all
Accessibility, Familiarity, Understand/Knowledge	I think we make it easier would be inclusion, including people from ethnic minority background in design of this, of the process and design of the programme and now having public people from coloured background involved in the whole process.
Comfortability, Stigma, Seeking help	I think the first thing is being comfortable talking about that problem
Comfortability, Stigma, Seeking help	I actually talked to my family about my condition
Comfortability, Stigma, Seeking help	my family quite helped because they were able to direct me, you know, provide recommendations
Comfortability, Stigma, Seeking help	will quite supportive, and wanted to know more about the condition generally
Comfortability, Stigma, Seeking help	I was quite sceptical of how well the service can serve its function and how well it can probably I can talk to somebody who's able to understand me, understand my challenges and be able to, you know, provide solution that can help. So I think I was quite impressed with the cap with the functionality of the service,
Delivery/format of sessions. Learning from others experience. 1-2-1 for personal support with therapist.	that I've liked about the session is the fact that it was quite flexible for me,
Delivery/format of sessions. Learning from others experience. 1-2-1 for personal support with therapist.	the focus group session was the one that I think I enjoyed the most because at some point in time, I also wanted to know about how others in different conditions or similar to mine
Delivery/format of sessions. Learning from others experience. 1-2-1 for personal support with therapist.	the focus group session, they really talked about it, and I was able to learn from all a lot of other people to
Delivery/format of sessions. Learning from others experience. 1-2-1 for personal support with therapist.	think I liked the fact that there were diverse means of delivery, that can be used, the ones that has been most important for me has being the online delivery, and the effectiveness of the online delivery.
Delivery/format of sessions. Learning from others experience. 1-2-1 for personal support with therapist.	I think group online as the first one. Then individual face to face comes next. And I think online face to face also comes next. Then group face to face would follow.
Delivery/format of sessions. Learning from others experience. 1-2-1 for personal support with therapist.	I like the group online sessions. I think it's flexible for everybody. So a lot of people, it's very easy for you, for the attendance to be high than it would be for attending a face to face group session
Delivery/format of sessions. Learning from others experience. 1-2-1 for personal support with therapist.	and attending the face to face group session, I think it's quite sensitive [...] easy to live with themselves online then meeting strangers face to face.

< > GH0420 JA9501 JD4495 JK9031 JO6368 KN3519 LT0492 MT7278 PD0224 SA4395 TL625 YM1720

Lack of understanding	
Family influenced MH views	most people [Black] to me do not really or are aware of the mental health problems. I don't think they are even at that point where they think they have a problem with their mental health
Culture	
Lack of understanding	
How other backgrounds deal with MH	seeking mental support is quite frequent, is quite normal for all the backgrounds, from the white perspective
How other backgrounds deal with MH	I know of as to why, and I know that they're very proactive when it comes to seeking mental health support, they very, very much take it serious then people from Black backgrounds or coloured backgrounds to.
Importance of MH eg: getting therapy etc and awareness of what MH is. Acceptance	At one point in time, it was really not something that I'll consider as something very important but at this point in time now, I understand that it's quite important.
Importance of MH eg: getting therapy etc and awareness of what MH is. Acceptance	Mental health is an important part of the whole body, the whole wellness. And then if that's not in check, I think it really is going to affect a whole lot of other things.
Importance of MH eg: getting therapy etc and awareness of what MH is. Acceptance	I think they're quite good. They're interesting. And the I think that I'm most likely going to see them through.
Importance of MH eg: getting therapy etc and awareness of what MH is. Acceptance	the opportunity to understand the activities in the in the treatment plan. I think that was the challenge. I wanted to really understand the need for all this. And also understand its relevance to my treatment.
Importance of MH eg: getting therapy etc and awareness of what MH is. Acceptance	[treatment plan] it should be done in such a way that people understand the whole process and understand the seriousness of all the whole plan
Ppts rank and summary of their iapt experience	nine [...] I would say effective.
Representation/diversity of staff in iapt	I think that it will be quite important to, for them to, to be able to provide versatility and also to be able to provide, to be able to provide patients or users with different options.
Therapist bond, building a rapport, similarity and differences ethnically, gender	, I think that being able to establish that one on one rapport, as you would have in the physical conversation, having that done online is a challenge. [...] It was, it took me a while before I could be able to establish that form of rapport.
Therapist bond, building a rapport, similarity and differences ethnically, gender	So took a couple of meetings for me to really be that much comfortable.
Therapist bond, building a rapport, similarity and differences ethnically, gender	I feel like we have a bond now. There's this whole relationship which we established and it's quite good
Therapist bond, building a rapport, similarity and differences ethnically, gender	My current therapist is Black. [...] that was quite interesting. And then it really helped me.

< > GH0420 JA9501 JD4495 JK9031 JO6368 KN3519 LT0492 MT7278 PD0224 SA4395 TL625 YM1720

## Appendices: Study Three – Effects of Autonomy And Ethnicity On Mental

### Health Outcomes


#### 6.a Study Poster

## Have You Previously Used The 'Improving Access To Psychological Therapies' (IAPT) Service In The Last 3-12 Months?

### Study Information

This study involves **previous IAPT service-users** who identify as **Asian, Black or dual heritage** that have **completed treatment between 3-12 months ago**.

The aim of the study is to gain an insight into the recovery of individuals who have finished their IAPT treatment.



### Eligibility Criteria



- ✓ 18 years or older
- ✓ Able to read English
- ✓ 3-12 months since treatment at an IAPT service has finished
- ✓ Identify as Asian, Black, dual heritage

Your views matter!

Quick

Easy

Online



### Interested in Participating?

- The study involves filling out a **15-20 minute online questionnaire**.
- **Scan the QR code** or use the **link below** to fill out the questionnaire
- If you have further questions please e-mail: **Paige.Clarke-Jeffers@mail.bcu.ac.uk**

[https://blss.eu.qualtrics.com/jfe/form/SV\\_9WxuxzCLwn0Ka3k](https://blss.eu.qualtrics.com/jfe/form/SV_9WxuxzCLwn0Ka3k)

Ethical Approval Granted by Birmingham City University

## **6.b Demographic Questionnaire**

### ***A Study of Improving Access to Psychological Therapies (IAPT) Service users Recovery and Quality of Life 3-12 months after IAPT treatment***

*Participant Study Information (located here when participants open Qualtrics)*

*Consent form (located here when participants go to the next page after reading the participant study information) - (forced response, otherwise they cannot proceed but participants are made aware that participant is voluntary and do not have to start, proceed or finish the study).*

#### **Section 1: Participant Identification**

***Please provide a Pseudonym*** (a fake/fictitious name used to conceal your real name, which can be used to identify your data if you wish to withdraw from the study within 14 days after completing the questionnaire.

*The pseudonym should be the first two initials of your first name and the last three digits of your mobile/home number e.g.: Joe Bloggs 07123456789 will be Jo789.*

*Click or tap here to enter text.*

*Please keep a note of the name you have provided.*

#### **Section 2: Participant Information** (please tick the box that most applies)

**1. Which gender do you most identify?**

- *Female*
- *Male*
- *Prefer not to say*
- *Non-binary*
- *Prefer to self-describe: \_\_\_\_\_*

**2. What is your sexual orientation?**

- *Bisexual*
- *Gay Woman/Lesbian*
- *Gay Man*
- *Heterosexual/Straight*
- *Prefer not to say*
- *Prefer to self-describe: \_\_\_\_\_*

**3. What is your age?**

Please state: \_\_\_\_\_

**4. Ethnic Group** (*Choose one option that best describes your ethnic group or background*)

**i. Asian/Asian British Chinese**

*If you have selected 'Other' (please describe) Click or tap here to enter text.*

**ii. Black/ African/ Caribbean/ Black British Caribbean**

*If you have selected 'Other' (please describe) Click or tap here to enter text.*

**iii. Mixed/ Multiple Ethic Group** White and Asian

*If you have selected 'Other' (please describe) Click or tap here to enter text*

**iv. White** *Click here to choose an item*

*If you have selected 'Other' (please describe) Click or tap here to enter text*

**v. Other Ethnic Group**

*Other (please describe) Click or tap here to enter text*

**vi.  Prefer not to say**

**5. What is your religious background?**

- *Christian (Catholic protestant or any other Christian denominations)*

- *Buddhist*
- *Hindu*
- *Muslim*
- *Jewish*
- *Sikh*
- *Atheist (No Religion)*
- *Other please, state: \_\_\_\_\_*

**6. What is your outcode of your postcode? Max 3 digits/letters** e.g.: B8 = Washwood Heath, Ward End, Saltley, WR9 = Droitwich, Ombersley, Wychbold, Rushock, CV1 = Coventry, B80 = Redditch etc

- *Please, state: \_\_\_\_\_* (will only allow participants to write a total of 3 numbers/letters to know their area code, this will prevent participants writing their full post code to ensure confidentiality).

**Section 3: Mental Health and the IAPT Service** (please tick the box that most applies)

**7. How did you access the IAPT service?**

- *Self-referral*
- *General Practitioner (GP)*
- *Other, please state what this was (write below)*

\_\_\_\_\_

**8. How long has it been since you finished your last IAPT appointment/session?**

- *3 months*
- *4 months*
- *5 months*
- *6 months*
- *7 months*
- *8 months*
- *9 months*
- *10 months*
- *11 months*
- *12 months*

**9. Have you been diagnosed with a mental health problem?**

- *No*
- *Yes*

<ul style="list-style-type: none"><li>• <i>If yes, please state what mental health problem (write below)?</i> _____</li></ul>
<p><b>10. Are you undergoing any other psychological treatment that is external to the IAPT service?</b></p> <ul style="list-style-type: none"><li>• <i>No</i></li><li>• <i>Yes</i></li><li>• <i>If selected yes, please state what this was (write below)</i> _____</li></ul>
<p><b>11. In the IAPT service what intensity of psychological treatment did you receive?</b></p> <ul style="list-style-type: none"><li>• <i>Low Intensity Treatment</i></li><li>• <i>High Intensity Treatment</i></li><li>• <i>Both levels of Intensity Treatment</i></li><li>• <i>Not sure</i></li></ul>
<p><b>12. Whilst at the IAPT service what psychological treatment were you receiving? Can choose multiple answers:</b></p> <ul style="list-style-type: none"><li>• <i>Self-help</i></li><li>• <i>Computerised Cognitive Behaviour Therapy</i></li><li>• <i>Cognitive Behaviour Therapy</i></li><li>• <i>Behavioural Activation</i></li><li>• <i>Psycho-Educational Groups</i></li><li>• <i>Counselling for Depression</i></li><li>• <i>Mindfulness-based Cognitive Therapy</i></li><li>• <i>Brief Psychodynamic Therapy</i></li><li>• <i>Interpersonal Psychotherapy</i></li><li>• <i>Couple Therapy</i></li><li>• <i>Any other, please state what this was (write below)</i> _____</li><li>• _____</li></ul>
<p><b>13. How were the psychological treatment you received in the IAPT service delivered? Can choose multiple answers:</b></p> <ul style="list-style-type: none"><li>• <i>Individual, face-to-face</i></li><li>• <i>Telephone</i></li></ul>

- *Computer*
- *Group, Online*
- *Group, face-to-face*

**14. Were you satisfied by the type of psychological treatment you received in the IAPT service?**

- *Very Satisfied*
- *Partly Satisfied*
- *Neither Satisfied nor Dissatisfied*
- *Partly Dissatisfied*
- *Very Dissatisfied*
- *Not Important to Me*

**15. Whilst at the IAPT service, how many sessions of treatment did you have in total?**

- *Please state what this was (write below)*

\_\_\_\_\_

**16. Were you satisfied by the number of sessions you received in the IAPT service?**

- *Very Satisfied*
- *Partly Satisfied*
- *Neither Satisfied nor Dissatisfied*
- *Partly Dissatisfied*
- *Very Dissatisfied*
- *Not Important to Me*

**17. How satisfied were you with your therapist?**

- *Very Satisfied*
- *Partly Satisfied*
- *Neither Satisfied nor Dissatisfied*
- *Partly Dissatisfied*
- *Very Dissatisfied*

**18. Since finishing treatment in the IAPT are you currently using any coping mechanism to help with your mental health?**

- *No*
- *Yes*
- *If selected yes, please state what this is (write below)*

\_\_\_\_\_

**19. How would you rate your overall experience in the IAPT service?**

- *Very Satisfied*
- *Satisfied*
- *Neither Satisfied nor Dissatisfied*
- *Dissatisfied*
- *Very Dissatisfied*

**20. If needed to, how likely would you use the IAPT service again?**

- *Highly Likely*
- *Likely*
- *Neither Likely nor Unlikely*
- *Unlikely*
- *Highly Unlikely*

**21. How likely is it that you would recommend the IAPT service to a colleague, friend or family member?**

- *Highly Likely*
- *Likely*
- *Neither Likely nor Unlikely*
- *Unlikely*
- *Highly Unlikely*

**22. Are there any suggestions (positive and/or negative) that could improve the IAPT service?**

- *No*
- *Yes, please state any positive and/or negative suggestions:*

<b>Section 4: Mental Health Questionnaires</b>				
<b>Patient Health Questionnaire</b>				
<b>Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)</b>				
	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>	<b>Nearly every day</b>
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

### Generalised Anxiety Disorder Questionnaire

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? <i>(Use "✓" to indicate your answer"</i>	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

### Work and Social Adjustment Scale Questionnaire

If you're retired or choose not to have a job for reasons unrelated to your problem, tick here

0      1      2      3      4      5      6      7      8  
 Not at all      Slightly      Definitely      Markedly      Very severely

- 1 Because of my [problem] my **ability to work** is impaired. '0' means 'not at all impaired' and '8' means very severely impaired to the point I can't work.
- 2 Because of my [problem] my **home management** (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired.
- 3 Because of my [problem] my **social leisure activities** (with other people e.g. parties, bars, clubs, outings, visits, dating, home entertaining) are impaired.
- 4 Because of my [problem], my **private leisure activities** (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired.
- 5 Because of my [problem], my ability to form and maintain **close relationships** with others, including those I live with, is impaired.

**Autonomy-Connectedness Scale**

1= I totally disagree 2= I slightly disagree 3= I partly disagree and partly agree 4= I slightly agree 5= I totally agree

	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
1. I often find it difficult to determine what I really want					
2. I am usually able to dismiss the thoughts of someone else's misery					
3. When I have to do something against others' will I am very restless					
4. I hate detachment					
5. It is difficult for me to start new activities on my own.					
6. I often do not know what my opinion about a given subject is					
7. I rarely care about others' feelings and experiences					
8. I find it easy to ignore other people's comments					
9. It is usually obvious to me what I like best					
10. If I disagree with others, I express it directly					
11. I am rarely occupied with other people's opinions about me					
12. I easily come to grips with a new problem on my own					
13. If I think of having to say goodbye to a beloved person, I break down in advance					
14. If it was up to me , I would spend most of my time in familiar surroundings					
15. When I am asked what I want I usually know the answer immediately					
16. I rarely tend to ask other people for advice					

	1	2	3	4	5
17. I often analyze others' feelings thoroughly					
18. I need a lot of time to get used to new surroundings					
19. I often wonder about other people think about me					
20. When I take important decisions concerning my life, I do not consider other people's wishes and opinions					
21. I can hardly bear the situations when someone is angry with me					
22. Under the influence of others' opinions I often change my opinion					
23. I am a very adventurous person					
24. Others' experiences significantly influence my moods					
25. I need others' advice and guidance very much					
26. When I do something that bothers other people I can easily stop thinking about it					
27. I quickly begin to feel at ease in new situations					
28. I often need love and warmth					
29. I can easily back out of things that people who are important to me want me to do					
30. I can directly express my opinions on most subjects					

**Section 5: Study Completion**

*In the meantime feel free to e-mail the researcher if you have any questions about the study (Paige.Clarke-Jeffers@mail.bcu.ac.uk) or if you are need to seek any emotional support you can contact the Samaritans on **116 123** or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org)*

*(Upon completion of the survey, Qualtrics will take the participants to the debrief sheet which will tell the participants to take a picture/screen shot of the form for safe keepings.*

## **6.c Participant Information Sheet**

### ***A Study of Improving Access to Psychological Therapies (IAPT) Service users Recovery and Quality of Life 3-12 months after IAPT treatment***

#### **STUDY BACKGROUND**

You are being invited to take part in a research study exploring previous IAPT service users recovery and quality of life since treatment at the IAPT service has finished. This study has been given approval by Birmingham City University Ethics Committee.

#### **WHAT WILL YOU NEED TO DO?**

In this study, you will be asked to take part in an online questionnaire on Qualtrics that you can complete in your own time that will explore questions into mental health and well-being.

#### **HOW LONG WILL THE STUDY LAST?**

On average, this study should take around 15-20 minutes to complete.

#### **What Is The Inclusion Criteria?**

- Be at 18 years or older.
- Understand English to respond to the questionnaires.
- Must currently **not** be receiving treatment in the IAPT service.
- Finished treatment in the IAPT service between 3-12 months.
- Participants can still be diagnosed with a common mental health disorder (*Depression, Anxiety, Generalised Anxiety Disorder (GAD), Panic Disorder, Obsessive-Compulsive Disorder (OCD), Post-Traumatic Stress Disorder (PTSD), Panic Disorder, Social Anxiety Disorder, agoraphobia, specific phobias (such as heights or small animals), health anxiety (hypochondriasis) and body dysmorphic disorder mixed depression and anxiety*) after having finished treatment at the IAPT service or no longer have a common mental health disorder.
- Participants **cannot** take part if they have a severe mental health conditions e.g.: Bipolar disorder, Psychosis and Schizophrenia.

