Ethnic Inequalities in Improving Access to Psychological Therapies (IAPT)

Appendices

NATIONAL COLLABORATING CENTRE FOR **MENTAL HEALTH**

NHS **RACE & HEALTH OBSERVATORY**

Correction, February 2024:
In Appendix 1.5.6, Tables 7–12 (pp. 30–35) have been replaced
with the correct data.

Contents

Appendix 1: Analysis of the national IAPT dataset

1.1.   Further information on datasets

The IAPT minimum dataset (MDS) data is collected at both the episode and the appointment level, detailing the start and end of care, as well as symptom severity scores which are used to calculate outcomes reported nationally by IAPT. The use of routine outcome measurement in this way has been a particular success of the programme, with the data being about 98.5% complete.[1]

All services are mandated to submit the IAPT MDS to NHS Digital, where it is compiled into monthly and annual national reports on IAPT service utilisation and treatment outcomes.

Data are provided by financial (fiscal) year for services, with data available from 2015–16 to the most recently released 2021–22 financial year available during the time span of this report. This aggregate data includes a breakdown of the total number of referrals, access to IAPT treatment, and routinely reported outcomes by patient characteristics at the national level, including patient-reported ethnicity.

The primary aim of the MODIFY project[a] (which obtained the dataset from NHS Digital, as described in *Section 3.2.* of the report), was to explore the impact of nationally delivered psychological therapy on later dementia risk, for which initial results have been reported.[2]

1.2.   Access and course of treatment

1.2.1.   Changes in access rate

Figure 1 (a–e) presents the access rates by the ethnicity groups of the detailed Office for National Statistics (ONS) ethnicity categories compared with the rates for the 'White British' group (as this was the largest group accessing services). Access rates by the high-level ONS ethnicity categories can be found in *Section 3.4.* of the report.

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[a] MODIFY = Mental Health and other psychological therapy Outcomes; their relationship to Dementia Incidence in the Following Years (MODIFY): a data linkage and feasibility project.

Figure 1: Access rates by the ethnicity groups of the detailed ONS ethnicity categories

Figure 1 (a): IAPT access rate for 'Asian' ethnic groups

IAPT access rate ('Asian' ethnic groups)
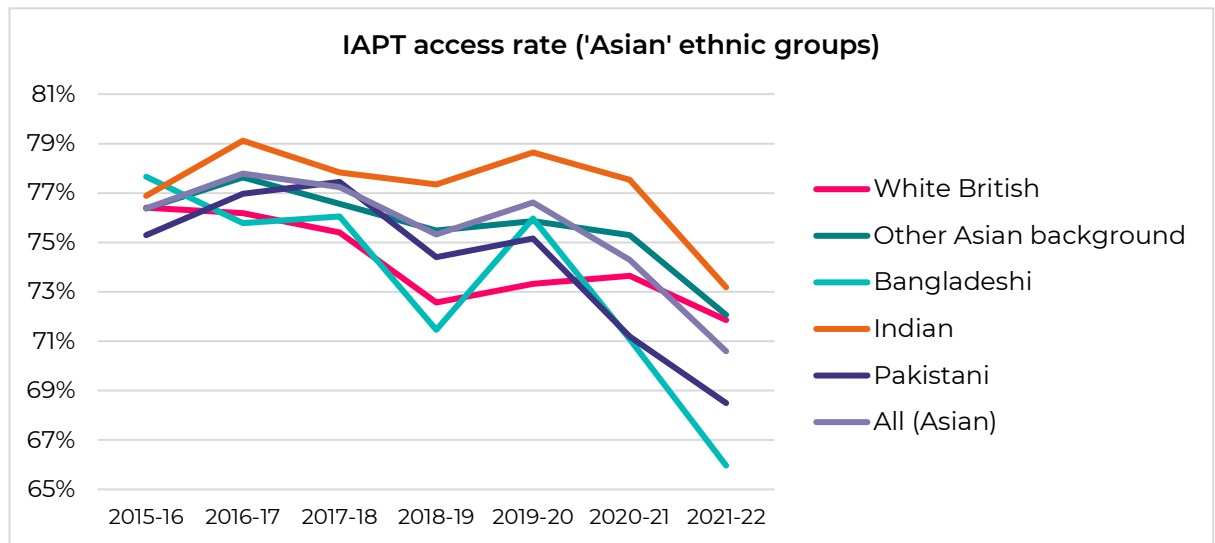
Figure 1 (b): IAPT access rate for 'Black' ethnic groups

IAPT access rate ('Black' ethnic groups)
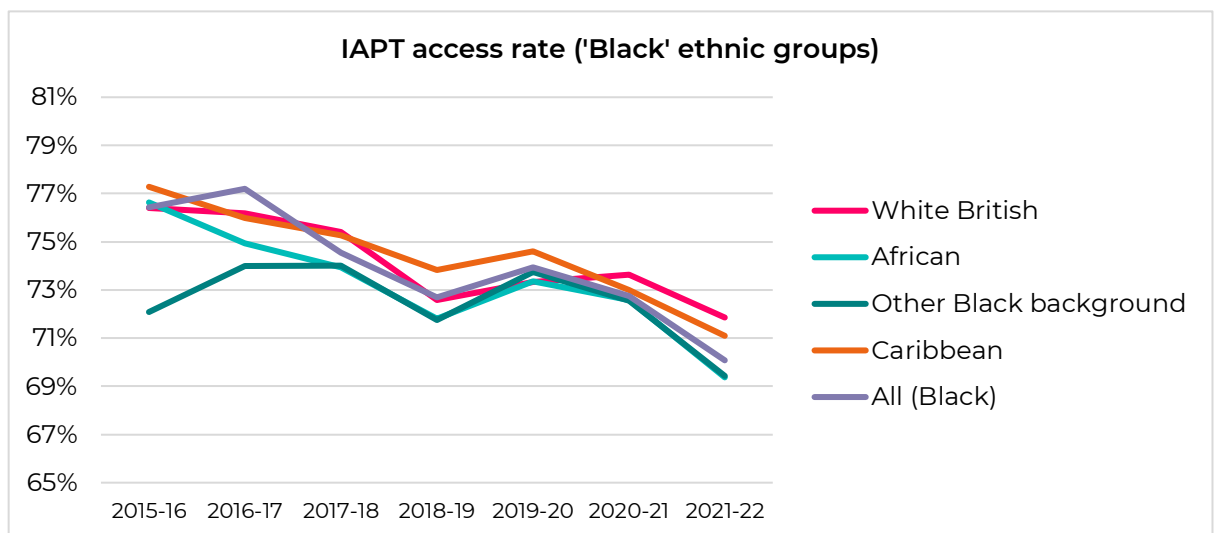
Figure 1 (c): IAPT access rate for 'Mixed' ethnic groups

IAPT access rate ('Mixed' ethnic groups)

Legend: White British, Other Mixed background, White & Asian, White & Black African, White & Black Caribbean, All (Mixed)
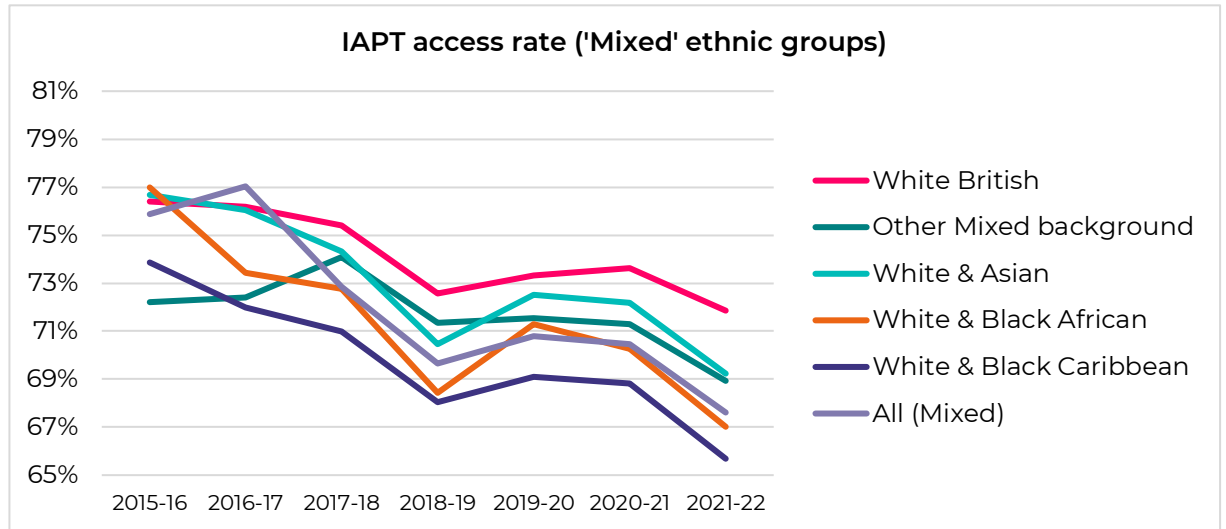
Figure 1 (d): IAPT access rate for 'Other' ethnic groups

IAPT access rate ('Other' ethnic groups)

Legend: White British, Any other Ethnic Groups, Chinese, All (Other)
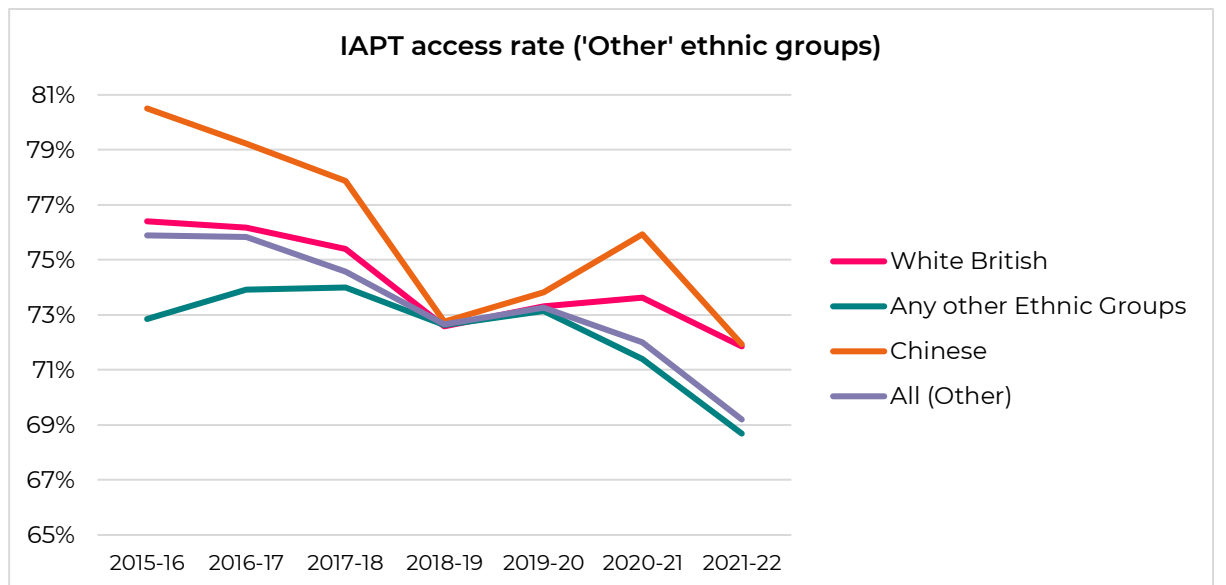
Figure 1 (e): IAPT access rate for 'White' ethnic groups

IAPT access rate ('White' ethnic groups)

Legend: White British, Other White background, White Irish, All (White)
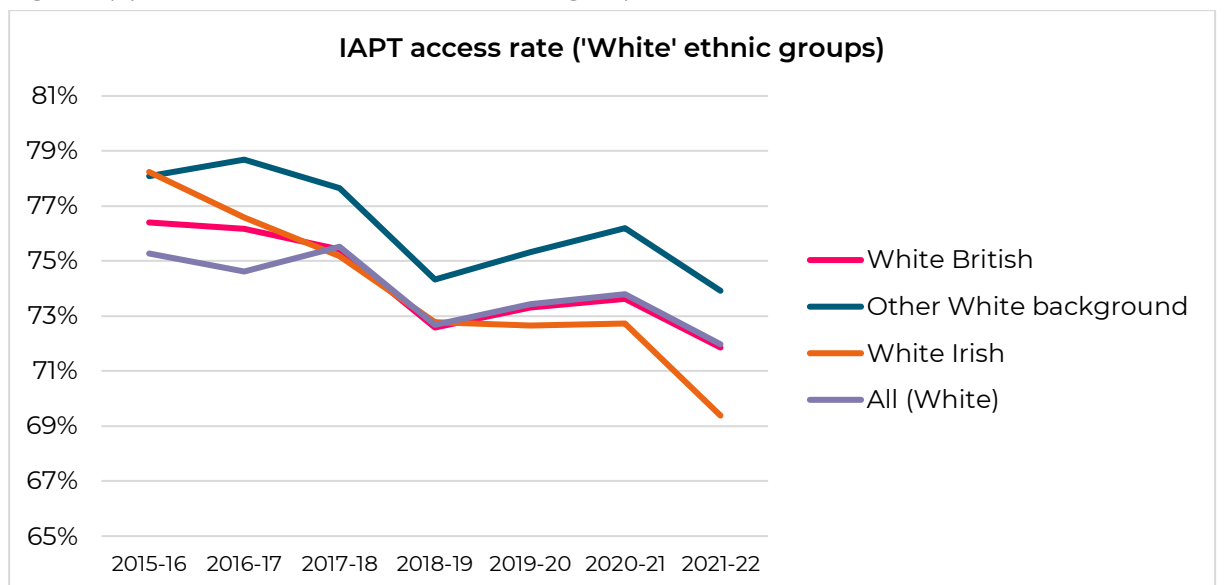
1.2.2. Changes in course of treatment rate

Figure 2 (a–e) presents the course of treatment rates by the detailed ONS ethnicity categories compared with the rates for the 'White British' group (as this was the largest group accessing services), which are also presented for comparison. Course of treatment rates by the high-level categories can be found in *Section 3.4.* of the report.