#### **ARE THERE ANY RISKS OF TAKING PART?**

There is a minimal risk of taking part in this study. Due to the nature of the research, you may feel uncomfortable at times when answering some questions on the questionnaire. At any time, you can choose to stop and not complete the rest of the questionnaire or resume when you feel more comfortable.

You will be provided with details of mental health support services and helplines at the end of this information sheet, so you are aware of the support available, should you require it.

#### **ARE THERE ANY BENEFITS OF TAKING PART?**

Although there are no direct benefits from taking part, it is hoped that through this research will allow a deeper understanding of service users experience in the IAPT service in terms of

an individual's recovery and quality of life after they have finished treatment in the IAPT service.

### **YOUR RIGHT TO WITHDRAW AND WITHHOLD INFORMATION**

Participation in this study is entirely voluntary and there is no obligation to take part. In line with the regulations outlined by the British Psychological Society, you can stop being a part of the study at any time without explanation. You are still entitled to the same benefits as an individual who completes the study.

If after completing the study, you decide you would like to withdraw, please contact the researcher within *14 working days* from taking part in the study.

Please note, participants will not be able to withdraw their data after 14 working days after they have completed the questionnaire as the researcher will be using the data to analyse and to use in their publication.

### **YOUR RIGHT TO CONFIDENTIALITY/ANONYMITY**

The study will not involve the collection of any personal information about you except your age, gender, ethnicity and other demographic information. Any personal information given will be unidentifiable to an external party – Your data will be stored confidentially, using a personalised anonymous pseudonym.

Your data will be stored on a password-protected laptop, on a password-protected University OneDrive folder, which will only be accessible to those within the research team. All identifiable features will be removed prior to publication or presentation at conferences.

### **FURTHER GUIDANCE**

For the first point of contact please get in touch with your general practitioner (GP). Your GP will be a good source of support as they will be aware of your mental health history and are able to provide you with medical advice on what is the best course of action to do next.

If you feel distressed as a result of taking part in this study you can ring the Samaritans who offer 24-hour emotional support for individuals experiencing distress. They can be called on **116 123** or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org).

Also, you can search for mental health services in your local area on the NHS site by providing your post code using the link below:

<https://www.nhs.uk/service-search/other-services/Mental-health-information-and-support/LocationSearch/330>

### **WHO IS ORGANISING THE RESEARCH?**

The study is part of the researchers PhD project.

Department of Psychology

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

School of Social Sciences  
Birmingham City University  
The Curzon Building  
4 Cardigan Street  
Birmingham B4 7BD

**Lead Researcher:** Paige Clarke-Jeffers

**Contact:** [Paige Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

Please contact Paige Clarke-Jeffers if you require any further information or wish to withdraw. Remember, you will need to provide your pseudonym (that you created) if you would like to withdraw your data.

If you are unhappy at any point in the study, or if there is a problem, please contact the Business, Law & Social Sciences faculty ethics committee directly at [blssethics@bcu.ac.uk](mailto:blssethics@bcu.ac.uk)

## **6.d Consent Form**

### ***A Study of Improving Access to Psychological Therapies (IAPT) Service users Recovery and Quality of Life 3-12 months after IAPT treatment***

#### **BRIEF SUMMARY OF PROJECT**

You are being invited to take part in a research study exploring previous IAPT service users recovery and quality of life since treatment at the IAPT service has finished. This study has been given approval by Birmingham City University Ethics Committee.

**In order to participate in this study, we need to ensure that you understand the nature of the research, as outlined on the [Participant Information](#) page.**

**Please tick the boxes to indicate that you understand and agree to the following conditions.**

- I confirm that I have read the participant information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that in order to take part in this study, I should be at least 18 years old.
- I understand that I need to be able to read English to answer the questions on the questionnaire.
- I understand that I must **not** be currently using the IAPT service.
- I understand that to complete the questionnaire I need to have finished the IAPT service between 3-12 months.
- I understand that personal data about me will be collected for the purposes of the research study including gender, ethnicity, and age, and that these will be processed in accordance with the information sheet.
- I understand that my participation is voluntary and that I am free to withdraw up to 14 working days after finishing the questionnaire without giving any reason, without my legal rights being affected.
- I understand that my data is anonymous and will be stored on secure university servers.

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

- I understand that the study findings from this project will be presented at academic conferences and research articles, published in peer reviewed journals.
- I agree to take part in this study

**Participant Name (Pseudonym):** Click or tap here to enter text.

**Date:** Click or tap here to enter text.

## **6.e Debrief Sheet**

### ***A Study of Improving Access to Psychological Therapies (IAPT) Service users Recovery and Quality of Life 3-12 months after IAPT treatment***

#### **SUMMARY OF PROJECT**

The aim of the research was to explore how effective the IAPT service for service users 3-12 months after they have finished their treatment. The researcher wanted to explore service users recovery and quality of life after treatment especially as mental health conditions can fluctuate (Broome et al., 2015; Starr & Davila, 2012).

Additionally, the researcher explored if there were any differences in recovery rates between white and Black, Asian, Ethnic Minority groups, this is because previous research has shown that Black, Asian, Ethnic Minority have lower recovery rates in the IAPT service (Moller et al., 2019). Also, the researcher used other demographic variables such as age, socio-economic background, religion etc to understand if any other factors influenced maintaining or having lower levels of recovery.

Due to mental health conditions fluctuating the researcher is expecting that after treatment has finished service users may start regressing, typically those that identify as Black, Asian, Ethnic Minority group due ethnic minorities experiencing barriers in mental health such as stigma, racism, discrimination or previous treatment not being culturally adapted (Benish et al., 2011; Grey et al., 2013; Henderson et al., 2013). Therefore, the researcher investigated if receiving psychological treatment in the IAPT service has been beneficial for service users in the long-term by measuring service users anxiety, depression and social/work functioning after treatment has finished.

#### **FURTHER GUIDANCE**

For the first point of contact please get in touch with your general practitioner (GP). Your GP will be a good source of support as they will be aware of your mental health history and are able to provide you with medical advice on what is the best course of action to do next.

If you feel distressed as a result of taking part in this study, you can ring the Samaritans who offer 24-hour emotional support for individuals experiencing distress. They can be called on **116 123** or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org).

Also, you can search for mental health services in your local area on the NHS site by providing your post code using the link below:

<https://www.nhs.uk/service-search/other-services/Mental-health-information-and-support/LocationSearch/330>

#### **YOUR RIGHT TO WITHDRAW AND WITHHOLD INFORMATION**

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

Participation in this study is entirely voluntary and there is no obligation to take part. In line with the regulations outlined by the British Psychological Society, you can stop being a part of the study at any time without explanation. You are still entitled to the same benefits as an individual who completes the study.

If after completing the study, you decide you would like to withdraw, please e-mail the researcher (myself- Paige) and simply state 'Withdraw from study' along with the pseudonym that you created. You can withdraw up to 14 working days after you have completed the questionnaire.

### **WHO IS ORGANISING THE RESEARCH?**

Department of Psychology  
School of Social Sciences  
Birmingham City University  
The Curzon Building  
4 Cardigan Street  
Birmingham B4 7BD

The primary research team are Paige Clarke-Jeffers, Dr Athfah Akhtar, Dr Panos Rentzelas, and Dr Silvio Aldrovandi.

Paige Clarke-Jeffers PhD Psychology student (Lead Researcher)

[Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

### **KEEPING IN TOUCH**

The findings from the study will be submitted as part of a PhD thesis and written up for publication. The following study may also be used to present at conferences and other journals.

Once the study has been completed in September 2024 you can request a copy of the findings by e-mailing the lead researcher using the contact details below.

### **ANY MORE QUESTIONS?**

We hope that you enjoyed participating in this study. If you have any further questions, please feel free to contact the researchers at the address below.

Paige Clarke-Jeffers PhD Psychology student (Lead Researcher)

[Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

If you are unhappy at any point in the study, or if there is a problem, please contact the Business, Law and Social Science Ethics Committee directly at [blssethics@bcu.ac.uk](mailto:blssethics@bcu.ac.uk)

**Appendices: Study Four – Ethnicity And Recovery Determinants**

**7.a Generalised Anxiety Disorder- 7**

<b>Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems?</b> <i>(Use "✓" to indicate your answer"</i>	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

## **7.b Patient Health Questionnaire-9**

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?  
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

### 7.c Work and Social Adjustment Scale

If you're retired or choose not to have a job for reasons unrelated to your problem, tick here

	0	1	2	3	4	5	6	7	8
	Not at all		Slightly		Definitely		Markedly		Very severely
1	Because of my [problem] my <b>ability to work</b> is impaired. '0' means 'not at all impaired' and '8' means very severely impaired to the point I can't work.								<input type="text" value="0"/>
2	Because of my [problem] my <b>home management</b> (cleaning, tidying, shopping, cooking, looking after home or children, paying bills) is impaired.								<input type="text" value="0"/>
3	Because of my [problem] my <b>social leisure activities</b> (with other people e.g. parties, bars, clubs, outings, visits, dating, home entertaining) are impaired.								<input type="text" value="0"/>
4	Because of my [problem], my <b>private leisure activities</b> (done alone, such as reading, gardening, collecting, sewing, walking alone) are impaired.								<input type="text" value="0"/>
5	Because of my [problem], my ability to form and maintain <b>close relationships</b> with others, including those I live with, is impaired.								<input type="text" value="0"/>

## Appendices Study Five – Ethnic Terminology

### 10.a Study Poster

**What Term Do You Prefer To Use?**

**BAME vs Other Terminology**

**Do You Identify as being Black, Asian, Or From A Ethnic Minority Group?**

**QR Code: Scan Me!**

**Link to the study:**  
[https://blss.eu.qualtrics.com/jfe/form/SV\\_5AVUS8n4E5FYTdk](https://blss.eu.qualtrics.com/jfe/form/SV_5AVUS8n4E5FYTdk)

**Study Information**

A study exploring **Black, Asian, Minority Ethnic** groups preferred terminology that they would like to see being used in research.

The main goal is to help improve inclusivity and to give voices to individuals from ethnic minority groups.

**Eligibility Criteria**

- **18 years** or older
- Identify as **Black, Asian, Or From A Ethnic Minority Group**
- Understand English

**Interested in Participating?**

Scan the **QR code** or use the **link** to fill out the questionnaire  
If you have further questions please e-mail:  
**Paige.Clarke-Jeffers@mail.bcu.ac.uk**

**Study involvement**

Filling out a **5-8 minute** online **questionnaire** on you preferred terminology.

Ethical Approval Granted by Birmingham City University

## **10.b Demographic Questionnaire**

### **A Study Exploring What Terminology Ethnic Minorities Prefer To Use.**

*Participant Study Information (located here when participants open Qualtrics)*

*Consent form (located here when participants go to the next page after reading the participant study information) - (forced response, otherwise they cannot proceed but participants are made aware that participant is voluntary and do not have to start, proceed or finish the study but also the researcher will get oral consent at the start of the interview).*

<b>Participant Information</b> (please tick the box that most applies)
<p><b>3. What is your gender identity?</b></p> <ul style="list-style-type: none"><li>• Female</li><li>• Male</li><li>• Prefer not to say</li><li>• Non-binary</li><li>• Prefer to self-describe: _____</li></ul>
<p><b>38. What is your age (in years)?</b></p> <ul style="list-style-type: none"><li>• Please state: _____</li></ul>
<p><b>39. What is your Ethnic Group?</b> (Choose one option that best describes your ethnic group or background)</p> <ul style="list-style-type: none"><li>• <b>Asian/Asian British</b> <i>Click here to choose an item.</i> <i>If you have selected 'Other' (please describe) Click or tap here to enter text.</i></li><li>• <b>Black/ African/ Caribbean/ Black British</b> <i>Click here to choose an item</i> <i>If you have selected 'Other' (please describe) Click or tap here to enter text.</i></li><li>• <b>Mixed/ Multiple Ethic Group</b> <i>Click here to choose an item</i> <i>If you have selected 'Other' (please describe) Click or tap here to enter text</i></li><li>• <b>Other Ethnic Group</b> <i>Other (please describe) Click or tap here to enter text</i></li></ul>

<b>Terminology Questions</b>
<p>1) <b>Please rate from 1-5 (1= strongly dislike – 5=strongly like) your preference of each term, that you would like to see in research?</b></p> <ul style="list-style-type: none"> <li>• The term: <b>BAME (Black, Asian, Ethnic Minority)</b></li> <li>• 1. Strongly Dislike</li> <li>• 2. Dislike</li> <li>• 3. Neither Dislike nor Like</li> <li>• 4. Like</li> <li>• 5. Strongly Like</li> </ul>
<ul style="list-style-type: none"> <li>• The term: <b>Ethnic Minority</b></li> <li>• 1. Strongly Dislike</li> <li>• 2. Dislike</li> <li>• 3. Neither Dislike nor Like</li> <li>• 4. Like</li> <li>• 5. Strongly Like</li> </ul>
<ul style="list-style-type: none"> <li>• The term: <b>Marginalised Ethnic Group</b></li> <li>• 1. Strongly Dislike</li> <li>• 2. Dislike</li> <li>• 3. Neither Dislike nor Like</li> <li>• 4. Like</li> <li>• 5. Strongly Like</li> </ul>
<ul style="list-style-type: none"> <li>• The term: <b>Racially Minoritised</b></li> <li>• 1. Strongly Dislike</li> <li>• 2. Dislike</li> <li>• 3. Neither Dislike nor Like</li> <li>• 4. Like</li> <li>• 5. Strongly Like</li> </ul>
<ul style="list-style-type: none"> <li>• The term: <b>Marginalised Majority</b></li> <li>• 1. Strongly Dislike</li> <li>• 2. Dislike</li> <li>• 3. Neither Dislike nor Like</li> <li>• 4. Like</li> <li>• 5. Strongly Like</li> </ul>
<ul style="list-style-type: none"> <li>• The term: <b>Culturally and Ethnically Diverse</b></li> <li>• 1. Strongly Dislike</li> <li>• 2. Dislike</li> <li>• 3. Neither Dislike nor Like</li> <li>• 4. Like</li> <li>• 5. Strongly Like</li> </ul>

<ul style="list-style-type: none"><li>• <b>Are there any other terms you prefer, if so please state below:</b></li><li>• Free text box</li></ul>
<p><b>2) Feel free to write reasons for your choices e.g., the terminologies you really like against the terminologies you do not like?</b></p> <p>Free text box</p>
<b>Debrief From</b>

## **10.c Participant Information Sheet**

### **A Study Exploring What Terminology Ethnic Minorities Prefer To Use.**

#### **STUDY BACKGROUND**

You are being invited to take part in a research study exploring individuals who identify as an ethnic minority and what phrase they like to use. This study has been given approval by Birmingham City University Ethics Committee.

#### **WHAT WILL YOU NEED TO DO?**

In this study, you will be asked to take part in an online questionnaire on Qualtrics that you can complete in your own time that will explore what terminology you would prefer to be used within research.

#### **HOW LONG WILL THE STUDY LAST?**

On average, this study should take around 5-8mins to complete.

#### **What Is The Inclusion Criteria?**

- Be at 18 years or older.
- Able to read and understand English to take part in the questionnaire
- Identify as an ethnic minority, that can be defined as below:
  - Asian or Asian British
  - Indian
  - Pakistani
  - Bangladeshi
  - Chinese
  - Any other Asian background
  - Black, Black British, Caribbean or African
  - Caribbean
  - African
  - Any other Black, Black British, or Caribbean background
  - Mixed or multiple ethnic groups
  - White and Black Caribbean
  - White and Black African
  - White and Asian
  - Any other Mixed or multiple ethnic background
  - Other ethnic group
  - Arab
  - Any other ethnic group

#### **What Is The Exclusion Criteria?**

- Identify as White British, White Gypsy/Irish Traveller, White Irish, Other White.

#### **ARE THERE ANY RISKS OF TAKING PART?**

There is a minimal risk of taking part in this study. Due to the nature of the research, you may feel uncomfortable. At any time, you can choose to stop and not complete the rest of the questionnaire or resume when you feel more comfortable.

You will be provided with details of mental health support services and helplines at the end of this information sheet, so you are aware of the support available, should you require it.

### **ARE THERE ANY BENEFITS OF TAKING PART?**

Although there are no direct benefits from taking part, it is hoped that this research will allow a deeper understanding of what term do individuals from an ethnic minority background prefer to use.

### **YOUR RIGHT TO WITHDRAW AND WITHHOLD INFORMATION**

Participation in this study is entirely voluntary and there is no obligation to take part. In line with the regulations outlined by the British Psychological Society, you can stop being a part of the study at any time without explanation. You are still entitled to the same benefits as an individual who completes the study.

If after completing the study, you decide you would like to withdraw, please contact the researcher within *10 working days* from taking part in the study.

Please note, participants will not be able to withdraw their data after 10 working days after they have completed the questionnaire as the researcher will be using the data to analyse and to use in their publication.

### **YOUR RIGHT TO CONFIDENTIALITY/ANONYMITY**

The study will not involve the collection of any personal information about you except your age, gender and ethnicity. Any personal information given will be unidentifiable to an external party – Your data will be stored confidentially, using a personalised anonymous pseudonym.

Your data will be stored on a password-protected laptop, on a password-protected University OneDrive folder, which will only be accessible to those within the research team. All identifiable features will be removed prior to publication or presentation at conferences.

### **FURTHER GUIDANCE**

If you feel distressed as a result of taking part in this study you can ring the Samaritans who offer 24-hour emotional support for individuals experiencing distress. They can be called on **116 123** or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org).

Also, you can search for mental health services in your local area on the NHS site by providing your post code using the link below:

<https://www.nhs.uk/service-search/other-services/Mental-health-information-and-support/LocationSearch/330>

### **WHO IS ORGANISING THE RESEARCH?**

The study is part of the researchers PhD project.