Figure 2: Course of treatment rates by granular categories of ethnicity

Figure 2 (a): IAPT course of treatment rate for 'Asian' ethnic groups
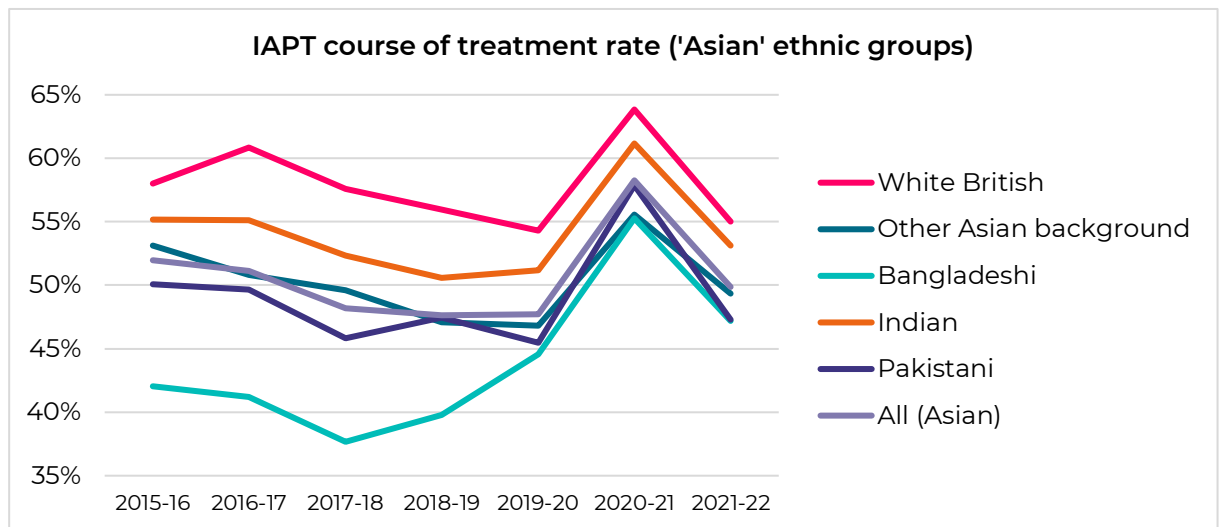
Figure 2 (b): IAPT course of treatment rate for 'Black' ethnic groups
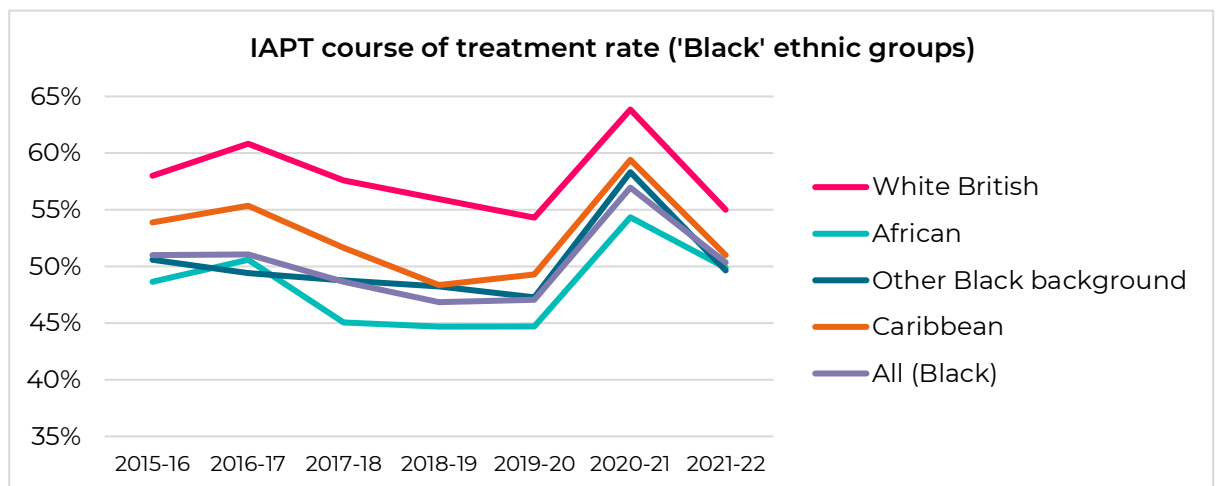
Figure 2 (c): IAPT course of treatment rate for 'Mixed' ethnic groups

IAPT course of treatment rate ('Mixed' ethnic groups)

Legend:
- White British
- Other Mixed background
- White & Asian
- White & Black African
- White & Black Caribbean
- All (Mixed)
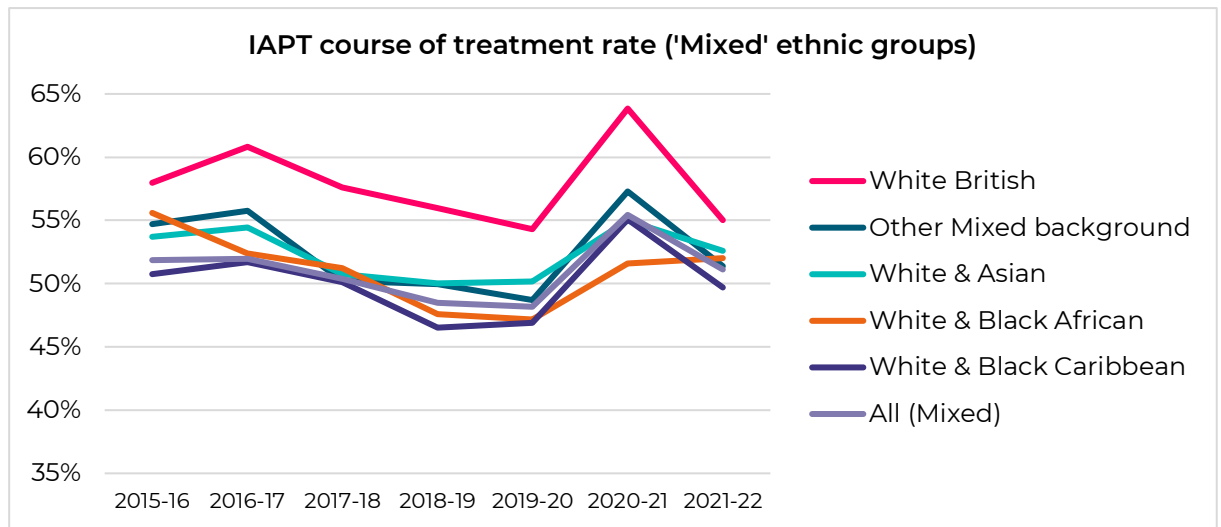
Figure 2 (d): IAPT course of treatment rate for 'Other' ethnic groups

IAPT course of treatment rate ('Other' ethnic groups)

Legend:
- White British
- Any other Ethnic Groups
- Chinese
- All (Other)
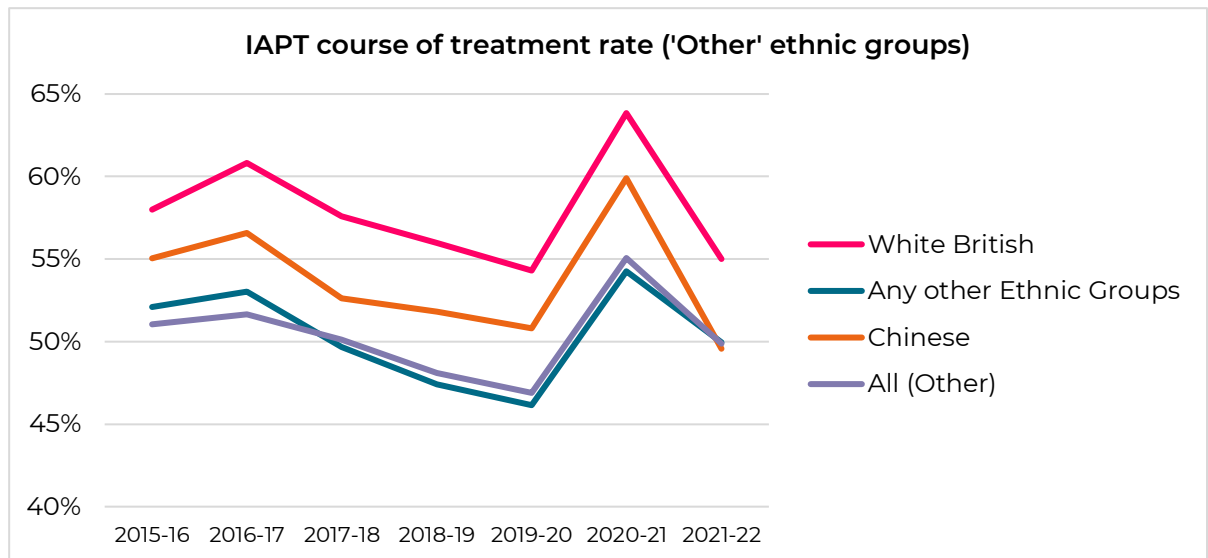
Figure 2 (e): IAPT course of treatment rate for 'White' ethnic groups