Department of Psychology  
School of Social Sciences  
Birmingham City University  
The Curzon Building  
4 Cardigan Street  
Birmingham B4 7BD

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

**Lead Researcher:** Paige Clarke-Jeffers

**Contact:** [Paige Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

Please contact Paige Clarke-Jeffers if you require any further information or wish to withdraw. Remember, you will need to provide your pseudonym (that you created) if you would like to withdraw your data.

If you are unhappy at any point in the study, or if there is a problem, please contact the Business, Law & Social Sciences faculty ethics committee directly at [blssethics@bcu.ac.uk](mailto:blssethics@bcu.ac.uk)

## **10.d Consent Form**

### **A Study Exploring What Terminology Ethnic Minorities Prefer To Use.**

#### **BRIEF SUMMARY OF PROJECT**

You are being invited to take part in a research study exploring what terminology do you prefer to use for your ethnic identity. This study has been given approval by Birmingham City University Ethics Committee.

**In order to participate in this study, we need to ensure that you understand the nature of the research, as outlined on the Participant Information page.**

**Please tick the boxes to indicate that you understand and agree to the following conditions.**

- I confirm that I have read the participant information sheet for this study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- I understand that in order to take part in this study, I should be at least 18 years old.
- I understand that I need to be able to read English to answer the questions on the questionnaire.
- I understand that personal data about me will be collected for the purposes of the research study including gender, ethnicity, and age, and that these will be processed in accordance with the information sheet.
- I confirm that writing in the 'free text box' section of the questionnaire that the researcher may use direct quotes for publications, but personal data will remain confidential.
- I understand that my participation is voluntary and that I am free to withdraw up to 10 working days after finishing the questionnaire without giving any reason, without my legal rights being affected.
- I understand that my data is anonymous and will be stored on secure university servers.
- I understand that the study findings from this project will be presented at academic conferences and research articles, published in peer reviewed journals.
- I agree to take part in this study

**Participant Name (Pseudonym):** Click or tap here to enter text.

(Pseudonym - a code that will conceal your real name which can be used to identify your data if you wish to withdraw from the study within 10 days after completing the questionnaire): The pseudonym should be the first two initials of your first name and the last three digits of your mobile/home number eg.: Joe Bloggs 07123456789 will be Jo789.

Please keep a note of the name you have provided

**Date:** Click or tap here to enter text.

## **10.e Debrief Sheet**

### **A Study Exploring What Terminology Ethnic Minorities Prefer To Use.**

#### **SUMMARY OF PROJECT**

The aim of the research was to explore what terminology ethnic minorities would like to be used in research. There has been debates whether researchers should continue to use BAME (Black, Asian, Ethnic Minority) or different terminology such as Ethnic Minority, Ethnic Marginalised, Racially Minoritised (Aspinall, 2020, 2021; Bunglawala et al., 2019). Therefore, this research wanted to get an insight into what terminology should be used which will also help the main researcher (Paige Clarke-Jeffers) to justify the choice of terminology for her thesis.

#### **FURTHER GUIDANCE**

If you feel distressed as a result of taking part in this study, you can ring the Samaritans who offer 24-hour emotional support for individuals experiencing distress. They can be called on **116 123** or by e-mailing [jo@samaritans.org](mailto:jo@samaritans.org).

#### **YOUR RIGHT TO WITHDRAW AND WITHHOLD INFORMATION**

Participation in this study is entirely voluntary and there is no obligation to take part. In line with the regulations outlined by the British Psychological Society, you can stop being a part of the study at any time without explanation. You are still entitled to the same benefits as an individual who completes the study.

If after completing the study you decide you would like to withdraw, please e-mail the researcher (myself- Paige) and simply state 'Withdraw from study' along with the pseudonym that you created. You can withdraw up to 10 working days after you have completed the questionnaire.

#### **WHO IS ORGANISING THE RESEARCH?**

Department of Psychology  
School of Social Sciences  
Birmingham City University  
The Curzon Building  
4 Cardigan Street  
Birmingham B4 7BD

The primary research team are Paige Clarke-Jeffers, Dr Athfah Akhtar and Dr Panos Rentzelas, Dr Silvio Aldrovandi

Paige Clarke-Jeffers PhD Psychology student (Lead Researcher)  
[Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

#### **KEEPING IN TOUCH**

The findings from the study will be submitted as part of a PhD thesis and written up for publication. The following study may also be used to present at conferences and other journals.

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

Once the study has been completed in September 2024 you can request a copy of the findings by e-mailing the lead researcher using the contact details below.

### **ANY MORE QUESTIONS?**

We hope that you enjoyed participating in this study. If you have any further questions, please feel free to contact the researchers at the address below.

Paige Clarke-Jeffers PhD Psychology student (Lead Researcher)

[Paige.Clarke-Jeffers@mail.bcu.ac.uk](mailto:Paige.Clarke-Jeffers@mail.bcu.ac.uk)

If you are unhappy at any point in the study, or if there is a problem, please contact the Business, Law and Social Science Ethics Committee directly at [blssethics@bcu.ac.uk](mailto:blssethics@bcu.ac.uk)

### 10.f Content Analysis Coding Example

I think it can be **unfair** to put different cultures under one category for example BAME because of the **differences between them** both.

Everyone has an **ethnicity** but the term is applied to those who are not white. I particularly **dislike** the term BAME as again all this means is non white. I am black not non white.

I think my issue with the terms such as "ethnic minority" and "BAME" specifically is that it is mainly used by white people to **describe those that aren't of the majority in predominantly white countries**, but for example, white people in the African continent aren't referred to as ethnic minorities. The term BAME also I feel **doesn't make much sense**. If black and Asian are classed as ethnic minorities why then are they separate letters within the acronym. **Also** I feel the word black describes skin colour, not an ethnicity unlike Asian so again makes very little sense in the acronym. I strongly dislike the term race, there is only one race, **the human race**

BAME - I **really dislike** the idea of **white vs all other ethnicities**. That's not helpful from a **unity perspective** and it's **insulting** to the diversity within all the other categories **lumped together**. People are more than their skin colour.

Many of the other terms seem to portray being of a **non white** skin colour as a vulnerability which seems a very western way of looking at the world. I'd prefer something more respectful of cultural **differences**

A preference towards a neutral term rather than highlighting a **majority, minority, marginalisation** etc. such adjectives carry subjectivity that can impact emotion, self-esteem etc, which can be **damaging** in ways such as self-fulfilling prophecy of feeling less by those called a minority or racism and more. The use of neutral terms however **are** less harmful although a person is no representation of their background but of themselves so highlighting race does not have much use unless it's culture and folklore teachings and so on.

I'm a **black woman** so that is what I'd like to be referred as.

I **hate** the term BAME. Black, Asian and other races **shouldn't be jumbled up into one category** when white people don't have to be. I also hate the term "blacks" that's very racist!

BAME **isn't inclusive**

Not a fan of being called a **minority** as it sounds very **downgrading**

BAME- **really dislike** this term. black and Asian people **do not have the same experiences** so why would they be (shouldn't) **grouped together**.

BAME **sounds to much like LAME**; **hate it**. Can you tell lol

I'd prefer to be **categorised as one's ethnicity/race** instead of generalised as a **minority/marginalised beings**. It is **degrading** and **limits diverse ethnic groups as insignificant** or inhumane, that we are not.

I really **dislike BAME** but I'm aware that it is **used as a quick way of categorising, 'other' non caucasian individuals**.

**Really dislike** the terminology BAME **doesn't sound pleasing** towards the group of people

Having **BAME** indicates that we are all the same which we are not. Black and Asian people are **different** and there are still many differences within their own communities. **Putting us together** just shows that we all should just be **pushed aside**. It also **hides injustices**. We know that Black people are not offered as **much** opportunities, therefore BAME gives us false data on how well individual communities do in every aspect of society.

The BAME terminology does not account for the **unique experiences** black people have of racism

I do not have any specific ideas, but I do think **culturally and ethically diverse** is a more inclusive term. I **feel very uncomfortable** with the term BAME. For example, a Black Caribbean person has different culturally experiences to a Black African. Using BAME combines Blacks with Asians and other so-called minority groups. Arguably, a **minority group depends upon geographical location**

The use of **marginalised** automatically supports prejudice and strengthens bias

Why do we **actually need** a term to merge all black & brown communities? This then suggests that all black & brown people have the same needs, are similar- which we know is not the case

If there are equal or similar terminologies for the majority **groups** then I am happy for the terms to be used. I would prefer the approach is that we **ALL** have an ethnicity

I **dislike** the term Bame as it **segregates minorities from white people** I feel it creates racism with this **term** and it makes minorities **protrayed as unimportant** in society.

'Marginalised' feels slightly negative compared to 'minorities', possibly because of what we/I tend to hear more often is ethnic minorities etc

BAME is **frustrating** as many people pronounce it incorrectly and use it as an **umbrella term** to mask issues that are often specific to a particular skin colour e.g Black people. It was and is used by many companies and even the government when reporting on the % of BAME employees/ members of Parliament following Black Lives Matter, but it hid the fact that there were no or very little actual Black people, despite the **"bame"** % sounding impressive.

Prefer **not to group** all together? Can they not be **separate- experiences** of a black british person vs a mixed person vs a South Asian person **are** very different

I don't like ethnic minorities IF/when talking about racially minoritised people. Ethnic minorities **includes** all those minoritised by ethnicity (e.g. white gypsy/traveller). Whilst there are overlapping experiences, it should be clear in research the distinctions between ethnicity and race and the two **cannot be conflated**.

BAME is **reductive**.

Some are **reductionist**.

Some are designed by white people to **group non-whites together**

Majority of terms only link people together because they are not white. Relevant?

**These terminologies single people out** and cause separation . They **never represent positivity**.

BAME came about during Co Vid which again arises from negativity

The term ethnic minority needs to be supported by context. E.g. In the UK, an Arab can be considered a minority, but this inherently marginalises Arabs or any other ethnic group that is spoken of, because the UK isn't considered to be their natural place of belonging regardless of where they were born and/or raised in the UK. Calling anybody a minority diminishes a human's significance, anywhere.

Paige Clarke-Jeffers ... Differences between races and ethnicities – shouldn't group them

Paige Clarke-Jeffers ... Not being a majority in white countries

Paige Clarke-Jeffers ... Sense of othering

Paige Clarke-Jeffers ... Dislike of the 3 M's

Paige Clarke-Jeffers ... Stating their specific race and ethnicity

Paige Clarke-Jeffers ... Rhyming pattern of the word doesn't sound great 02 September 2022, 16:00

Paige Clarke-Jeffers ... Don't like the M's

Paige Clarke-Jeffers ... Know that people use it to quick summarise everyone who is not white

Paige Clarke-Jeffers ... Don't like the M's

Paige Clarke-Jeffers ... Stating all ethnicities

Paige Clarke-Jeffers ... Segregates – whites vs others

Paige Clarke-Jeffers ... Hiding true facts Grouping all EM but not knowing specific groups

Paige Clarke-Jeffers ... EM includes white gypsy etc to



## Supplementary Information Study Three – Effects of Autonomy And Ethnicity

### On Mental Health Outcomes

#### 6.a.1 SPSS Outputs

##### Descriptives

	Session	Treatment	GAD	PHQ	WSAS	SA_centre	SO_centre	CNS_centre
Valid	203	203	203	203	203	203	203	203
Missing	0	0	0	0	0	0	0	0
Mean	8.148	2.044	9.015	10.626	14.813	-0.027	0.035	0.134
Std. Deviation	5.030	1.306	5.653	6.355	9.478	4.999	9.676	4.769
Skewness	1.272	0.617	0.312	0.344	0.206	-0.052	-0.265	0.241
Std. Error of Skewness	0.171	0.171	0.171	0.171	0.171	0.171	0.171	0.171
Kurtosis	1.821	-1.440	-0.858	-0.541	-0.850	0.314	0.446	0.066
Std. Error of Kurtosis	0.340	0.340	0.340	0.340	0.340	0.340	0.340	0.340
Minimum	0.000	1.000	0.000	0.000	0.000	-14.515	-36.507	-10.575
Maximum	26.000	4.000	21.000	27.000	36.000	13.485	24.493	13.425
25th percentile	5.000	1.000	5.000	6.000	8.000	-3.515	-6.507	-3.575
50th percentile	7.000	1.000	8.000	10.000	14.000	-0.515	0.493	0.425
75th percentile	10.000	4.000	14.000	15.000	22.000	2.485	6.493	2.425

	Session		Treatment		GAD		PHQ		WSAS		SA_centre		SO_centre		CNS_centre	
	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Valid	84	119	84	119	84	119	84	119	84	119	84	119	84	119	84	119
Missing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mean	8.214	8.101	2.024	2.059	8.810	9.160	10.929	10.412	15.917	14.034	-0.265	0.140	-0.543	0.443	-0.575	0.635
Std. Deviation	4.960	5.100	1.280	1.330	5.859	5.523	7.088	5.804	10.277	8.832	5.262	4.821	9.575	9.766	5.001	4.553
Skewness	1.235	1.313	0.661	0.595	0.383	0.267	0.276	0.373	0.027	0.315	-0.355	0.242	0.442	-0.741	0.377	0.197
Std. Error of Skewness	0.263	0.222	0.263	0.222	0.263	0.222	0.263	0.222	0.263	0.222	0.263	0.222	0.263	0.222	0.263	0.222
Kurtosis	2.083	1.781	-1.350	-1.507	-0.727	-0.951	-0.718	-0.496	-1.108	-0.561	0.044	0.509	-0.203	1.127	0.062	0.218
Std. Error of Kurtosis	0.520	0.440	0.520	0.440	0.520	0.440	0.520	0.440	0.520	0.440	0.520	0.440	0.520	0.440	0.520	0.440
Minimum	1.000	0.000	1.000	1.000	0.000	0.000	0.000	0.000	0.000	0.000	-14.515	-11.515	-19.507	-36.507	-10.575	-9.575
Maximum	26.000	24.000	4.000	4.000	21.000	21.000	27.000	27.000	36.000	35.000	10.485	13.485	24.493	20.493	13.425	13.425
25th percentile	5.000	4.000	1.000	1.000	4.000	5.000	5.750	6.000	7.000	8.000	-3.515	-3.515	-7.757	-5.507	-3.575	-2.575
50th percentile	6.000	8.000	1.000	1.000	8.000	9.000	11.000	10.000	16.500	14.000	-0.515	-0.515	-1.507	1.493	-0.575	0.425
75th percentile	12.000	10.000	3.000	4.000	13.000	14.000	15.000	15.000	24.000	20.000	3.485	2.485	5.493	7.493	2.425	3.425

## Correlations

Pearson's Correlations

Variable		Ethnic	Session	Treatment	PHQ	GAD	WSAS	SA_centre	SO_centre	CNS_centre
1. Ethnic	Pearson's r	—								
	p-value	—								
2. Session	Pearson's r	-0.011	—							
	p-value	0.875	—							
3. Treatment	Pearson's r	0.013	0.042	—						
	p-value	0.851	0.552	—						
4. PHQ	Pearson's r	-0.040	0.061	0.038	—					
	p-value	0.570	0.389	0.587	—					
5. GAD	Pearson's r	0.031	0.095	0.107	0.826	—				
	p-value	0.665	0.178	0.128	< .001	—				
6. WSAS	Pearson's r	-0.098	0.081	0.117	0.615	0.539	—			
	p-value	0.164	0.250	0.096	< .001	< .001	—			
7. SA_centre	Pearson's r	0.040	-0.027	0.034	-0.359	-0.308	-0.268	—		
	p-value	0.571	0.705	0.632	< .001	< .001	< .001	—		
8. SO_centre	Pearson's r	0.050	0.126	0.069	0.183	0.276	0.150	-0.464	—	
	p-value	0.476	0.074	0.325	0.009	< .001	0.033	< .001	—	
9. CNS_centre	Pearson's r	0.125	-0.071	-0.025	-0.477	-0.429	-0.435	0.479	-0.437	—
	p-value	0.075	0.312	0.724	< .001	< .001	< .001	< .001	< .001	—

## Assumption checks

Shapiro-Wilk Test for Multivariate Normality

Shapiro-Wilk	p
0.962	< .001

Shapiro-Wilk Test for Bivariate Normality

		Shapiro-Wilk	p
Ethnic	- Session	0.929	< .001
Ethnic	- Treatment	0.866	< .001
Ethnic	- PHQ	0.971	< .001
Ethnic	- GAD	0.980	0.005
Ethnic	- WSAS	0.973	< .001
Ethnic	- SA_centre	0.990	0.189
Ethnic	- SO_centre	0.987	0.064
Ethnic	- CNS_centre	0.988	0.077
Session	- Treatment	0.906	< .001
Session	- PHQ	0.895	< .001
Session	- GAD	0.963	< .001
Session	- WSAS	0.944	< .001
Session	- SA_centre	0.908	< .001
Session	- SO_centre	0.928	< .001
Session	- CNS_centre	0.912	< .001
Treatment	- PHQ	0.977	0.002
Treatment	- GAD	0.984	0.021
Treatment	- WSAS	0.978	0.003
Treatment	- SA_centre	0.987	0.069
Treatment	- SO_centre	0.987	0.071
Treatment	- CNS_centre	0.983	0.017
PHQ	- GAD	0.991	0.215
PHQ	- WSAS	0.970	< .001
PHQ	- SA_centre	0.991	0.277
PHQ	- SO_centre	0.992	0.289
PHQ	- CNS_centre	0.989	0.116
GAD	- WSAS	0.981	0.008
GAD	- SA_centre	0.994	0.570
GAD	- SO_centre	0.992	0.324
GAD	- CNS_centre	0.992	0.366
WSAS	- SA_centre	0.995	0.764
WSAS	- SO_centre	0.991	0.278
WSAS	- CNS_centre	0.991	0.266
SA_centre	- SO_centre	0.989	0.115
SA_centre	- CNS_centre	0.990	0.164
SO_centre	- CNS_centre	0.989	0.110

Ordinal Regression Analysis

**PLUM - Ordinal Regression**

		Estimate	Std. Error	Wald	df	Sig.	95% Confidence Interval	
							Lower Bound	Upper Bound
Location	Ethnic	.191	.256	.555	1	.456	-.311	.693
	Session	.013	.025	.254	1	.614	-.036	.061
	Treatment	.085	.094	.808	1	.369	-.100	.270
	SA_centre	-.415	.101	16.716	1	.000	-.614	-.216
	SO_centre	-.098	.053	3.391	1	.066	-.201	.006
	CNS_centre	-.367	.103	12.741	1	.000	-.568	-.165
	SACentrebyEt	.214	.061	12.153	1	.000	.094	.335
	SOcentrebyEt	.048	.031	2.390	1	.122	-.013	.110
	CNScentrebyEt	.105	.063	2.767	1	.096	-.019	.229

**R-Square**

Nagelkerke .333

Location	Ethnic	.384	.255	2.261	1	.133	-.116	.883
	Session	.025	.025	1.006	1	.316	-.024	.074
	Treatment	.164	.095	3.008	1	.083	-.021	.350
	SA_centre	-.308	.100	9.476	1	.002	-.504	-.112
	SO_centre	-.046	.053	.771	1	.380	-.149	.057
	CNS_centre	-.305	.102	9.021	1	.003	-.504	-.106
	SACentrebyEt	.161	.061	6.985	1	.008	.042	.280
	SOcentrebyEt	.033	.031	1.156	1	.282	-.028	.095
	CNScentrebyEt	.092	.063	2.147	1	.143	-.031	.215

**R-Square**

Nagelkerke .281

Location	Ethnic	-.153	.253	.367	1	.545	-.648	.342
	Session	.025	.025	.977	1	.323	-.024	.073
	Treatment	.173	.095	3.341	1	.068	-.013	.359
	SA_centre	-.218	.099	4.834	1	.028	-.412	-.024
	SO_centre	-.083	.053	2.506	1	.113	-.187	.020
	CNS_centre	-.232	.101	5.319	1	.021	-.429	-.035
	SACentrebyEt	.106	.060	3.057	1	.080	-.013	.224
	SOcentrebyEt	.042	.031	1.813	1	.178	-.019	.103
	CNScentrebyEt	.048	.062	.598	1	.439	-.074	.170

**R-Square**

Nagelkerke .228

Linear Regression For WSAS

Discrepancy as in this analysis the data showed significant here compared to the ordinal regression that was non-significant.

Model		Unstandardized	Standard Error	Standardized*	t	p
	SO_centre	-0.219	0.119	-0.224	-1.844	0.067
	SA_centre * Ethnic (2)	0.638	0.292		2.185	0.030

Correlations

Ethnic			PHQ	SA_centre
CED	PHQ	Pearson Correlation	1	-.552**
		Sig. (2-tailed)		<.001
		N	84	84
	SA_centre	Pearson Correlation	-.552**	1
		Sig. (2-tailed)	<.001	
		N	84	84
White	PHQ	Pearson Correlation	1	-.178
		Sig. (2-tailed)		.053
		N	119	119
	SA_centre	Pearson Correlation	-.178	1
		Sig. (2-tailed)	.053	
		N	119	119

\*\* . Correlation is significant at the 0.01 level (2-tailed).

Ethnic			GAD	SA_centre
CED	GAD	Pearson Correlation	1	-.502**
		Sig. (2-tailed)		<.001
		N	84	84
	SA_centre	Pearson Correlation	-.502**	1
		Sig. (2-tailed)	<.001	
		N	84	84
White	GAD	Pearson Correlation	1	-.153
		Sig. (2-tailed)		.097
		N	119	119
	SA_centre	Pearson Correlation	-.153	1
		Sig. (2-tailed)	.097	
		N	119	119

\*\* . Correlation is significant at the 0.01 level (2-tailed).

## Supplementary Information Study Four – Exploring Ethnicity and Recovery

### Determinants in IAPT Mental Health Services'

#### 7.a.1 SPSS Outputs

##### Frequencies

			Statistics						
white vs Ethnic			white vs Ethnic	GAD_FirstScore	GAD_LastScore	PHQ9_FirstScore2	PHQ9_LastScore	WSAS FirstScore	WSAS LastScore
1	N	Valid	5880	5880	5880	5880	5880	5880	5880
		Missing	0	0	0	0	0	0	0
	Mean		1.00	15.09	8.38	16.67	9.36	21.19	13.97
	Median		1.00	16.00	7.00	17.00	8.00	21.00	12.00
	Std. Deviation		.000	4.105	5.823	5.384	6.724	9.590	10.478
	Std. Error of Skewness		.032	.032	.032	.032	.032	.032	.032
	Std. Error of Kurtosis		.064	.064	.064	.064	.064	.064	.064
	Minimum		1	1	0	0	0	0	0
	Maximum		1	21	21	27	27	40	40
	Percentiles	25	1.00	12.00	4.00	13.00	4.00	14.00	5.00
		50	1.00	16.00	7.00	17.00	8.00	21.00	12.00
		75	1.00	18.00	13.00	21.00	14.00	28.00	22.00
	Skewness			-.541	.564	-.373	.640	-.061	.540
	Kurtosis			-.339	-.766	-.338	-.476	-.750	-.749
	2	N	Valid	24485	24485	24485	24485	24485	24485
Missing			0	0	0	0	0	0	0
Mean		2.00	14.83	8.06	15.94	8.68	19.23	12.03	
Median		2.00	15.00	7.00	16.00	7.00	19.00	10.00	
Std. Deviation		.000	4.319	5.591	5.656	6.350	9.194	9.707	
Std. Error of Skewness		.016	.016	.016	.016	.016	.016	.016	
Std. Error of Kurtosis		.031	.031	.031	.031	.031	.031	.031	
Minimum		2	0	0	0	0	0	0	
Maximum		2	21	21	27	27	40	40	
Percentiles		25	2.00	12.00	4.00	12.00	4.00	12.00	4.00
		50	2.00	15.00	7.00	16.00	7.00	19.00	10.00
		75	2.00	18.00	12.00	20.00	13.00	26.00	18.00
Skewness			-.576	.651	-.303	.743	.047	.768	
Kurtosis			-.250	-.573	-.498	-.285	-.641	-.226	

# Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

## Independent T-test

		Levene's Test for Equality of Variances		t-test for Equality of Means							
		F	Sig.	t	df	Significance		Mean Difference	Std. Error Difference	95% Confidence Interval of the Difference	
						One-Sided p	Two-Sided p			Lower	Upper
GAD_FirstScore	Equal variances assumed	23.072	<.001	4.274	30363	<.001	<.001	.266	.062	.144	.387
	Equal variances not assumed			4.409	9263.037	<.001	<.001	.266	.060	.148	.384
GAD_LastScore	Equal variances assumed	38.285	<.001	3.886	30363	<.001	<.001	.318	.082	.158	.479
	Equal variances not assumed			3.790	8668.222	<.001	<.001	.318	.084	.154	.483
PHQ9_FirstScore2	Equal variances assumed	35.682	<.001	8.904	30363	<.001	<.001	.725	.081	.565	.884
	Equal variances not assumed			9.177	9251.779	<.001	<.001	.725	.079	.570	.879
PHQ9_LastScore	Equal variances assumed	52.434	<.001	7.279	30363	<.001	<.001	.679	.093	.496	.862
	Equal variances not assumed			7.028	8572.229	<.001	<.001	.679	.097	.490	.869
WSAS_FirstScore	Equal variances assumed	27.040	<.001	14.605	30363	<.001	<.001	1.967	.135	1.703	2.230
	Equal variances not assumed			14.232	8659.240	<.001	<.001	1.967	.138	1.696	2.237
WSAS_LastScore	Equal variances assumed	138.686	<.001	13.516	30363	<.001	<.001	1.936	.143	1.655	2.216
	Equal variances not assumed			12.898	8465.471	<.001	<.001	1.936	.150	1.641	2.230
Differences in GAD	Equal variances assumed	26.171	<.001	-.620	30363	.268	.535	-.052	.085	-.218	.113
	Equal variances not assumed			-.603	8646.590	.273	.546	-.052	.087	-.223	.118
Differences in WSAS	Equal variances assumed	116.634	<.001	.209	30363	.417	.835	.031	.149	-.260	.322
	Equal variances not assumed			.195	8284.339	.423	.845	.031	.159	-.281	.343
Differences in PHQ-9	Equal variances assumed	20.387	<.001	.481	30363	.315	.630	.046	.095	-.140	.231
	Equal variances not assumed			.469	8661.677	.319	.639	.046	.097	-.145	.236

## One-Way MANOVA

### Multivariate Tests<sup>a</sup>

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	.897	44004.674 <sup>b</sup>	6.000	30358.000	<.001	.897
	Wilks' Lambda	.103	44004.674 <sup>b</sup>	6.000	30358.000	<.001	.897
	Hotelling's Trace	8.697	44004.674 <sup>b</sup>	6.000	30358.000	<.001	.897
	Roy's Largest Root	8.697	44004.674 <sup>b</sup>	6.000	30358.000	<.001	.897
whitevsEthnic	Pillai's Trace	.011	54.800 <sup>b</sup>	6.000	30358.000	<.001	.011
	Wilks' Lambda	.989	54.800 <sup>b</sup>	6.000	30358.000	<.001	.011
	Hotelling's Trace	.011	54.800 <sup>b</sup>	6.000	30358.000	<.001	.011
	Roy's Largest Root	.011	54.800 <sup>b</sup>	6.000	30358.000	<.001	.011

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	GAD_FirstScore	334.411 <sup>a</sup>	1	334.411	18.270	<.001	.001
	GAD_LastScore	479.678 <sup>b</sup>	1	479.678	15.098	<.001	.000
	PHQ9_FirstScore2	2489.811 <sup>c</sup>	1	2489.811	79.281	<.001	.003
	PHQ9_LastScore	2186.709 <sup>d</sup>	1	2186.709	52.984	<.001	.002
	WSAS FirstScore	18336.127 <sup>e</sup>	1	18336.127	213.303	<.001	.007
	WSAS LastScore	17762.277 <sup>f</sup>	1	17762.277	182.677	<.001	.006
	Differences in GAD	13.066 <sup>g</sup>	1	13.066	.384	.535	.000
	Differences in PHQ-9	9.833 <sup>h</sup>	1	9.833	.232	.630	.000
	Differences in WSAS	4.561 <sup>i</sup>	1	4.561	.044	.835	.000
Intercept	GAD_FirstScore	4243968.008	1	4243968.008	231865.576	<.001	.884
	GAD_LastScore	1282171.981	1	1282171.981	40356.325	<.001	.571
	PHQ9_FirstScore2	5041519.966	1	5041519.966	160532.033	<.001	.841
	PHQ9_LastScore	1542388.568	1	1542388.568	37372.324	<.001	.552
	WSAS FirstScore	7745638.032	1	7745638.032	90104.553	<.001	.748
	WSAS LastScore	3204797.412	1	3204797.412	32959.946	<.001	.521
	Differences in GAD	860736.740	1	860736.740	25328.287	<.001	.455
	Differences in PHQ-9	1006818.697	1	1006818.697	23734.083	<.001	.439
	Differences in WSAS	985858.038	1	985858.038	9404.762	<.001	.236
whitevsEthnic	GAD_FirstScore	334.411	1	334.411	18.270	<.001	.001
	GAD_LastScore	479.678	1	479.678	15.098	<.001	.000
	PHQ9_FirstScore2	2489.811	1	2489.811	79.281	<.001	.003
	PHQ9_LastScore	2186.709	1	2186.709	52.984	<.001	.002
	WSAS FirstScore	18336.127	1	18336.127	213.303	<.001	.007
	WSAS LastScore	17762.277	1	17762.277	182.677	<.001	.006
	Differences in GAD	13.066	1	13.066	.384	.535	.000
	Differences in PHQ-9	9.833	1	9.833	.232	.630	.000
	Differences in WSAS	4.561	1	4.561	.044	.835	.000
Error	GAD_FirstScore	555751.322	30363	18.304			
	GAD_LastScore	964671.274	30363	31.771			
	PHQ9_FirstScore2	953552.183	30363	31.405			
	PHQ9_LastScore	1253107.627	30363	41.271			
	WSAS FirstScore	2610087.943	30363	85.963			
	WSAS LastScore	2952288.322	30363	97.233			
	Differences in GAD	1031832.496	30363	33.983			
	Differences in PHQ-9	1288022.619	30363	42.421			
	Differences in WSAS	3182813.835	30363	104.825			
Total	GAD_FirstScore	7277245.000	30365				
	GAD_LastScore	2969624.000	30365				
	PHQ9_FirstScore2	8809527.000	30365				
	PHQ9_LastScore	3612131.000	30365				
	WSAS FirstScore	14301323.000	30365				
	WSAS LastScore	7643711.000	30365				
	Differences in GAD	2416529.000	30365				
	Differences in PHQ-9	2893848.000	30365				
	Differences in WSAS	4757084.000	30365				
Corrected Total	GAD_FirstScore	556085.734	30364				
	GAD_LastScore	965150.952	30364				
	PHQ9_FirstScore2	956041.993	30364				
	PHQ9_LastScore	1255294.336	30364				
	WSAS FirstScore	2628424.069	30364				
	WSAS LastScore	2970050.599	30364				
	Differences in GAD	1031845.562	30364				
	Differences in PHQ-9	1288032.452	30364				
	Differences in WSAS	3182818.397	30364				

# Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

## Correlations

**Correlations**

		GAD_FirstScore	GAD_LastScore	PHQ9_FirstScore2	PHQ9_LastScore	WSAS FirstScore	WSAS LastScore
GAD_FirstScore	Pearson Correlation	1	.332**	.548**	.256**	.363**	.214**
	Sig. (2-tailed)		.000	.000	.000	.000	.000
	N	31083	31083	31083	31083	31083	31083
GAD_LastScore	Pearson Correlation	.332**	1	.322**	.865**	.254**	.693**
	Sig. (2-tailed)	.000		.000	.000	.000	.000
	N	31083	31083	31083	31083	31083	31083
PHQ9_FirstScore2	Pearson Correlation	.548**	.322**	1	.423**	.546**	.350**
	Sig. (2-tailed)	.000	.000		.000	.000	.000
	N	31083	31083	31083	31083	31083	31083
PHQ9_LastScore	Pearson Correlation	.256**	.865**	.423**	1	.319**	.739**
	Sig. (2-tailed)	.000	.000	.000		.000	.000
	N	31083	31083	31083	31083	31083	31083
WSAS FirstScore	Pearson Correlation	.363**	.254**	.546**	.319**	1	.435**
	Sig. (2-tailed)	.000	.000	.000	.000		.000
	N	31083	31083	31083	31083	31083	31083
WSAS LastScore	Pearson Correlation	.214**	.693**	.350**	.739**	.435**	1
	Sig. (2-tailed)	.000	.000	.000	.000	.000	
	N	31083	31083	31083	31083	31083	31083

\*\* . Correlation is significant at the 0.01 level (2-tailed).