IAPT course of treatment rate ('White' ethnic groups)

Legend:
- White British
- Other White background
- White Irish
- All (White)
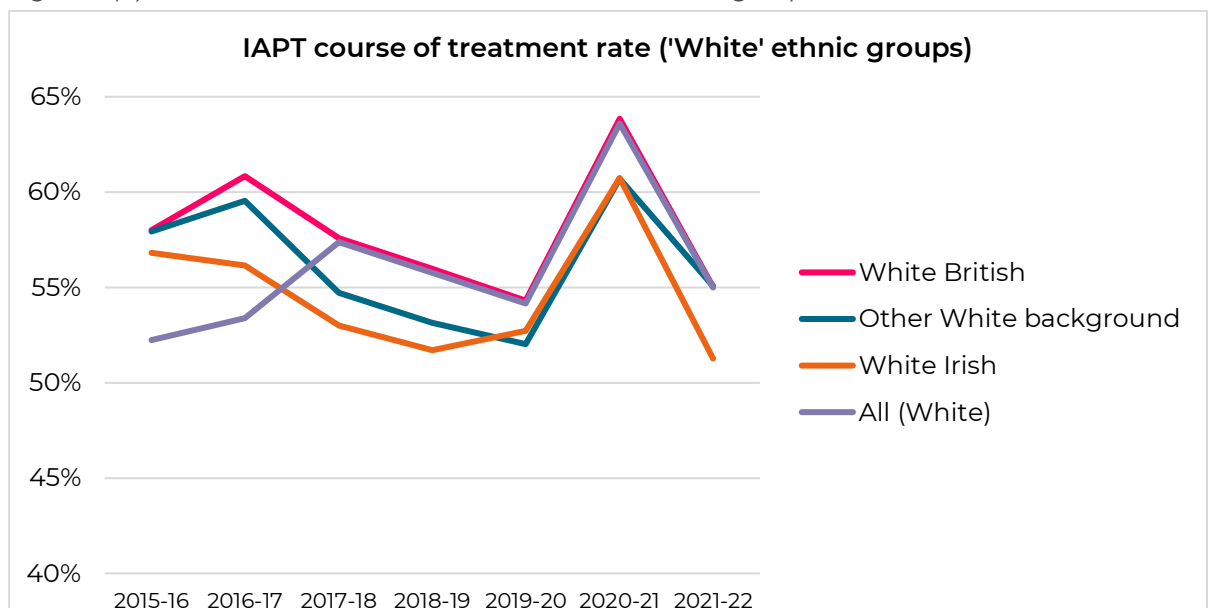
1.2.3. Odds of access and completing a course of treatment

Table 1 presents the odds ratios (ORs) of (a) accessing IAPT services after initial referral and (b) receiving a course of treatment after assessment for each ethnic group compared with the 'White British' group, listed from highest to lowest ORs.

The odds of accessing services are higher for some ethnic groups (for example 'Indian' and 'Other Asian Backgrounds'), and lower for others (for example 'Other Black backgrounds').

The odds of having a course of treatment was statistically lower for all ethnic groups compared with the 'White British' group.

Table 1: ORs for each recorded ethnicity compared with 'White – British' of (a) accessing IAPT services after referral and (b) receiving a course of treatment after assessment

(a)	Access to services	
Ethnicity	OR (95% CI)	P-value
White – British	Ref	Ref
Other – Chinese	1.25 (1.18; 1.33)	<0.001
White – Other White Background	1.15 (1.14; 1.17)	<0.001
Asian – Indian	1.13 (1.11; 1.15)	<0.001
Asian – Other Asian Background	1.07 (1.04; 1.1)	<0.001
Asian – Bangladeshi	1.03 (1; 1.07)	0.076
White – Irish	1.03 (1; 1.06)	0.024
Mixed – White and Asian	1.02 (0.98; 1.07)	0.274
Asian – Pakistani	1.01 (0.99; 1.03)	0.392
Black – Caribbean	1.01 (0.99; 1.03)	0.255
Black – African	0.98 (0.96; 1.01)	0.165
Mixed – White and Black African	0.94 (0.89; 0.99)	0.030
Other – Any Other Ethnic Group	0.90 (0.88; 0.92)	<0.001
Black – Other Black Background	0.88 (0.85; 0.91)	<0.001
Mixed – Other Mixed Background	0.85 (0.83; 0.87)	<0.001
Mixed – White and Black Caribbean	0.83 (0.81; 0.85)	<0.001

Notes: CI = confidence interval; *Ref* = reference category

(b)	Course of treatment	
Ethnicity	**OR (95% CI)**	**P-value**
White – British	*Ref*	*Ref*
White – Other White Background	0.98 (0.97; 0.99)	0.004
Other – Chinese	0.92 (0.87; 0.97)	0.003
White – Irish	0.87 (0.84; 0.89)	<0.001
Mixed – White and Asian	0.85 (0.82; 0.89)	<0.001
Mixed – Other Mixed Background	0.84 (0.82; 0.86)	<0.001
Asian – Indian	0.83 (0.82; 0.85)	<0.001
Mixed – White and Black African	0.83 (0.78; 0.87)	<0.001
Black – Caribbean	0.78 (0.77; 0.8)	<0.001
Other – Any Other Ethnic Group	0.76 (0.75; 0.78)	<0.001
Asian – Other Asian Background	0.75 (0.73; 0.77)	<0.001
Mixed – White and Black Caribbean	0.71 (0.69; 0.73)	<0.001
Black – Other Black Background	0.71 (0.68; 0.73)	<0.001
Black – African	0.68 (0.66; 0.7)	<0.001
Asian – Pakistani	0.68 (0.66; 0.69)	<0.001
Asian – Bangladeshi	0.48 (0.47; 0.5)	<0.001