## Frequencies

### Descriptive Statistics

	CED_DummyVEthnicity_1	
	0	1
Valid	5225	23568
Missing	0	0
Mean	1.000	0.000
Std. Deviation	0.000	0.000
Minimum	1.000	0.000
Maximum	1.000	0.000

### Descriptive Statistics

	Dummy_Black			
	Black	Asian	Mixed	white
Valid	979	3308	938	23568
Missing	0	0	0	0
Mean	1.000	0.000	0.000	0.000
Std. Deviation	0.000	0.000	0.000	0.000
Minimum	1.000	0.000	0.000	0.000
Maximum	1.000	0.000	0.000	0.000

### Descriptive Statistics

	dummy_GP		
	GP	Self	Rest
Valid	5700	20233	2860
Missing	0	0	0
Mean	1.000	0.000	0.000
Std. Deviation	0.000	0.000	0.000
Minimum	1.000	0.000	0.000
Maximum	1.000	0.000	0.000

Linear Mixed Model For Each Three Well-being Scales

**GAD Linear Mixed Models**

*ANOVA Summary*

Effect	df	F	p
Ethnic_binary	1, 0.85	0.127	0.790

**Model summary ▼**

*Fit statistics ▼*

Deviance (REML)	log Lik.	df	AIC	BIC
182942.386	-91471.193	15	182972.386	183096.404

*Fixed Effects Estimates*

Term	Estimate	SE	df	t	p
Intercept	6.626	0.439	2.292	15.107	0.002
Ethnic_binary (1)	-0.058	0.164	0.847	-0.357	0.790

**Random Effect Estimates**

*pathway\_three: Random Effect Estimates*

pathway_three	(Intercept)	Ethnic_binary1
GP	0.000	1.846×10 <sup>-8</sup>
Self	0.000	-7.824×10 <sup>-9</sup>
Rest	0.000	-1.064×10 <sup>-8</sup>

*religion\_binary: Random Effect Estimates*

religion_binary	(Intercept)	Ethnic_binary1
religious	0.242	-0.012
not religious	-0.242	0.012

**PHQ Linear Mixed Models ▼**

*ANOVA Summary*

Effect	df	F	p
Ethnic_binary	1, 0.91	0.138	0.778

**Model summary**

*Fit statistics*

Deviance (REML)	log Lik.	df	AIC	BIC
189468.415	-94734.207	15	189498.415	189622.433

*Fixed Effects Estimates*

Term	Estimate	SE	df	t	p
Intercept	7.266	0.485	2.017	14.990	0.004
Ethnic_binary (1)	-0.085	0.229	0.913	-0.371	0.778

**Random Effect Estimates**

*pathway\_three: Random Effect Estimates*

pathway_three	(Intercept)	Ethnic_binary1
GP	0.000	$3.475 \times 10^{-10}$
Self	0.000	$-4.218 \times 10^{-11}$
Rest	0.000	$-3.053 \times 10^{-10}$

*religion\_binary: Random Effect Estimates*

religion_binary	(Intercept)	Ethnic_binary1
religious	0.387	0.020
not religious	-0.387	-0.020

**WSAS Linear Mixed Models**

*ANOVA Summary*

Effect	df	F	p
Ethnic_binary	1, 1.35	0.118	0.777

**Model summary**

*Fit statistics*

Deviance (REML)	log Lik.	df	AIC	BIC
215510.835	-107755.417	15	215540.835	215664.853

*Fixed Effects Estimates*

Term	Estimate	SE	df	t	p
Intercept	7.564	0.692	1.272	10.935	0.033
Ethnic_binary (1)	-0.100	0.293	1.352	-0.343	0.777

**Random Effect Estimates**

*pathway\_three: Random Effect Estimates*

pathway_three	(Intercept)	Ethnic_binary1
GP	$3.844 \times 10^{-7}$	$-3.792 \times 10^{-7}$
Self	$-1.508 \times 10^{-6}$	$1.487 \times 10^{-6}$
Rest	$1.123 \times 10^{-6}$	$-1.108 \times 10^{-6}$

*religion\_binary: Random Effect Estimates*

religion_binary	(Intercept)	Ethnic_binary1
religious	0.225	0.011
not religious	-0.225	-0.011

Cross-tabulations

# Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

## GAD - Contingency Tables

Contingency Tables

ClinincaIAD7Caseness	Dummy_Black		Total
	0	1	
Recovered	16433	526	16959
Not Recovered	11381	453	11834
Total	27814	979	28793

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	11.196	1	< .001
N	28793		

Contingency Tables

ClinincaIAD7Caseness	Dummy_Mixed		Total
	0	3	
Recovered	16437	522	16959
Not Recovered	11418	416	11834
Total	27855	938	28793

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	4.229	1	0.040
N	28793		

Contingency Tables

ClinincaIAD7Caseness	Dummy_Asian		Total
	0	2	
Recovered	14995	1964	16959
Not Recovered	10490	1344	11834
Total	25485	3308	28793

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	0.343	1	0.558
N	28793		

Contingency Tables

ClinincaIAD7Caseness	dummy_GP		Total
	gp	0	
Recovered	3492	13467	16959
Not Recovered	2208	9626	11834
Total	5700	23093	28793

Note. Each cell displays the observed counts

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	16.399	1	< .001
N	28793		

Contingency Tables

ClinincaIAD7Caseness	Self_paths_2		Total
	0	1	
Recovered	4954	12005	16959
Not Recovered	3606	8228	11834
Total	8560	20233	28793

Note. Each cell displays the observed counts

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	5.296	1	0.021
N	28793		

# Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

Contingency Tables

ClinincaI GAD7 Caseness	dummy_other		Total
	Rest	0	
Recovered	1462	15497	16959
Not Recovered	1398	10436	11834
Total	2860	25933	28793

Note. Each cell displays the observed counts

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	79.414	1	< .001
N	28793		

Contingency Tables

ClinincaI GAD7 Caseness	religion_binary		Total
	religious	not religious	
Recovered	6351	10608	16959
Not Recovered	4227	7607	11834
Total	10578	18215	28793

Note. Each cell displays the observed counts

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	8.976	1	0.003
N	28793		

## PHQ - Contingency Tables

Contingency Tables

ClinincaI PHQ9 Caseness	Dummy_Black		Total
	0	1	
Recovered	17704	586	18290
Not Recovered	10110	393	10503
Total	27814	979	28793

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	5.876	1	0.015
N	28793		

Contingency Tables

ClinincaI PHQ9 Caseness	Dummy_Mixed		Total
	0	3	
Recovered	17746	544	18290
Not Recovered	10109	394	10503
Total	27855	938	28793

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	12.781	1	< .001
N	28793		

Contingency Tables

ClinincaI PHQ9 Caseness	Dummy_Asian		Total
	0	2	
Recovered	16277	2013	18290
Not Recovered	9208	1295	10503
Total	25485	3308	28793

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	11.498	1	< .001

Contingency Tables

ClinincaI PHQ9 Caseness	dummy_GP		Total
	self	gp	
Recovered	14579	3711	18290
Not Recovered	8514	1989	10503
Total	23093	5700	28793

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	7.685	1	0.006
N	28793		

Contingency Tables

ClinincaI PHQ9 Caseness	Self_paths_2		Total
	0	1	
Recovered	5296	12994	18290
Not Recovered	3264	7239	10503
Total	8560	20233	28793

Note. Each cell displays the observed counts

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	14.368	1	< .001
N	28793		

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

Contingency Tables

ClinincaI PHQ9 Caseness	dummy_other		Total
	self	Rest	
Recovered	16705	1585	18290
Not Recovered	9228	1275	10503
Total	25933	2860	28793

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	89.974	1	< .001
N	28793		

Contingency Tables

ClinincaI PHQ9 Caseness	religion_binary		Total
	religious	not religious	
Recovered	6856	11434	18290
Not Recovered	3722	6781	10503
Total	10578	18215	28793

Chi-Squared Tests

	Value	df	p
X <sup>2</sup>	12.034	1	< .001
N	28793		

### Logistic Regression

#### GAD Caseness - Logistic Regression

Model Summary - ClinincaI GAD7 Caseness

Model	Deviance	AIC	BIC	df	X <sup>2</sup>	p	McFadden R <sup>2</sup>	Nagelkerke R <sup>2</sup>	Tjur R <sup>2</sup>	Cox & Snell R <sup>2</sup>
H <sub>0</sub>	38998.472	39000.472	39008.740	28792						
H <sub>1</sub>	38884.250	38898.250	38956.126	28786	114.222	< .001	0.003	0.004	0.004	0.004

Coefficients

	Estimate	Standard Error	Standardized*	Odds Ratio	z	Wald Test			95% Confidence interval	
						Wald Statistic	df	p	Lower bound	Upper bound
(Intercept)	-0.457	0.024	-0.457	0.633	-18.880	356.459	1	< .001	-0.505	-0.410
Dummy_Black (1)	0.248	0.066	0.248	1.281	3.731	13.922	1	< .001	0.118	0.378
Dummy_Asian (2)	0.039	0.040	0.039	1.040	0.987	0.974	1	0.324	-0.039	0.118
Dummy_Mixed (3)	0.167	0.067	0.167	1.181	2.477	6.138	1	0.013	0.035	0.298
religion_binary (not religious)	0.096	0.026	0.096	1.101	3.640	13.251	1	< .001	0.045	0.148
dummy_GP (gp)	-0.083	0.031	-0.083	0.921	-2.679	7.178	1	0.007	-0.143	-0.022
dummy_other (Rest)	0.333	0.040	0.333	1.396	8.306	68.992	1	< .001	0.255	0.412

# Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

## PHQ Caseness - Logistic Regression

Model Summary - ClinincaIPHQ9Caseness

Model	Deviance	AIC	BIC	df	X <sup>2</sup>	p	McFadden R <sup>2</sup>	Nagelkerke R <sup>2</sup>	Tjur R <sup>2</sup>	Cox & Snell R <sup>2</sup>
H <sub>0</sub>	37783.143	37785.143	37793.411	28792						
H <sub>1</sub>	37631.059	37645.059	37702.934	28786	152.084	< .001	0.004	0.005	0.005	0.005

Coefficients

	Estimate	Standard Error	Standardized*	Odds Ratio	z	Wald Test			95% Confidence interval	
						Wald Statistic	df	p	Lower bound	Upper bound
(Intercept)	-0.718	0.025	-0.718	0.488	-28.732	825.531	1	< .001	-0.767	-0.669
Dummy_Black (1)	0.230	0.068	0.230	1.259	3.399	11.555	1	< .001	0.097	0.363
Dummy_Asian (2)	0.214	0.040	0.214	1.238	5.286	27.939	1	< .001	0.134	0.293
Dummy_Mixed (3)	0.287	0.068	0.287	1.333	4.240	17.981	1	< .001	0.155	0.420
religion_binary (not religious)	0.146	0.027	0.146	1.157	5.366	28.799	1	< .001	0.093	0.199
dummy_GP (gp)	-0.051	0.032	-0.051	0.950	-1.619	2.620	1	0.106	-0.113	0.011
dummy_other (Rest)	0.366	0.040	0.366	1.442	9.046	81.831	1	< .001	0.287	0.445

## Parallel Mediation Analysis

### Mediation Analysis

#### Parameter estimates

Direct effects

	Estimate	Std. Error	z-value	p	95% Confidence Interval	
					Lower	Upper
Ethnic_binary → WSASFirstScore	0.146	0.013	11.388	< .001	0.121	0.171

Note. Delta method standard errors, normal theory confidence intervals, ML estimator.

Indirect effects

	Estimate	Std. Error	z-value	p	95% Confidence Interval	
					Lower	Upper
Ethnic_binary → GAD_FirstScore → WSASFirstScore	0.008	0.002	5.299	< .001	0.005	0.011
Ethnic_binary → PHQ9_FirstScore2 → WSASFirstScore	0.063	0.007	8.506	< .001	0.049	0.078

Note. Delta method standard errors, normal theory confidence intervals, ML estimator.

Total effects

	Estimate	Std. Error	z-value	p	95% Confidence Interval	
					Lower	Upper
Ethnic_binary → WSASFirstScore	0.217	0.015	14.260	< .001	0.187	0.247

Note. Delta method standard errors, normal theory confidence intervals, ML estimator.

Total indirect effects

	Estimate	Std. Error	z-value	p	95% Confidence Interval	
					Lower	Upper
Ethnic_binary → WSASFirstScore	0.072	0.008	8.598	< .001	0.055	0.088

Note. Delta method standard errors, normal theory confidence intervals, ML estimator.

Residual covariances

	Estimate	Std. Error	z-value	p	95% Confidence Interval	
					Lower	Upper
GAD_FirstScore ↔ PHQ9_FirstScore2	0.543	0.007	81.129	< .001	0.530	0.556

Note. Delta method standard errors, normal theory confidence intervals, ML estimator.

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### Path coefficients

						95% Confidence Interval	
						Lower	Upper
			Estimate	Std. Error	z-value	p	
GAD_FirstScore	→	WSASFirstScore	0.095	0.006	16.223	< .001	0.084 0.107
PHQ9_FirstScore2	→	WSASFirstScore	0.485	0.006	82.555	< .001	0.474 0.497
Ethnic_binary	→	WSASFirstScore	0.146	0.013	11.388	< .001	0.121 0.171
Ethnic_binary	→	GAD_FirstScore	0.086	0.015	5.606	< .001	0.056 0.116
Ethnic_binary	→	PHQ9_FirstScore2	0.131	0.015	8.551	< .001	0.101 0.161

Note. Delta method standard errors, normal theory confidence intervals, ML estimator.

### R-Squared

	R <sup>2</sup>
WSASFirstScore	0.301
GAD_FirstScore	0.001
PHQ9_FirstScore2	0.003

## **Supplementary Information Study Five – Ethnic Terminology**

### **Exploring Perceptions of Ethnic Terms: A Mixed Methods Study**

#### **10.1. Chapter Overview**

This chapter critically examined the ongoing debate surrounding the use of the term 'Black Asian, Minority Ethnic' (BAME). The term is widely used across sectors such as healthcare, academia, and policy. However, its appropriateness and effectiveness have been questioned. The term BAME oversimplifies and disregards the unique cultural differences experienced by specific ethnic groups. A mixed-method study with 119 CED volunteered participants who stated their preference towards the six terms 'BAME, Racially Minoritised, Marginalised Ethnic Group, Marginalised Majority, Ethnic Minority and Culturally and Ethnically Diverse (CED)'. The findings aligned with existing literature that criticised the monolithic nature of the BAME acronym, which lumps all non-white individuals into a single category and dismisses distinct ethnic and cultural identities. The term CED was the most favourable terminology, as it encompassed a wide range of ethnic groups without minimising individual identities or contributing to feelings of being "othered." Although it was noted that, when possible, individuals would prefer to be identified by their ethnic group, for instance, Black or Asian.

#### **10.2. Introduction**

There is an ongoing research debate on whether the term Black Asian, Minority Ethnic (BAME) should be used (Aspinall, 2020; Harris et al., 2005). Race relations and ethnicity are salient within public health and research. In the United Kingdom (UK), BAME is a collective term used to identify anyone who is not white. The term BAME encompasses

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individuals who identify as Black, Asian or Mixed/Dual-Heritage. The term Black refers to individuals who share an African and/or Caribbean ancestry. Asian refers to South Asian, East Asian or Southeast Asian heritage. Mixed/Dual-Heritage refers to individuals who have two or more different racial heritages. The term BAME does not include white minority ethnic groups such as Gypsy, Roma and Irish (GOV.UK, 2022a).

The term BAME is frequently used within the healthcare sector, academia, and the workplace (Aspinall, 2021). Similarly, BAME is embedded in social, community and policy documents (GOV.UK, 2020). It has been argued that the term BAME is commonly used as an act of being 'politically correct and/or politically neutral' when wanting to collectively address racial identities, cultural beliefs and inequalities (Boakye, 2019; Treweek et al., 2020), although it ignores the nuances of an individual's identity. It has been argued that using the term BAME implies grouping all races and ethnicities into a single category, thus disregarding the variations of specific ethnic groups. Additionally, conflating various ethnicity groups reduces the different cultural upbringings, language and colourism and assumes that everyone who is non-white has the same lived experiences of racism, discrimination and oppression (Hylton, 2018). Therefore, categorising does not allow for intricacies between different ethnic groups to be explored in order to better support specific groups (Aspinall, 2021; Harrison et al., 2019; Milner & Jumbe, 2020). Indeed, the UK government has recognised that using the term BAME is unintentionally divisive (GOV.UK, 2022b). The Government advocated against using the term by June 2023 as a plan to develop reforms on how to responsibly report on race and ethnicity (GOV.UK, 2022c). The government have suggested using the collective term 'ethnic minorities' or 'people from ethnic minority background' (GOV.UK, 2021c).

The importance of understanding the nuances between different ethnicities and cultures has recently become prominent in the health sector. For example, Milner and Jumbe (2020) highlighted that in the height of the COVID-19 pandemic, the salience of using appropriate terms was important to understand what specific ethnic groups were more likely to be impacted by COVID-19 (Bosworth et al., 2023; Morales & Ali, 2021). Milner and Jumbe (2020) argued that the term BAME lacks specificity towards specific ethnicity groups and sub-groups, and the classification of BAME may lead to a lack of understanding about systemic issues experienced by CED individuals. For instance, research has highlighted the medical biases and discrimination that Black individuals specifically experience (Hall et al., 2015; Iacobucci, 2022; Obermeyer et al., 2019). For example, there are stereotypes held by some medical practitioners that Black individuals have a higher pain tolerance than other groups (Green et al., 2021; Hoffman et al., 2016). Similarly, Black individuals are more likely to receive a misdiagnosis or do not receive the appropriate psychological treatment compared to other ethnicity groups, for instance, individuals from an Asian background (Hankerson et al., 2015; Mann et al., 2014; Memon et al., 2016). Clustering ethnicity backgrounds in this manner might lead to 'averaging,' which results in squashing wider gaps when classifying under the BAME term.

Similarly, the term BAME is used within the academic sector, where there is generally a focus on separating white and BAME students when examining the attainment gap, for example, the likelihood of achieving and leaving university with a 2:1 or higher degree classification (Mercer-Mapstone et al., 2019; Williams, 2021). GOV.UK (2022b) found that undergraduate students achieving a first-class degree from a white background was 39.4% between the academic year 2020-2021, compared to 35% of Mixed individuals, 33.3% Asian individuals and the lowest of 20% from those from a Black background. Thus, the

breakdown allows for better clarity between ethnic groups (GOV.UK, 2022b), as grouping using BAME as one category has the potential to skew the results. Moreover, GOV.UK's (2021a) research on ethnic, socio-economic status (SES) and sex inequalities has shown variation in the outcomes for educational achievement at age 16. The main findings were that boys and girls (-0.77 SD and -0.54 SD respectively) who were both from a low SES background and who are Black Caribbean, and Mixed white and Black Caribbean, scored the lowest academic performance. In comparison, low SES Asian boys and girls (-0.11 SD and 0.17 SD respectively) achieved better academically than Black Caribbean, and Mixed white and Black Caribbean, which provides evidence for having an ethnicity (plus other demographic characteristics) split to see the contrast in achievement levels (GOV.UK, 2021d).

Furthermore, it is important to recognise individuals' unique experiences and identity. Encompassing self and identity are individuals' personality traits, beliefs, characteristics, and appearance (Bamberg, 2011). An individual can take pride in belonging to their ethnic background (e.g., Black, Asian or Mixed/Dual-Heritage). Therefore, stating an individual's specific ethnic background emphasises their self and identity rather than masking or clustering that takes away individuality. Additionally, Tajfel's (1974) Social Identity Theory postulates that being part of an ingroup can create a sense of belonging and boost an individual's self-esteem when being associated with that particular group. However, grouping Black, Asian or Mixed/Dual-Heritage individuals into a single term has the potential effect of minimising a specific group's identity. The term BAME assumes a homogenous identity which may reinforce a 'us' and 'them' dichotomy, further relegating ethnic minorities as a homogenous outgroup (Tajfel et al., 1979). Allocating to a single category, anyone who is non-white might feed into the sense of 'othering'. The sense of

'othering' further highlights the divide between the 'us' and 'them' dynamic that may perpetuate the reduction of a particular cultural group's values and ethnic identities (Aspinall et al., 2021).

This supplementary study intends to explore which term is preferred by individuals who identify as Black, Asian, and Dual/Mixed-Heritage. The terms chosen for examination are BAME, Racially Minoritised, Marginalised Ethnic Group, Marginalised Majority, Ethnic Minority and Culturally and Ethnically Diverse, which were terms used in previous research on ethnicity (Aspinall, 2020, 2021; Chauhan et al., 2020; Harrison et al., 2019; Milner & Jumbe, 2020). This study is one of the few scientific types of research in the UK that explores term preferences both quantitatively and qualitatively. Based on the literature findings, it is predicted that the term BAME will not be rated as the most favourable term chosen by Black, Asian and Dual/Mixed-Heritage individuals.

## 10.3 Method

### 10.3.1 Participants

A total of 119 participants took part in the study. A power analysis was calculated using G\*Power (Faul et al., 2007), to achieve power = .80 and given an anticipated small effect size to maximise the chance of observing an effect (if there is one) in the population (Cohen, 1992), the required sample size was 109. Eighty-seven participants identified as female, 31 identified as male and one identified as non-binary. Ethnicity was aggregated, for instance, Black African, Black Caribbean and Black Other were grouped as Black. The categories are as follows: 1) Asian (n = 26), 2) Black (n = 59), 3) Mixed/Dual-Heritage (n = 28) and 4) Other Ethnic (n = 6). The mean age was 31.1 (*SD* = 10.9), and the age range was 18 – 70.

The inclusion criteria for the study were that participants had to be 18 years old or older, they could read and understand English, and had to identify as an ethnic minority as defined in the following classification (GOV.UK, 2021e): Asian or Asian British, Indian, Pakistani, Bangladeshi, Chinese, Any other Asian background, Black, Black British, Caribbean or African, Caribbean, African, Any other Black, Black British, or Caribbean background, Mixed or multiple ethnic groups, white and Black Caribbean, white and Black African, white and Asian, Any other Mixed or multiple ethnic backgrounds, other ethnic group, Arab, Any other ethnic group. Individuals from white British, white Gypsy/Irish Traveller, white Irish, or other white ethnic backgrounds were unable to participate as the aim of the study was to identify preferences of people from Black, Asian and Mixed/Dual-Heritage backgrounds.

### *10.3.2 Design and Materials*

A cross-sectional design was used to measure the preference towards one of the six terms used to collectively delineate ethnicity, which were the term BAME (Black, Asian, Minority Ethnic), Ethnic Minority, Marginalised Ethnic Group, Racially Minoritised, Marginalised Majority and Culturally and Ethnically Diverse. The six terms were chosen as they were used in previous research when discussing ethnicity (Aspinall, 2020, 2021; Chauhan et al., 2020; Harrison et al., 2019; Milner & Jumbe, 2020). There were eight questions in total; the first six questions participants were asked to rate on a Likert scale ranging from 1 = Strongly Dislike to 5 = Strongly Like, their preference for each of the six above-listed terms. Then, for the other two questions, participants had the chance to provide written responses. The first question was for participants to state if there was any other term they would prefer. The second question was to write reasons why they liked a particular term over another term.

### *10.3.3 Ethics and Procedure*

Ethical approval was granted by Birmingham University, BLSS Ethics Committee (approval reference: Clarke-Jeffers /#10519 /sub2 /R(A) /2022 /May /BLSS FAEC), and the study was OSF pre-registered (<https://osf.io/eig7z>). The study was promoted on social media (*See*, Appendix 10.a) with a link to the Qualtrics® questionnaire (*See*, Appendix 10.b). Participants read through the information sheet (*See*, Appendix 10.c), signed the consent form (*See*, Appendix 10.d), where participants created their unique pseudonym code for anonymity and confidentiality. Upon completion, participants had access to the debrief form (*See*, Appendix 10.e).

### *10.3.4 Data Analysis*

A one-way repeated measures ANOVA was conducted to determine the preference for the six terms. Content Analysis (Stemler, 2000) was used to summarise participants' quotes (n = 82) as to reasons why they selected their chosen term as their preference. Step one involved the researcher familiarising themselves with the data by reading and re-reading all the quotes. In step two, the units of meaning were deductively coded as the researcher observed the frequency of specific words or phrases across the 82 quotes, which was carried out by highlighting and making comments across the dataset before summing the frequency (*See*, Appendix 10.f). In step three, the researcher revised steps one and two to ensure they had covered all the coding and evaluated the language in the quotes. Step four entailed finishing the coding to draw conclusions from the data. The researcher created a table (*See*, Table 10.2) to visually analyse the patterns to reach a conclusion of the manifested content, making the meaning of the quotes clear at a surface level. This helped

identify overarching themes related to the research question: 'What are participants' thoughts on the use of using the term BAME versus other terms?'

## 10.4 Results

A one-way repeated measures ANOVA was conducted to determine the preference for the term and its six independent levels (BAME, EM, MEG, RM, MM and CED). As per pre-registration, follow-up paired *t*-tests with Bonferroni adjustment were run to further inspect the significant main effect of the term. The term Culturally and Ethnically Diverse presented the highest preference scores; mean (3.47), median (4), standard deviation (1.12), Skewness (-.65) and Kurtosis (-.20).

Assumptions of normality and homogeneity of variance were met. The one-way within-subjects ANOVA showed a significant main effect of the preferred term category to use,  $F(3.68, 433.77) = 34.36, p < .001, \eta^2p = .225$ , a large effect size. Thus, showing that from the term category, 'Culturally and Ethnically Diverse' was the preferred term.

Table 10.1 below outlines the outcomes of the follow-up paired-samples *t*-tests. The results support the hypothesis that 'BAME' would be rated as one of the least favourable terms, compared to the other suggested terms. The results show that the terms 'Culturally and Ethnically Diverse' or 'Ethnic Minority' were the most favourably rated.

**Table 10.1**

*Pairwise Comparisons of the Term Category*

Pairwise Term Comparisons	Mean	Std. Deviation	95% CI		<i>t</i>	<i>df</i>	<i>d</i>	Sig. <sup>a</sup>	
			Lower	Upper					
CED	BAME	1.08	1.39	.83	1.34	8.49	118	0.94	<.001
	EM	.70	1.27	.47	.93	5.98	118	0.63	<.001
	MEG	1.15	1.24	.93	1.38	10.13	118	1.07	<.001
	RM	1.37	1.46	1.11	1.64	10.23	118	1.25	<.001
	MM	1.23	1.31	.99	1.47	10.21	118	1.15	<.001
EM	BAME	.39	1.26	.16	.62	3.36	118	0.33	.001
	MEG	.45	1.29	.22	.69	3.83	118	0.42	<.001
	RM	.67	1.39	.42	.93	5.27	118	0.61	<.001
	MM	.53	1.39	.28	.78	4.16	118	0.50	<.001
BAME	MEG	.07	1.50	-.21	.34	.49	118	0.06	.626
	RM	.27	1.65	-.01	.59	1.89	118	0.26	.062
	MM	.14	1.59	-.15	.43	.98	119	.14	.328

<sup>a</sup>Adjustment for multiple comparisons: Bonferroni (*p.* two-tailed, .05 / 15 = .003)

*Note.* CED = Culturally and Ethnically Diverse, BAME = Black, Asian, Minority Ethnic, EM= Ethnic Minority, MEG = Marginalised Ethnic Group, RM = Racially Minoritised, MM = Marginalised Majority

The questionnaire utilised two free-text options. For the first question, 38 (32%) participants responded. Out of the total sample (*N* =119), 21 participants (18%) stated they wanted to be identified by their specific ethnic group, such as Black or Asian. Six participants (5%) stated they preferred Person of Colour<sup>15</sup>, five (4%) for CED, four (3%) for Global Majority and two (2%) for RM.

For the second question, 82 (69%) participants out of 119 answered what terms they did and did not prefer, with the reasons why. The researcher undertook the approach of content analysis and coded all participants' comments, which resulted in three themes (See, Table 10.2).

<sup>15</sup> Participants who stated 'POC' as their preferred term did not discuss their reasons thus, this was not elaborated on in theme three.

**Table 10.2**

Content Analysis Themes and Codes

Theme	Codes
Theme One: Categorisation Is the Issue	Unfair, Differences between cultures, Non-white, Dislike BAME, Insulting, Lumped together, One category, Hate, Other, Pushed aside, Uniqueness not considered, Merging, Unimportant, Frustrating, Outsider, Lazy
Theme Two: Negative Adjectives	Self-fulfilling prophecy, Less than, No representation, Subjective, Downgrading, Minority, Uncomfortable, white superiority, Prejudice, Bias, Inaccurate, Harmful, Damaging
Theme Three: Positive Term Attitudes	Does what it says on the label, Can successfully group, Easy, Inclusive, Simple, Include all, Understandable, Like the term, Specific, Not complicated, Pleasant, Constructive

**Note.** Some participants had multiple views, so were categorised and counted in more than one theme. Other participants' quotes were miscellaneous and did not fit into a theme; thus, were removed.

### **10.4.1 Theme 1: Categorisation Is The Issue**

There were 34 out of 82 participants (41%) who conveyed their dislike towards the acronym BAME. Individuals stated that the term is “*unfair*” to use as it puts every ethnic background (Black, Asian, Mixed/Dual-Heritage) into “*one category*.” The acronym is covertly saying everyone who is “non-white” goes into one category, which can make the CED groups feel “*unimportant in society*,” hence can “*create a divide between us and white people and emphasises we are not equal*.”

Twenty-nine participants explicitly spoke about the categorisation of the term BAME and the problematic consequences of using it:

“*I think it categorises and segregates unnecessarily.*” (E1763, 34 years old, Mixed/  
Multiple Ethnic Group - white and Asian, female)

*“BAME tends to box people into a group they don't identify with and sometimes leaves out other ethnic minority groups who may not be well reflected in research. (ME278, 30 years old, Other Ethnic Group - Iranian, male)*

In addition, participants went on to further explain how categorising is harmful:

*“I do not like the term BAME, it categorises such a large proportion of individuals. Realistically within BAME, there are many races which will all experience varying types of racism and injustice. So, combine all of this into the same category seems unreasonable.” (P2, 25 years old, Black/Black British - Caribbean, female)*

Participants also spoke about the acronym BAME within the industry and workplace setting, which can mask the representation of other ethnic groups.

*“It also hides injustices. We know that Black people are not offered as much opportunities, therefore BAME gives us false data on how well individual communities do in every aspect of society.” (Re918, 21 years old, Black/Black British – Other, female)*

Participants emphasised that some work settings do not explicitly showcase the ethnic breakdown of who is being employed in their company, which is harmful, as the surface-level data would appear that diversity and representation are high, although it might favour a particular ethnic group. Furthermore, the negative connotations towards the term BAME were frequently conveyed by participants. There were 13 participants who denoted that they would prefer if their specific ethnicity were used instead:

*“Just address each person with their ethnicity [...] rather than grouping all of us as a whole (e.g. BAME), it would also increase feelings of individualism/uniqueness/representation.” (Vi438, 26 years old, Asian/Asian British – Chinese, female)*

*“Black - it is nice to just be referred to as what you are without any reference to being marginalised or a minority.” (T1846, 24 years old, Black/Black British – Caribbean, male)*

*“I think Dual Heritage for me is the best way I’d like people to describe me because I feel that it is simple and a direct description of my ethnicity.” (Ty986, 21 years old, Mixed/Multiple Ethnic Group - White and Asian, male)*

Furthermore, participants expressed that the sound of BAME is not appealing:

*“BAME sounds too much like LAME; hate it.” (STC378, 36 years old, Black/Black British - Caribbean, female)*

*“Really dislike the terminology BAME doesn’t sound pleasing towards the group of people.” (Ch473, 28 years old, Black/Black British – Caribbean, female)*

Overall, there was a consensus of the dislike towards the term BAME, with participants denoting that the acronym inaccurately groups individuals’ ethnicity and sounds distasteful.

#### **10.4.2 Theme 2: Negative Adjectives**

There were 27 out of 82 (33%) participants who expressed dislike towards the terms Ethnic Minority, Marginalised Ethnic Group, Racially Minoritised and Marginalised Majority, but more specifically, it was the adjectives that they all uphold. The adjectives carried a negative undertone that implied a reduction to one’s ethnicity group and identity:

*“Minority can be a dangerously used term in terms of rhetoric that implies these groups are ‘less than’.” (Wa568, 24 years old, Black/Black British – Caribbean, male)*

*“The words 'racialised', 'marginalised', or 'racially minoritised' to me have a connotation that as a group we are those things, as if diminishing the value of our ethnicity, rather than feeling accepted into society.” (Vi438, 26 years old, Asian/Asian British – Chinese, female)*

Furthermore, feeling a part of “society” and being equal in “society” was emphasised. For participants, the adjectives Marginalised, Minoritised and Minority, seemed to create a hierarchy, where Black, Asian, and Mixed/Dual-Heritage individuals who are categorised under these terms felt as though they were considered of a lower status compared to white individuals:

*“Marginalised feels like once again there are white people, and everybody else would be considered marginalised. I feel this terminology gives white people a more superior complex.” (Ka294, 41 years old, Black/Black British – Caribbean, female)*

*“Minority almost feels like we are a part of an inferior group compared to majority which sounds more superior.” (AD770, 21 years, Mixed/ Multiple Ethnic Group - Other, female)*

*“Often, these terms are used inaccurately because it serves the purpose of furthering the white narrative that white people are the global majority or the master race when they are statistically and scientifically not.” (Qo251, 25 years old, Black/Black British – Other, female)*

Participants conveyed the negative implications of these terms and “such adjectives carry subjectivity that can impact emotion, self-esteem, etc., which can be damaging in ways

*such as self-fulfilling prophecy.*” The consensus from this theme was that the three M’s (Marginalised, Minoritised and Minority) were a distasteful term, and it did not empower Black, Asian, and Mixed/Dual-Heritage individuals. The 27 participants felt that using one of the three M’s is not progressive.

### **10.4.3 Theme 3: Positive Terminology Attitudes**

There were 16 out of 82 (20%) participants who showed agreeable preferences towards one of the six terms used in the study. Three participants liked the term Ethnic Minority due to it being easy to understand who the term was referring to, and it being a well-known term that they and others around them have constantly used:

*“I think the most understandable and least complicated term is ethnic minority, and probably the one I prefer the most.”* (So804, 25 years old, Asian/Asian British - Pakistani, female)

*“Ethnic minority is what I’m use to and is acknowledged globally and is what many are already familiar.”* (Ja517, 34 years old, Black/Black British - Caribbean, male)

*“Ethnic minority is nice and simple and grammatically accurate - most people (I know) aren’t offended by it, and it means what it says on the tin.”* (Ra286, 36 years old, Asian/Asian British – Indian, male)

In opposition, four participants preferred the term BAME as they felt that the acronym did include all ethnicity groups:

*“I like the use of the word BAME because I feel it encompasses a large proportion of ethnic people.”* (AK389, 23 years old, Asian/Asian British - Pakistani, female)

*“BAME I think is more respectful and allows white people to refer to us better than ‘coloured people’.” (OL820, 25 years old, Black/Black British - Caribbean, female)*

Then there were five participants who picked Culturally and Ethnically Diverse as a favourable term choice, as they felt that the term was inclusive and encompassed a variety of ethnic groups without excluding a specific group:

*“I like culturally and ethnically diverse due to positive connotation that the word diversity has.” (As761, 24 years old, Black/Black British - Caribbean, male)*

*“Culturally and ethnically diverse is palatable and is good in acknowledging the range of diverse groups.” (Wa568, 24 years old, Black/Black British – Caribbean, male)*

This theme highlighted that there were different groups of individuals who had a positive attitude towards some of the terms within the study. Participants had different views, depending on their chosen preferred term, which ranged from the term being easily applicable to incorporating all ethnic groups. Three participants stated no preference, but they had positive attitudes towards the terms mentioned above.

## **10.5 Discussion**

The present study explored Black, Asian, and Mixed/Dual-Heritage groups’ preference for the term BAME in relation to other collective terms. The results showed that the terms CED and EM were preferred to BAME. Additionally, this outcome was further supported in the content analysis, whereby the majority of participants stated their dislike towards BAME and terms that contained the adjectives ‘minority’ or ‘marginalised’.

Participants preferred the CED term but were in favour of their exact ethnicity being stated when possible.

The results are in line with previous literature that found that the acronym BAME is monolithic in nature, as it groups everyone who is non-white into one category. Dismissing one's ethnicity and cultural experiences can minimise one's identity, which can heighten the feeling of being '*othered*' (Tajfel et al., 1979). Furthermore, the sense of Black, Asian, and Mixed/Dual-Heritage individuals feeling '*othered*' is driven by the imbalance of power dynamics that being white is the privileged identity and normative standard in society (Aspinall, 2021), thus reducing the identities and self-worth of everyone who is not white. Moreover, in line with current literature, this study found that participants did not like that the term BAME is '*homogenising*' everyone who is not white '*disregards their own ethnic identity*'. Some participants explicitly indicated that they would want their ethnic group to be specifically stated, to further not reduce one's identity.