Notes: CI = confidence interval; *Ref* = reference category

1.2.4.   Likelihood of having a course of treatment

Figure 3: Likelihood of receiving a course of treatment, by ethnicity group (adjusted for waiting time between referral and assessment)
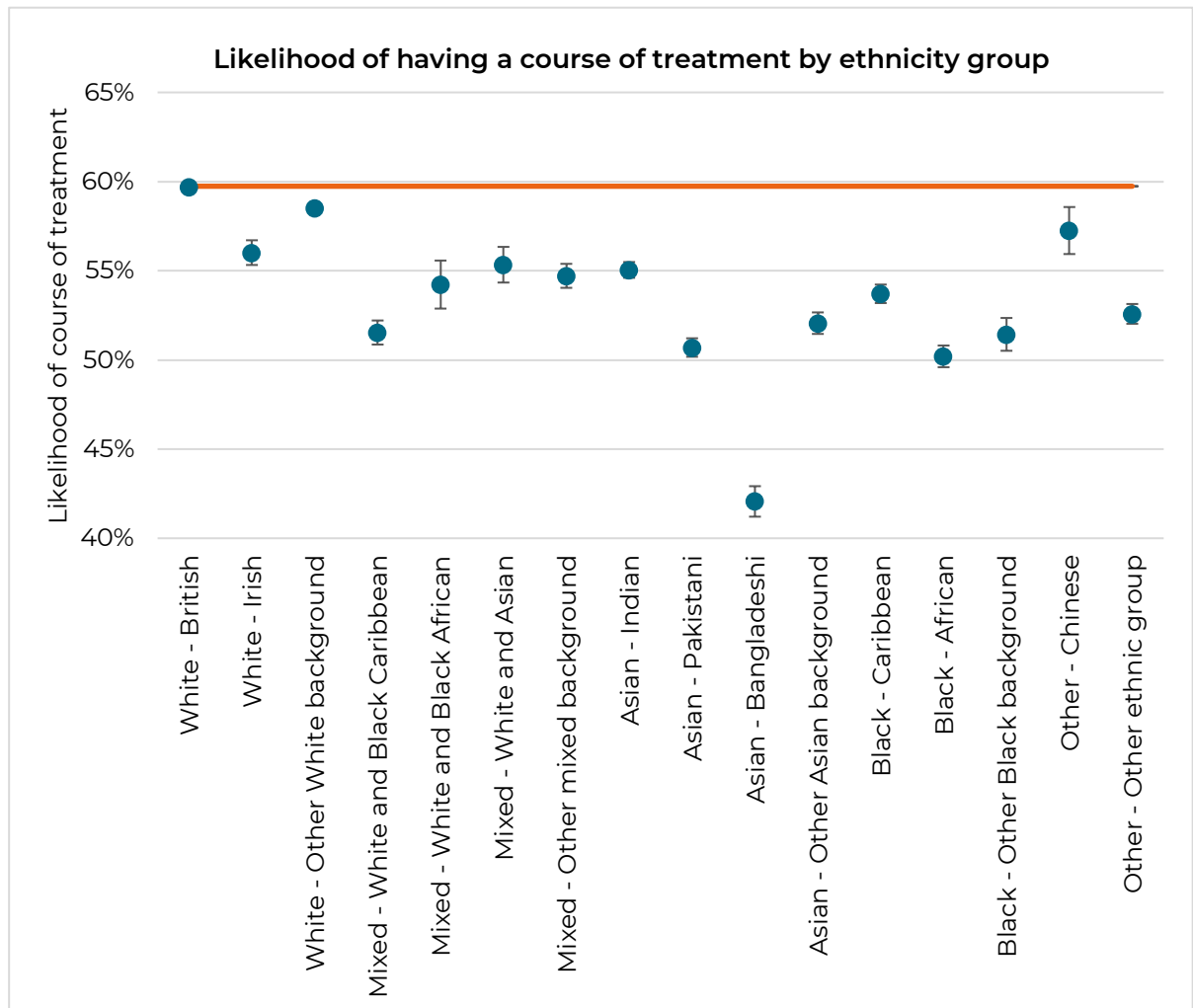
1.3.   Sociodemographics

It was noted across all three samples (Table 2, Table 3 and Table 4) that people from the 'White: Irish' and then 'White: British' groups were older on average than all other ethnic groups, whereas those of any 'Mixed ethnicity' and either 'Asian: Bangladeshi' or 'Asian: Pakistani' ethnicity were on average the youngest (Figure 4a).

The 'White: British' followed by 'Mixed: White and Asian', 'Asian: Indian' and 'Other: Chinese' ethnic groups were on average more likely to be living in areas of relatively less deprivation, as indicated by higher index of multiple deprivation (IMD) scores (Figure 4b). Conversely, people identifying as 'Asian: Bangladeshi', followed by 'Asian: Pakistani', and then those of any of the 'Black' ethnic groups, were on average the most likely to live in areas of higher deprivation.

In all three samples, there were proportionately more males identified as 'White: Irish' and 'Asian: Other Asian Background' compared with the 'White: British' group. In the samples of people accessing services and those receiving a course of treatment, the 'Asian: Bangladeshi' group were also more likely to be male than the 'White: British' group.

In all three samples, the 'Other: Chinese' group were least likely to be unemployed on average, followed by those identifying as 'White: Other White Background' and 'Mixed: White and Asian'. In contrast, people in 'Black: Caribbean', 'Other: Any Other Ethnic Group', and 'Asian: Other Asian Background' ethnicity groups were the most likely to be unemployed.

At the high-level category, the 'White' ethnicity group were the least likely and the 'Black' ethnicity group the most likely to be unemployed on average.

Figure 4: Comparison of (a) mean age and (b) IMD score across ethnic groups, among those who completed a course of treatment (error bars indicate 95% CIs)

Figure 4 (a): Mean age (years)
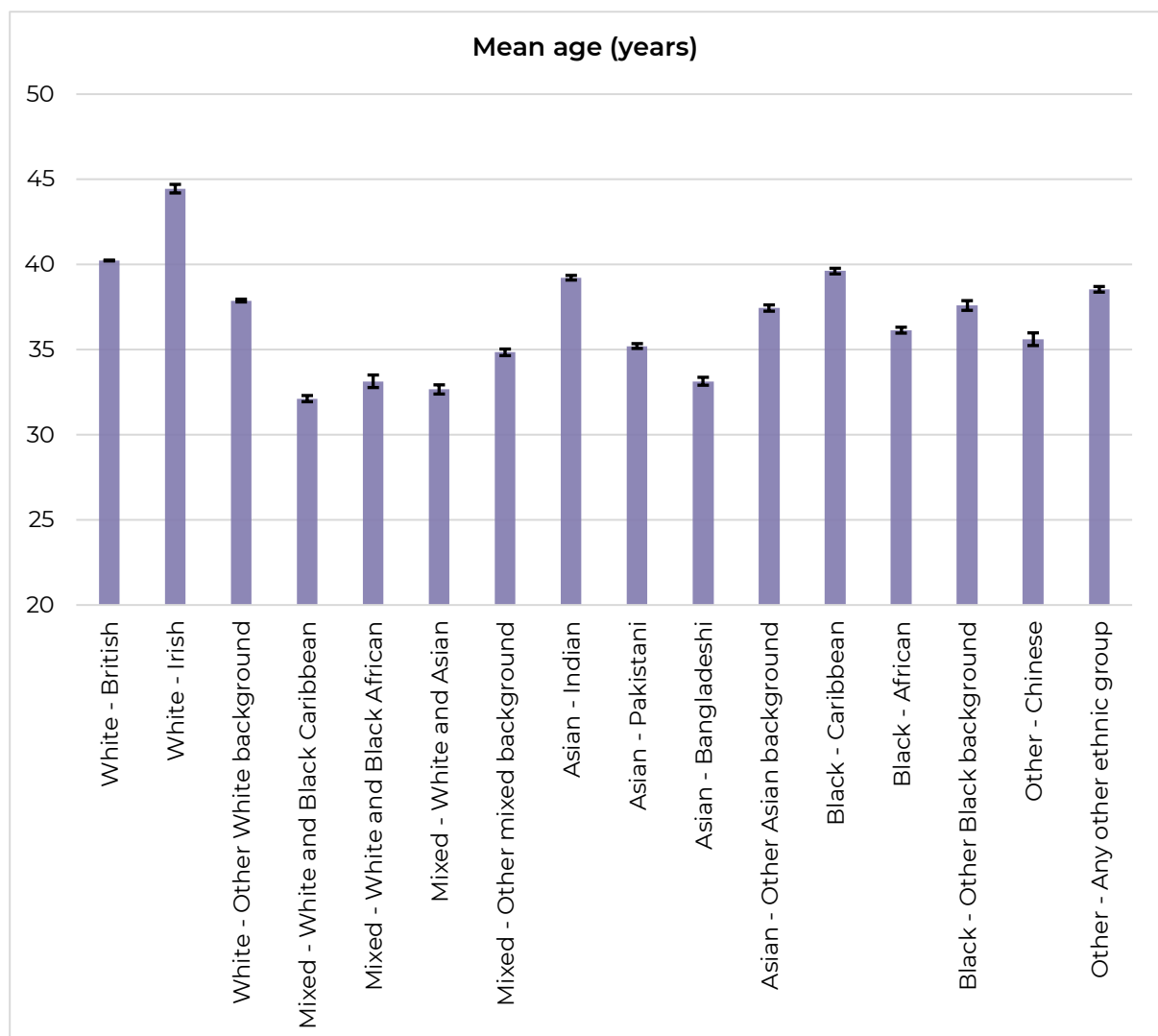
Figure 4 (b): Mean IMD decile score

Mean IMD decile score
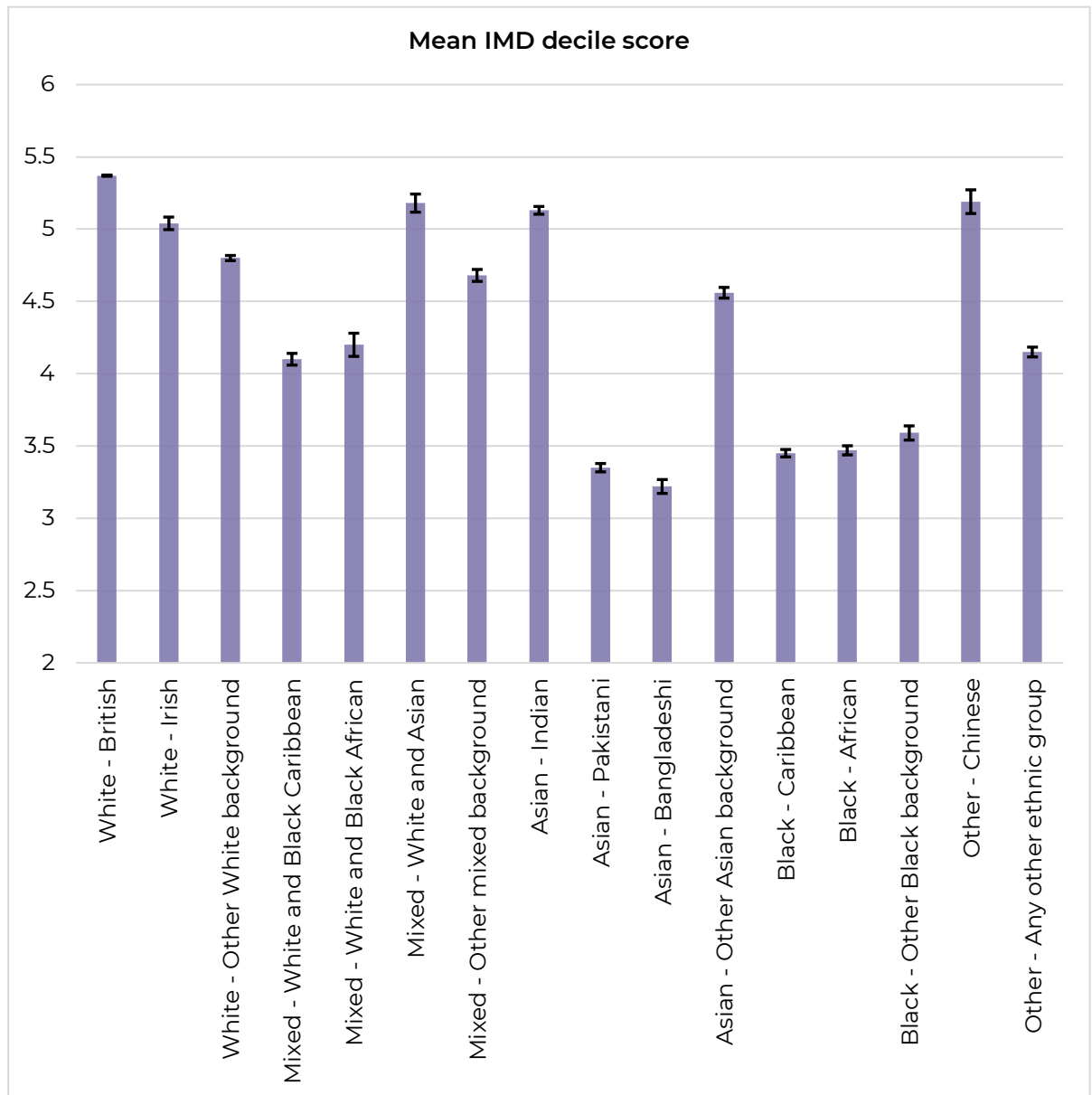
1.4. Descriptive statistics of people by referral, access and receipt of treatment

*Table 2: Descriptive statistics of people **referred** to services, by ethnic group*

Ethnicity group	Age	IMD decile	Initial PHQ-9 score	Initial GAD-7 score	Weeks: Referral to Assessment	Weeks: Assessment to next session	Number of sessions	Medication status				Gender			Unemployment status		
								Prescribed, not taking	Prescribed and taking	Not prescribed	Missing	Male	Female	Missing	Not unemployed	Unemployed	Missing
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	%	%	%	%	%	%	%	%	%	%
White – British	39.05 (15.56)	5.07 (2.86)	15.16 (6.33)	13.58 (5.22)	2.54 (3.39)	6.76 (7.84)	4.23 (4.38)	3.26	36.93	29.51	30.30	35.38	64.29	0.33	54.42	16.58	29.00
White – Irish	43.94 (16.27)	4.73 (2.73)	14.85 (6.58)	13.24 (5.48)	2.7 (3.51)	7.31 (8.2)	4.12 (4.32)	3.43	33.69	32.09	30.79	35.43	64.04	0.54	53.88	16.95	29.17
White – Other White Background	37.4 (12.64)	4.6 (2.65)	14.66 (6.34)	13.31 (5.25)	2.75 (3.46)	7.35 (8.13)	4.4 (4.56)	4.12	29.43	38.55	27.91	27.62	72.07	0.31	58.82	15.15	26.03
Mixed – White and Black Caribbean	31.19 (11.33)	3.85 (2.53)	16.03 (6.01)	14 (5.05)	2.55 (3.31)	7.44 (8.14)	3.76 (4.24)	4.41	28.23	33.25	34.11	30.24	69.35	0.41	46.37	21.38	32.25
Mixed – White and Black African	32.46 (11.94)	4.02 (2.58)	15.68 (6.09)	13.67 (5.14)	2.68 (3.46)	7.15 (7.87)	3.89 (4.18)	4.73	27.30	35.08	32.90	30.90	68.47	0.63	49.13	19.48	31.39
Mixed – White and Asian	32.07 (12.12)	4.85 (2.81)	15.25 (6.25)	13.39 (5.2)	2.67 (3.6)	7.18 (8.09)	4.11 (4.44)	3.53	26.97	37.27	32.24	32.31	67.06	0.63	54.13	15.77	30.10
Mixed – Other Mixed Background	34.18 (12.65)	4.35 (2.66)	15.62 (6.21)	13.74 (5.14)	2.83 (3.83)	7.58 (8.3)	4.14 (4.46)	3.90	26.13	36.41	33.56	31.46	67.96	0.58	49.52	18.29	32.19