In addition, the content analysis data revealed that the terms that used the adjectives '*minority*', '*marginalised*' and '*minoritised*' were viewed to be problematic for similar reasons when participants discussed the dislike towards the term BAME. However, instead of the focus being on the inadequacy of grouping all ethnic groups together, there was an emphasis on the power relations and negative connotations that the three Ms (Marginalised, Minoritised and Minority) implied. Participants described that using one of the three M's conveyed a message of being less than and lower ranked compared to white individuals (Selvarajah et al., 2020). Participants indicated that the three M's depicted that Black, Asian, and Mixed/Dual-Heritage individuals are continuously being overlooked and degraded in society. Simultaneously, feeling less than others created a self-fulfilling prophecy for some Black, Asian, and Mixed/Dual-Heritage participants, which served as a

constant reminder that they are not viewed as equal in society (Merton, 1948).

Consequently, using terms that incorporate one of the three M's in this study was shown to be negative and counterproductive for Black, Asian, and Mixed/Dual-Heritage individuals.

Both quantitative and content analysis data showed that the five terms, 'BAME, EM, MEG, RMM MM', were less favourable than the term Culturally and Ethnically Diverse. Specifically, the content analysis depicted that the majority of participants felt the five terms (of which contained one of the three M's) minimised one's identity and created an ethnic power imbalance. Instead, researchers need to understand the implications that certain words/terms have on specific groups; thus, researchers need to break out the normative guidelines and represent individuals from different racial backgrounds that are often referred to as '*hard to reach*' (Bunten et al., 2020; Lamb et al., 2012). Thus, from this study, in both the quantitative and content analysis, the term 'CED' was voted most positively, with participants further expressing that the term encompassed a range of ethnicity groups without minimising or making certain groups feel othered.

Overall, the study findings have shown the implications of the term BAME clustering different racial groups, resulting in a loss of ethnic identity and the term not being clear about the distinct variations of the unique lived experiences between each cultural group (Aspinall, 2021; Hylton, 2018). Instead, this study found that CED was favoured, and the term circumvented some of the limitations inherent to the other terms in this study.

### **10.5.1 Implications and Limitations**

The findings suggest that changing the terminology used within clinical, research and education fields can increase staff/researchers' knowledge and sensitively promote inclusivity and accessibility in their work or research. When a collective term is required, Culturally and Ethnically Diverse should be considered rather than terms that contain one of

the three 'M' adjectives. However, staff/researchers should also understand that they should label individuals as Black, Asian, and Dual/Mixed Heritage to empower their voices and not group their experiences as being the same (Islam et al., 2021).

A limitation of the study was the recruitment strategy. The researcher promoted it on their academic social media page; thus, the individuals who may have participated in the study could have been from an academic field, whereby they were familiar with the research surrounding the negativity of the term BAME, which could have influenced their choices. Another limitation was the simplicity of the questions elicited in the quantitative data. Rather than asking participants to rate their preferences for the terms, an experimental design could have been implemented. Participants could have been assigned vignettes with the different terms to explore the impact on more complex psychological constructs such as self-esteem, empowerment, and social integration.

### **10.5.2 Future Research and Recommendations**

Future research should consider using different recruitment techniques, such as physical posters in universities, waiting rooms in various health settings and general workplace settings to target a varied demographic and to recruit more people. Broadening the pool of participants across the UK would help strengthen the rationale to avoid using the term BAME. Additionally, a different recruitment method would gather more opinions on other terms that could be used, and to observe if Culturally and Ethnically Diverse remains the preferred term.

Furthermore, future research should consider adding the term 'Global Majority' for participants to rank. The term Global Majority should have been included in hindsight. Due to the lack of familiarity with the term and it not being evident in previous research, the term was not originally picked when the study was being designed. The term should have

been added, especially as Black, Asian, and Mixed/Dual-Heritage individuals are the world's majority population. Thus, observing the significance of the term Global Majority and whether it is a preferred term to further aid researchers in choosing positive and productive language that represents Black, Asian, and Mixed/Dual-Heritage individuals. Making simple changes may allow Black, Asian, and Mixed/Dual-Heritage groups to feel included and heard, especially in research.

## **10.6 Conclusion**

The study aimed to explore whether the term BAME should be used and what other term was preferred. The term Culturally and Ethnically Diverse was voted more favourably by participants, with the extension of participants stating they would also like to be referred to by their specific ethnic background. By conducting this study, the researcher has provided some clarity, supported with descriptive and inferential statistics and participants' opinions, of what terms researchers should be using. Researchers need to be culturally sensitive and constantly reflect on their work and how it is represented. Therefore, the academic/research sector should be one of the first to make a transformation when reporting data to be inclusive in their language.

## **10.7 Chapter Summary**

The study underscores the implications of using the homogenising term BAME, which can reinforce the societal power dynamics. Where whiteness is positioned as the normative standard, as well as obscuring the unique experiences and identities of different racial groups. The findings show that Culturally and Ethnically Diverse was the preferred term to capture individuals who identify as Black, Asian, and Mixed/Dual-Heritage. Thus, suggesting that the term CED is more inclusive as it avoids some of the negative

connotations associated with other terms (BAME, Racially Minoritised, Marginalised Ethnic Group, Marginalised Majority, Ethnic Minority) examined in this research. The chapter concludes by emphasising not only to researchers but across the various sectors (healthcare, academia, and policy) the need for all to critically consider the language used to accurately represent ethnic identity in public discourse.

## Supplementary Information Study Five – Ethnic Terminology

### 10.a.1 SPSS Outputs

#### Frequencies

		<b>Statistics</b>					
		BAME	Ethnic_Minority	Marginalised_Ethnic_Group	Racially_Minoritised	Marginalised_Majority	Culturally_ethnically_diverse
N	Valid	119	119	119	119	119	119
	Missing	1	1	1	1	1	1
Mean		2.39	2.77	2.32	2.10	2.24	3.47
Median		2.00	3.00	2.00	2.00	2.00	4.00
Std. Deviation		1.180	1.085	1.025	1.077	1.017	1.119
Skewness		.340	.060	.380	.708	.428	-.646
Std. Error of Skewness		.222	.222	.222	.222	.222	.222
Kurtosis		-.960	-.671	-.761	-.262	-.486	-.200
Std. Error of Kurtosis		.440	.440	.440	.440	.440	.440

#### Frequency Table

##### **BAME**

	N	%
Strong Dislike	36	30.0%
Dislike	29	24.2%
Neither Dislike nor Like	30	25.0%
Like	20	16.7%
Strongly Like	4	3.3%
Missing System	1	0.8%

##### **Ethnic\_Minority**

	N	%
Strongly Dislike	16	13.3%
Dislike	32	26.7%
Neither Dislike nor Like	40	33.3%
Like	25	20.8%
Strongly Like	6	5.0%
Missing System	1	0.8%

# Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

**Marginalised\_Ethnic\_Group**

	N	%
Strongly Dislike	28	23.3%
Dislike	45	37.5%
Neither Dislike nor Like	27	22.5%
Like	18	15.0%
Strongly Like	1	0.8%
Missing System	1	0.8%

**Racially\_Minoritised**

	N	%
Strongly Dislike	44	36.7%
Dislike	35	29.2%
Neither Dislike nor Like	27	22.5%
Like	10	8.3%
Strongly Like	3	2.5%
Missing System	1	0.8%

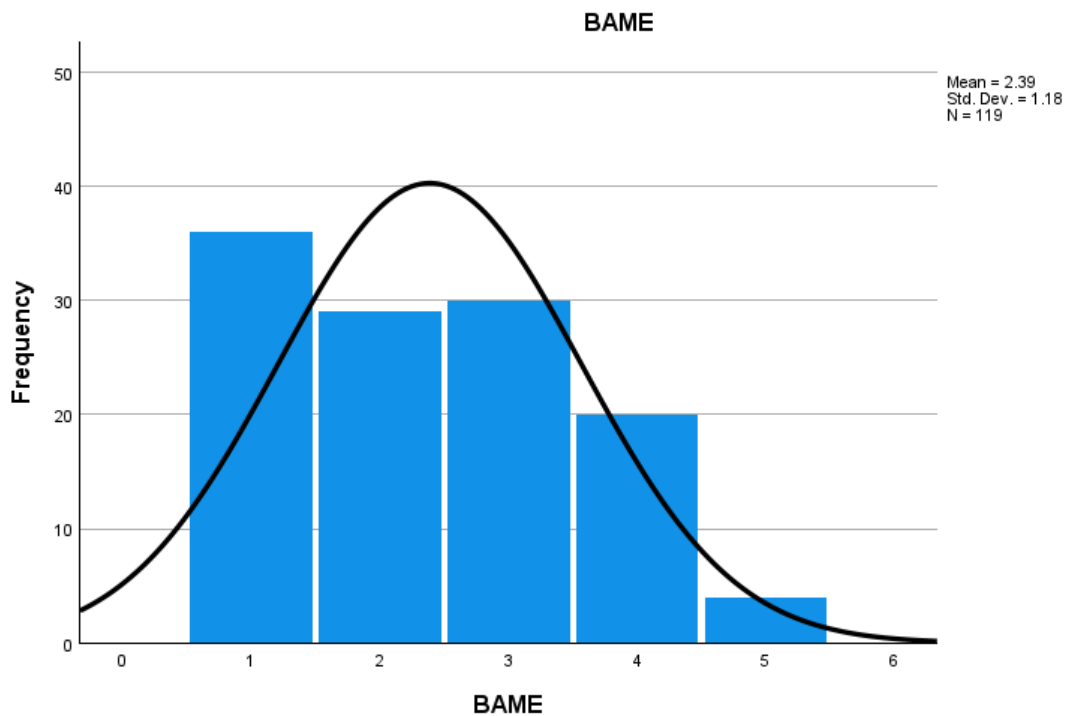
**Marginalised\_Majority**

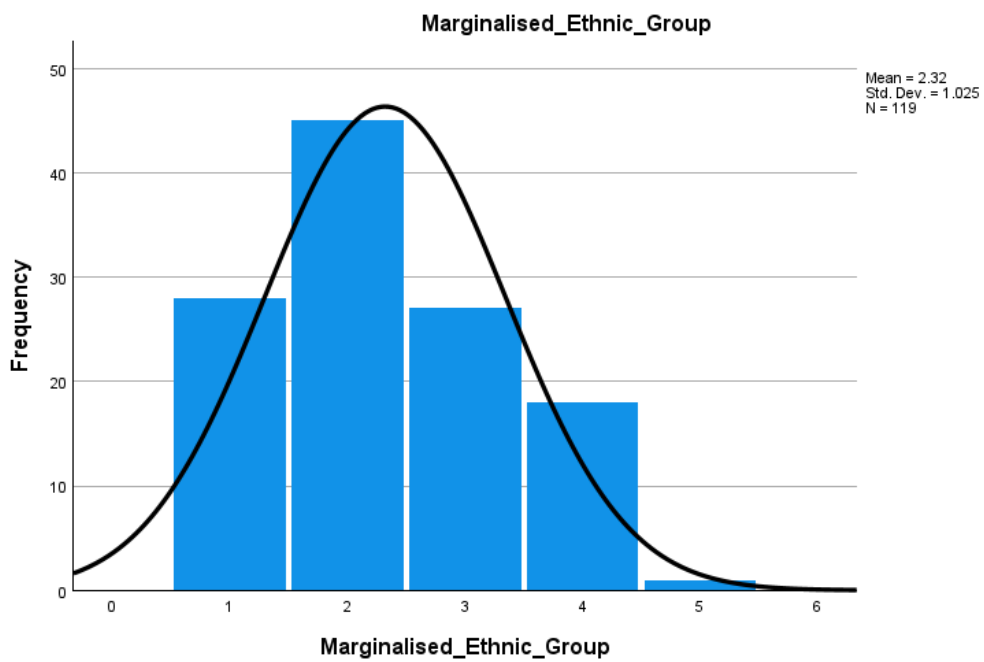
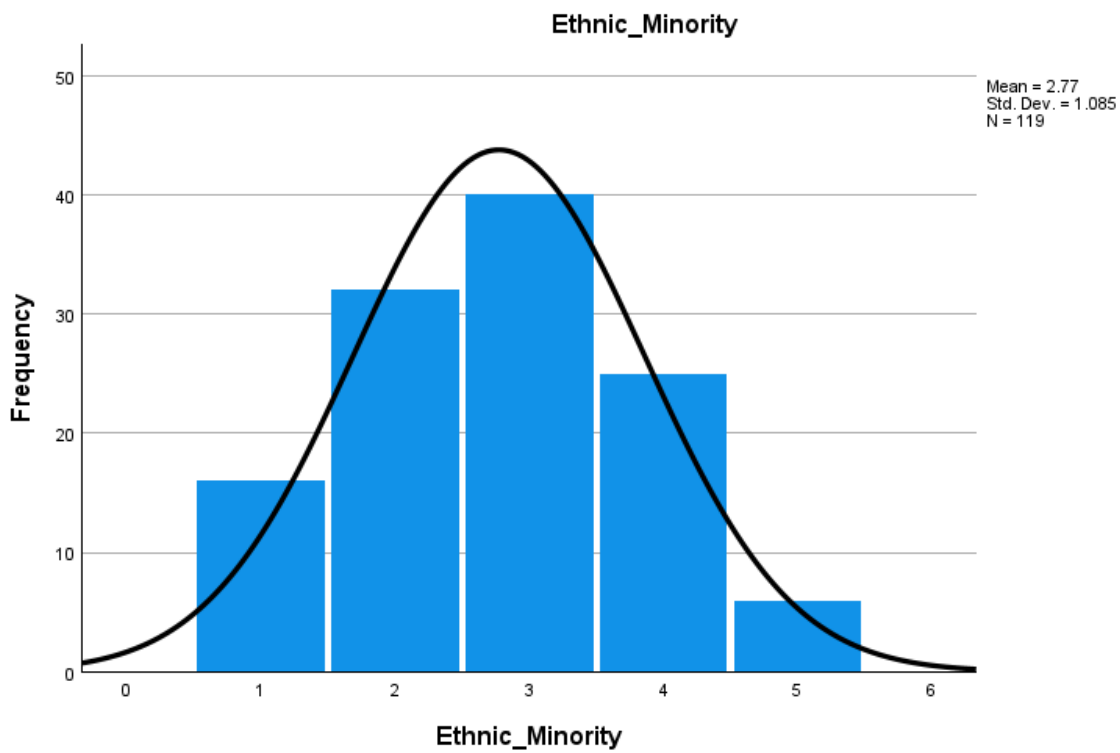
	N	%
Strongly Dislike	33	27.5%
Dislike	39	32.5%
Neither Dislike nor Like	34	28.3%
Like	11	9.2%
Strongly Like	2	1.7%
Missing System	1	0.8%

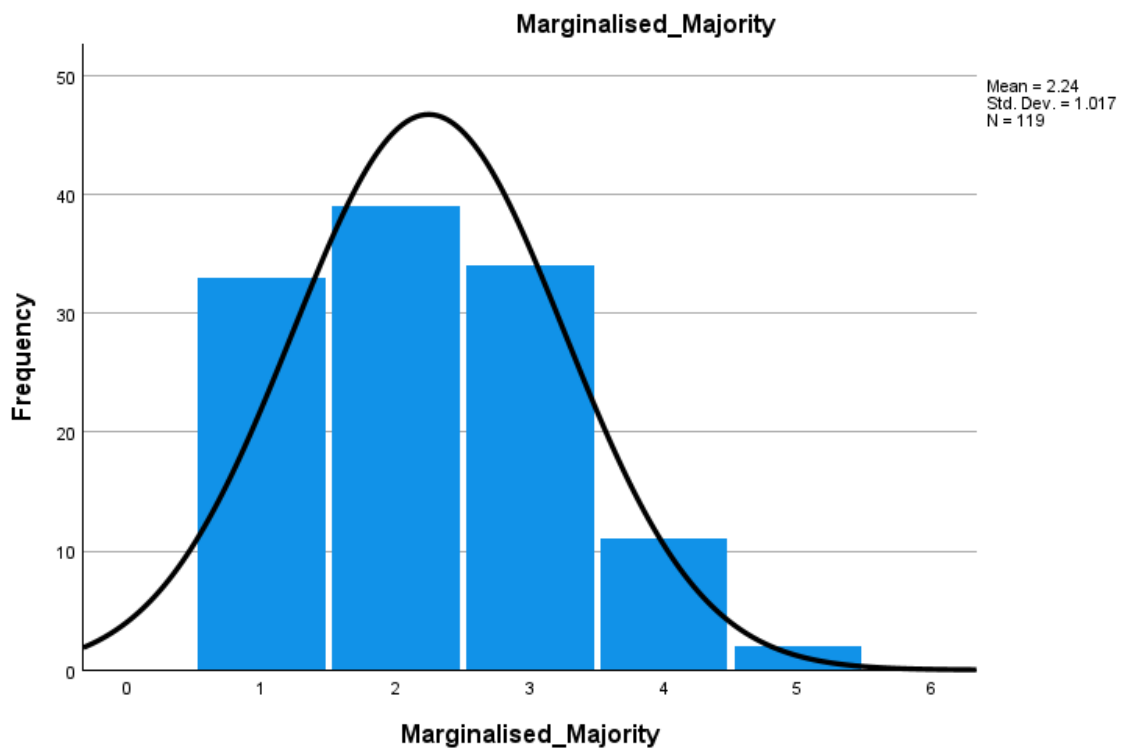
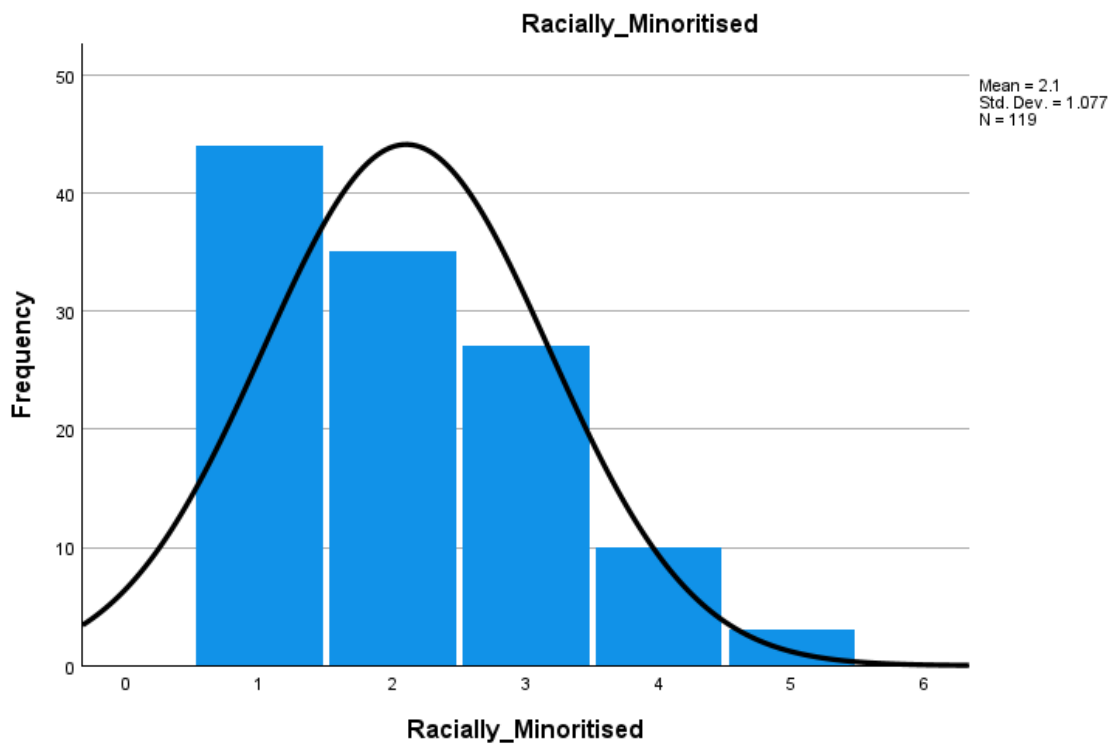
**Culturally\_ethnically\_diverse**