Ethnicity group	Age	IMD decile	Initial PHQ-9 score	Initial GAD-7 score	Weeks: Referral to Assessment	Weeks: Assessment to next session	Number of sessions	Medication status				Gender			Unemployment status		
								Prescribed, not taking	Prescribed and taking	Not prescribed	Missing	Male	Female	Missing	Not unemployed	Unemployed	Missing
Asian – Indian	38.99 (13.87)	4.89 (2.64)	15.03 (6.56)	13.41 (5.48)	2.53 (3.77)	7.41 (7.86)	4.01 (4.23)	4.23	25.31	41.62	28.84	34.50	65.29	0.22	57.88	16.62	25.50
Asian – Pakistani	34.72 (12.1)	3.19 (2.33)	16.04 (6.53)	14.18 (5.46)	2.42 (3.63)	7.54 (8.09)	3.52 (3.96)	4.63	27.54	32.51	35.32	35.04	64.34	0.62	45.55	22.30	32.14
Asian – Bangladeshi	33.45 (11.29)	2.91 (2.04)	15.64 (6.76)	13.65 (5.72)	2.6 (3.51)	8.76 (8.93)	3.25 (3.9)	4.38	25.32	34.84	35.45	35.26	64.24	0.50	44.67	22.03	33.30
Asian – Other Asian Background	36.99 (13.35)	4.37 (2.6)	15.9 (6.45)	14 (5.37)	2.85 (3.88)	7.54 (8.17)	3.87 (4.26)	4.58	29.30	36.94	29.18	37.54	62.02	0.44	48.22	24.08	27.70
Black – Caribbean	38.8 (14.04)	3.34 (2.11)	15.74 (6.27)	13.43 (5.35)	2.45 (3.22)	7.76 (8.21)	4.06 (4.42)	4.48	24.76	40.81	29.95	28.88	70.82	0.30	47.46	24.51	28.03
Black – African	35.4 (12.33)	3.32 (2.19)	15.66 (6.47)	13.44 (5.48)	2.6 (3.57)	7.4 (8.01)	3.68 (4.11)	4.27	24.67	39.60	31.46	31.51	68.07	0.42	46.78	23.31	29.91
Black – Other Black Background	36.72 (13.36)	3.43 (2.24)	15.78 (6.36)	13.53 (5.36)	2.71 (3.68)	7.61 (8.19)	3.83 (4.3)	4.35	25.02	37.72	32.92	32.48	66.94	0.59	44.94	23.89	31.17
Other – Chinese	35.66 (13.22)	4.97 (2.75)	14.17 (6.43)	12.5 (5.47)	2.79 (3.62)	7.34 (8.39)	4.29 (4.48)	4.04	22.86	43.89	29.21	26.27	73.12	0.61	59.06	14.03	26.91
Other – Any Other Ethnic Group	37.84 (13.12)	3.89 (2.58)	16.04 (6.46)	14.14 (5.35)	3.15 (4.1)	7.51 (8.37)	3.9 (4.25)	3.56	29.61	33.33	33.50	35.22	64.48	0.29	43.30	24.42	32.28

*Table 3: Descriptive statistics of people **accessing** services by ethnic group*

Ethnicity group	Age	IMD decile	Initial PHQ-9 score	Initial GAD-7 score	Weeks: Referral to assessment	Weeks: Assessment to next session	Number of sessions	Medication status				Gender			Unemployment status		
								Prescribed, not taking	Prescribed and taking	Not prescribed	Missing	Male	Female	Missing	Not unemployed	Unemployed	Missing
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	%	%	%	%	%	%	%	%	%	%
White – British	39.86 (15.67)	5.21 (2.86)	15.15 (6.31)	13.58 (5.20)	2.54 (3.38)	6.76 (7.84)	Mean (SD)	4.27	48.40	38.70	8.63	35.17	64.59	0.24	71.64	21.51	6.85
White – Irish	44.63 (16.27)	4.86 (2.74)	14.83 (6.56)	13.24 (5.47)	2.69 (3.5)	7.31 (8.2)	4.23 (4.38)	4.53	44.21	42.28	8.98	35.27	64.35	0.38	71.08	22.10	6.82
White – Other White Background	37.72 (12.58)	4.69 (2.66)	14.66 (6.32)	13.32 (5.23)	2.74 (3.42)	7.35 (8.13)	4.12 (4.32)	5.30	37.76	49.44	7.50	27.11	72.66	0.23	75.56	19.34	5.10
Mixed – White and Black Caribbean	31.60 (11.55)	3.94 (2.56)	16.03 (5.99)	14.01 (5.03)	2.54 (3.3)	7.44 (8.14)	4.4 (4.56)	6.17	39.38	46.42	8.03	29.45	70.27	0.28	64.91	29.69	5.40
Mixed – White and Black African	32.97 (12.05)	4.08 (2.59)	15.66 (6.07)	13.68 (5.13)	2.66 (3.41)	7.15 (7.87)	3.76 (4.24)	6.42	37.27	47.82	8.49	29.95	69.59	0.45	67.19	26.50	6.30
Mixed – White and Asian	32.38 (12.23)	4.97 (2.82)	15.23 (6.22)	13.40 (5.18)	2.67 (3.58)	7.18 (8.09)	3.89 (4.18)	4.70	35.89	49.88	9.52	32.07	67.46	0.46	72.50	20.92	6.58
Mixed – Other Mixed Background	34.52 (12.72)	4.49 (2.67)	15.61 (6.20)	13.74 (5.14)	2.83 (3.83)	7.58 (8.3)	4.11 (4.44)	5.35	35.77	49.88	9.00	30.70	68.90	0.39	68.02	24.93	7.05