	N	%
Strongly Dislike	9	7.5%
Dislike	13	10.8%
Neither Dislike nor Like	29	24.2%
Like	49	40.8%
Strongly Like	19	15.8%
Missing System	1	0.8%

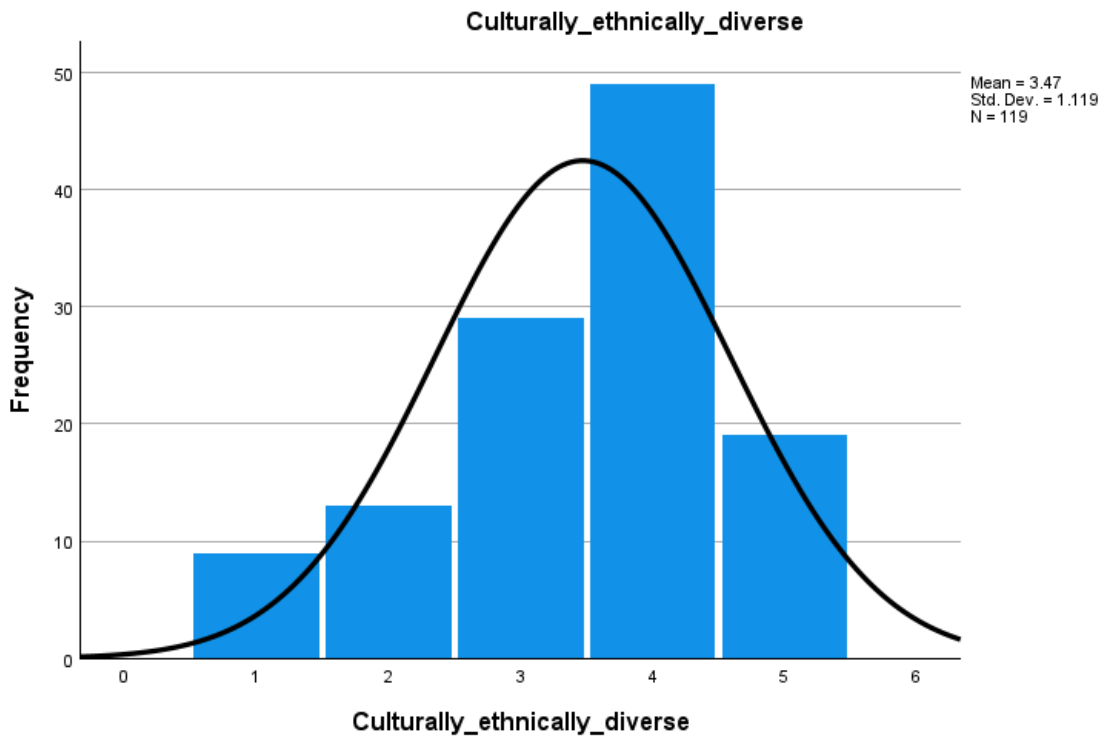
## Histograms



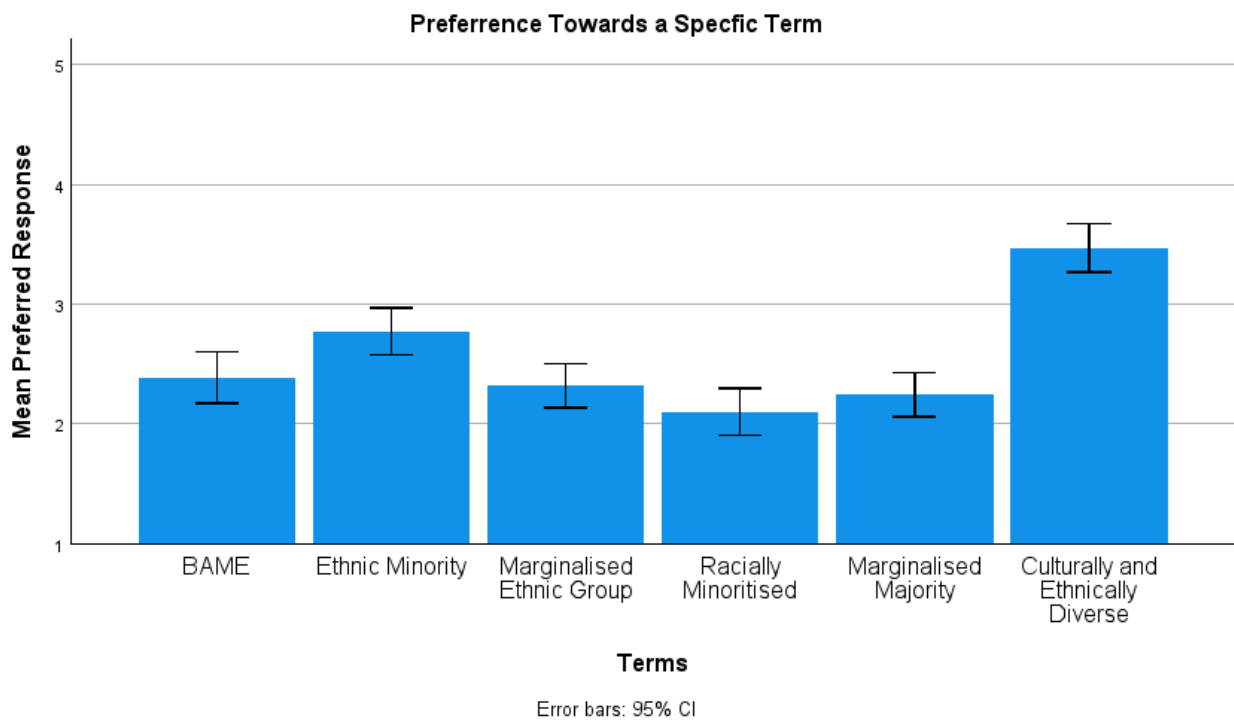




# Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users



## Histogram Of All Terms With Standard Error Bars



One-way within-subjects ANOVA

Tests of Within-Subjects Effects							
Measure: MEASURE_1							
Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Terms	Sphericity Assumed	151.457	5	30.291	34.355	.000	.225
	Greenhouse-Geisser	151.457	3.676	41.202	34.355	.000	.225
	Huynh-Feldt	151.457	3.809	39.765	34.355	.000	.225
	Lower-bound	151.457	1.000	151.457	34.355	.000	.225
Error(Terms)	Sphericity Assumed	520.210	590	.882			
	Greenhouse-Geisser	520.210	433.765	1.199			
	Huynh-Feldt	520.210	449.443	1.157			
	Lower-bound	520.210	118.000	4.409			

Paired Samples T-tests

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Culturally_ethnically_diverse	18.47	119	1.119	.103
	BAME	17.39	119	1.180	.108
Pair 2	Culturally_ethnically_diverse	18.47	119	1.119	.103
	Ethnic_Minority	17.77	119	1.085	.099
Pair 3	Culturally_ethnically_diverse	18.47	119	1.119	.103
	Marginalised_Ethnic_Group	17.32	119	1.025	.094
Pair 4	Culturally_ethnically_diverse	18.47	119	1.119	.103
	Racially_Minoritised	17.10	119	1.077	.099
Pair 5	Culturally_ethnically_diverse	18.47	119	1.119	.103
	Marginalised_Majority	17.24	119	1.017	.093

Paired Samples Correlations					
		N	Correlation	Significance	
				One-Sided p	Two-Sided p
Pair 1	Culturally_ethnically_diverse & BAME	119	.266	.002	.004
Pair 2	Culturally_ethnically_diverse & Ethnic_Minority	119	.333	.000	.000
Pair 3	Culturally_ethnically_diverse & Marginalised_Ethnic_Group	119	.334	.000	.000
Pair 4	Culturally_ethnically_diverse & Racially_Minoritised	119	.115	.106	.213
Pair 5	Culturally_ethnically_diverse & Marginalised_Majority	119	.249	.003	.006

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

### Paired Samples Test

		Paired Differences					t	df	Significance	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
					Lower	Upper				
Pair 1	Culturally_ethnically_diverse - BAME	1.084	1.394	.128	.831	1.337	8.486	118	.000	.000
Pair 2	Culturally_ethnically_diverse - Ethnic_Minority	.697	1.273	.117	.466	.928	5.979	118	.000	.000
Pair 3	Culturally_ethnically_diverse - Marginalised_Ethnic_Group	1.151	1.239	.114	.926	1.376	10.132	118	.000	.000
Pair 4	Culturally_ethnically_diverse - Racially_Minoritised	1.370	1.461	.134	1.105	1.635	10.230	118	.000	.000
Pair 5	Culturally_ethnically_diverse - Marginalised_Majority	1.227	1.311	.120	.989	1.465	10.207	118	.000	.000

### Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	BAME	2.39	119	1.180	.108
	Ethnic_Minority	2.77	119	1.085	.099
Pair 2	BAME	2.39	119	1.180	.108
	Marginalised_Ethnic_Group	2.32	119	1.025	.094
Pair 3	BAME	2.39	119	1.180	.108
	Racially_Minoritised	2.10	119	1.077	.099
Pair 4	BAME	2.39	119	1.180	.108
	Marginalised_Majority	2.24	119	1.017	.093
Pair 5	BAME	2.39	119	1.180	.108
	Culturally_ethnically_diverse	3.47	119	1.119	.103

### Paired Samples Correlations

		N	Correlation	Significance	
				One-Sided p	Two-Sided p
Pair 1	BAME & Ethnic_Minority	119	.387	.000	.000
Pair 2	BAME & Marginalised_Ethnic_Group	119	.079	.196	.391
Pair 3	BAME & Racially_Minoritised	119	-.071	.222	.443
Pair 4	BAME & Marginalised_Majority	119	-.037	.345	.691
Pair 5	BAME & Culturally_ethnically_diverse	119	.266	.002	.004

### Paired Samples Test

		Paired Differences					t	df	Significance	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
					Lower	Upper				
Pair 1	BAME - Ethnic_Minority	-.387	1.256	.115	-.615	-.159	-3.357	118	.001	.001
Pair 2	BAME - Marginalised_Ethnic_Group	.067	1.500	.137	-.205	.340	.489	118	.313	.626
Pair 3	BAME - Racially_Minoritised	.286	1.653	.151	-.014	.586	1.886	118	.031	.062
Pair 4	BAME - Marginalised_Majority	.143	1.585	.145	-.145	.431	.983	118	.164	.328
Pair 5	BAME - Culturally_ethnically_diverse	-1.084	1.394	.128	-1.337	-.831	-8.486	118	.000	.000

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

**Paired Samples Statistics**

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Ethnic_Minority	17.77	119	1.085	.099
	BAME	17.39	119	1.180	.108
Pair 2	Ethnic_Minority	17.77	119	1.085	.099
	Marginalised_Ethnic_Group	17.32	119	1.025	.094
Pair 3	Ethnic_Minority	17.77	119	1.085	.099
	Racially_Minoritised	17.10	119	1.077	.099
Pair 4	Ethnic_Minority	17.77	119	1.085	.099
	Marginalised_Majority	17.24	119	1.017	.093
Pair 5	Ethnic_Minority	17.77	119	1.085	.099
	Culturally_ethnically_diverse	18.47	119	1.119	.103

**Paired Samples Correlations**

		N	Correlation	Significance	
				One-Sided p	Two-Sided p
Pair 1	Ethnic_Minority & BAME	119	.387	.000	.000
Pair 2	Ethnic_Minority & Marginalised_Ethnic_Group	119	.249	.003	.006
Pair 3	Ethnic_Minority & Racially_Minoritised	119	.172	.031	.061
Pair 4	Ethnic_Minority & Marginalised_Majority	119	.127	.084	.167
Pair 5	Ethnic_Minority & Culturally_ethnically_diverse	119	.333	.000	.000

**Paired Samples Test**

		Paired Differences						Significance		
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	One-Sided p	Two-Sided p
					Lower	Upper				
Pair 1	Ethnic_Minority - BAME	.387	1.256	.115	.159	.615	3.357	118	.001	.001
Pair 2	Ethnic_Minority - Marginalised_Ethnic_Group	.454	1.294	.119	.219	.689	3.826	118	.000	.000
Pair 3	Ethnic_Minority - Racially_Minoritised	.672	1.391	.127	.420	.925	5.273	118	.000	.000
Pair 4	Ethnic_Minority - Marginalised_Majority	.529	1.389	.127	.277	.782	4.158	118	.000	.000
Pair 5	Ethnic_Minority - Culturally_ethnically_diverse	-.697	1.273	.117	-.928	-.466	-5.979	118	.000	.000

### **10.1.b Content Analysis Outputs**

## Recovery Outcomes: Supporting Culturally and Ethnically Diverse IAPT Service Users

### First Question Total Of 38 Individuals Responding

38 said other terms ( see below)		
Global majority / Global Ethnic Majority Groups	4	3%
Racially minoritised person / Minoritised Ethnic	2	2%
Culturally Diverse	5	4%
Person of Colour (POC)	6	5%
Identifying groups by the ethnicity - (example included: Instead of BAME, we should have separate 'categories', Black African, Afro Caribbean, Indian Asian, Chinese Asian, Identifying groups by the ethnicity I.e. black oriole, We're just people. Just use Black, Asian and White, specifically what the person's ethnicity is, e.g. British Chinese, Kittitian and Nevisian, Nationality that applies to a passport )	21	18%
	<b>38</b>	

### Second Question Total Of 82 Individuals Responding

Culturally and ethnically diverse sounds really good but racially minoritised doesn't sound inclus
Ethic minority is what I'm use to and is acknowledged globally and is what many are already far
I have seen the use of "racially minoritized" as a relatively new phenomenon in academia - I can
It would be helpful to get to the point where we don't need these labels to consider how we tre
I like it when people of different cultures come together to create a diversity and learn.
I like these terms because lots of people think all West Indians are from Jamaica and there are
Black as BAME or minorities is not specific
I'm really not fussed about the terminologies used as long as they are discriminatory or used of
Marginalised has quite negative connotations. Other than that, I'm not too bothered
The terms are too broad. Whilst I can see a place for terms like BAME (when conducting multi-g
I don't consider black to be an offensive term and the other terms seem very political and impe
Marginalised' not a term every ethnic person can identify with 'Minority' I believe this term is on
I think Dual Heritage for me is the best way I'd like people to describe me because I feel that it i
POC - is quite a simple and straight to the point termBlack - it is nice to just be referred to as wh
I do like the term BAME, however, I don't feel it is fully inclusive of all ethnic minorities. I appre
I use person of colour. Not that I prefer it it is just part of my language.
The terms stated encaptures the neglect of certain ethnicities and highlights this as an importar
I dont mind BAME I feel as it's more specific behind the meaning
Not a fan of the word "group" to describe people's race and/or heritage, group sounds like som
I like black british because it represents me the best since I am black and british
BAME I think is more respectful and allows white people to refers to us better than "coloured p
I hate the term half cast
Black being used to describe people other than African descendents
I personally don't like to think of myself under any kind of terminology if I can help it, I'm just a
I prefer terminology that follows the JEDI terminology of justice, equity, diversity and inclusion
I think they are context dependent e.g marginalised majority may not always work in some con
I don't liked coloured being used but I do not mind black being used. People also have to releas
I like the use of the word BAME because I feel it encompasses a large proportion of ethnic peop
<b>82</b>

**END**