Ethnicity group	Age	IMD decile	Initial PHQ-9 score	Initial GAD-7 score	Weeks: Referral to assessment	Weeks: Assessment to next session	Number of sessions	Medication status				Gender			Unemployment status		
								Prescribed, not taking	Prescribed and taking	Not prescribed	Missing	Male	Female	Missing	Not unemployed	Unemployed	Missing
Asian – Indian	39.34 (13.86)	4.96 (2.65)	15.05 (6.54)	13.43 (5.46)	2.52 (3.77)	7.41 (7.86)	4.14 (4.46)	5.44	32.33	53.31	8.93	34.00	65.83	0.17	74.09	21.23	4.68
Asian – Pakistani	34.93 (12.17)	3.23 (2.35)	16.03 (6.52)	14.18 (5.46)	2.41 (3.62)	7.54 (8.09)	4.01 (4.23)	6.09	36.15	42.84	14.91	34.88	64.70	0.43	60.15	29.22	10.63
Asian – Bangladeshi	33.61 (11.26)	2.95 (2.08)	15.63 (6.77)	13.64 (5.72)	2.58 (3.47)	8.76 (8.93)	3.52 (3.96)	5.83	33.80	46.56	13.81	35.55	63.94	0.52	59.80	29.28	10.92
Asian – Other Asian Background	37.31 (13.40)	4.44 (2.61)	15.91 (6.43)	14.02 (5.34)	2.84 (3.85)	7.54 (8.17)	3.25 (3.9)	5.96	37.97	47.94	8.14	36.86	62.81	0.34	62.68	31.19	6.13
Black – Caribbean	39.36 (14.05)	3.38 (2.14)	15.75 (6.25)	13.43 (5.34)	2.44 (3.19)	7.76 (8.21)	3.87 (4.26)	5.94	32.76	54.09	7.21	27.81	71.99	0.20	62.93	32.35	4.71
Black – African	35.82 (12.35)	3.37 (2.20)	15.67 (6.45)	13.45 (5.46)	2.59 (3.55)	7.4 (8.01)	4.06 (4.42)	5.71	32.95	53.06	8.27	31.15	68.57	0.28	62.69	31.11	6.20
Black – Other Black Background	37.25 (13.49)	3.48 (2.25)	15.78 (6.35)	13.53 (5.35)	2.69 (3.66)	7.61 (8.19)	3.68 (4.11)	5.91	33.88	51.35	8.87	31.29	68.31	0.41	61.20	32.33	6.47
Other – Chinese	36.09 (13.22)	5.05 (2.76)	14.16 (6.41)	12.50 (5.46)	2.78 (3.63)	7.34 (8.39)	3.83 (4.3)	5.13	28.96	55.81	10.11	26.05	73.56	0.39	75.13	17.80	7.07
Other – Any Other Ethnic Group	38.30 (13.08)	4.01 (2.61)	16.04 (6.44)	14.15 (5.34)	3.13 (4.09)	7.51 (8.37)	4.29 (4.48)	4.80	39.71	44.86	10.63	34.54	65.24	0.22	58.54	32.65	8.81

*Table 4: Descriptive statistics of people **receiving a course of treatment** by ethnic group*

Ethnicity group	Age	IMD decile	Initial PHQ-9 score	Initial GAD-7 score	Weeks: Referral to assessment	Weeks: Assessment to next session	Number of sessions	Medication status				Gender			Unemployment status		
								Prescribed, not taking	Prescribed and taking	Not prescribed	Missing	Male	Female	Missing	Not unemployed	Unemployed	Missing
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	%	%	%	%	%	%	%	%	%	%
White – British	40.23 (15.49)	5.37 (2.84)	15.09 (6.00)	13.74 (4.90)	2.63 (3.62)	7.03 (7.89)	6.42 (4.5)	4.28	48.93	39.74	7.06	34.42	65.40	0.19	75.78	19.28	4.94
White – Irish	44.45 (15.92)	5.04 (2.75)	14.70 (6.19)	13.36 (5.15)	2.81 (3.77)	7.63 (8.24)	6.57 (4.44)	4.70	43.82	43.98	7.49	34.62	65.08	0.29	76.14	19.11	4.75
White – Other White Background	37.88 (12.32)	4.80 (2.67)	14.65 (6.05)	13.50 (4.97)	2.78 (3.71)	7.63 (8.16)	6.81 (4.64)	5.51	37.76	50.20	6.53	25.94	73.87	0.19	78.64	17.64	3.72
Mixed – White and Black Caribbean	32.12 (11.67)	4.10 (2.61)	15.84 (5.70)	14.01 (4.79)	2.66 (3.66)	7.73 (8.16)	6.36 (4.59)	6.22	39.10	47.88	6.80	27.79	72.01	0.20	70.08	25.68	4.25
Mixed – White and Black African	33.14 (12.16)	4.20 (2.64)	15.70 (5.71)	13.90 (4.81)	2.73 (3.6)	7.42 (7.87)	6.35 (4.38)	6.38	37.69	48.57	7.36	28.70	71.16	0.14	70.41	25.03	4.56
Mixed – White and Asian	32.66 (12.08)	5.18 (2.81)	15.16 (5.88)	13.56 (4.91)	2.78 (3.83)	7.45 (8.04)	6.65 (4.64)	5.07	36.06	51.14	7.73	30.81	68.92	0.27	76.15	19.20	4.65
Mixed – Other Mixed Background	34.84 (12.69)	4.68 (2.70)	15.42 (5.92)	13.79 (4.89)	2.95 (4.3)	7.85 (8.34)	6.74 (4.63)	5.46	35.06	50.92	8.56	29.45	70.28	0.27	71.34	22.12	6.53
Asian – Indian	39.22 (13.52)	5.13 (2.66)	15.31 (6.08)	13.87 (4.99)	2.69 (4.26)	7.72 (7.88)	6.48 (4.37)	5.72	32.73	54.48	7.07	32.84	67.08	0.08	77.01	19.56	3.43

Ethnicity group	Age	IMD decile	Initial PHQ-9 score	Initial GAD-7 score	Weeks: Referral to assessment	Weeks: Assessment to next session	Number of sessions	Medication status				Gender			Unemployment status		
								Prescribed, not taking	Prescribed and taking	Not prescribed	Missing	Male	Female	Missing	Not unemployed	Unemployed	Missing
Asian – Pakistani	35.21 (11.82)	3.35 (2.42)	16.44 (5.87)	14.76 (4.81)	2.58 (3.99)	8.05 (8.13)	6.02 (4.32)	6.77	37.19	42.88	13.15	34.07	65.72	0.21	63.20	28.34	8.46
Asian – Bangladeshi	33.14 (10.76)	3.22 (2.22)	16.25 (5.92)	14.40 (4.92)	2.76 (3.84)	9.26 (8.92)	6.36 (4.44)	6.96	35.43	48.60	9.01	36.13	63.77	0.11	66.08	28.76	5.16
Asian – Other Asian Background	37.44 (13.20)	4.56 (2.65)	15.97 (6.02)	14.21 (4.96)	2.94 (4.2)	7.95 (8.2)	6.51 (4.5)	6.05	37.77	49.25	6.93	35.47	64.34	0.18	66.41	28.95	4.64
Black – Caribbean	39.61 (13.86)	3.45 (2.16)	15.78 (5.88)	13.59 (5.02)	2.5 (3.41)	8.06 (8.21)	6.71 (4.61)	6.03	32.54	54.91	6.52	25.90	73.94	0.16	66.68	29.59	3.72
Black – African	36.14 (12.30)	3.47 (2.25)	15.97 (5.97)	13.83 (5.03)	2.64 (3.76)	7.83 (8.04)	6.36 (4.41)	6.25	34.26	52.77	6.72	29.62	70.23	0.15	66.37	29.16	4.47
Black – Other Black Background	37.59 (13.28)	3.59 (2.29)	15.91 (5.89)	13.79 (4.95)	2.8 (4.1)	7.96 (8.21)	6.51 (4.6)	5.99	33.53	52.87	7.61	29.08	70.66	0.25	65.25	29.66	5.09
Other – Chinese	35.61 (12.58)	5.19 (2.77)	14.36 (6.01)	12.87 (5.07)	2.87 (3.92)	7.66 (8.4)	6.74 (4.58)	5.02	29.52	57.30	8.17	25.91	73.79	0.30	78.70	16.67	4.63
Other – Any Other Ethnic Group	38.54 (12.88)	4.15 (2.65)	16.06 (6.08)	14.36 (4.97)	3.23 (4.4)	7.96 (8.42)	6.5 (4.47)	4.98	39.96	46.09	8.97	32.88	67.01	0.10	62.82	30.81	6.37

1.5.   IAPT outcomes

1.5.1.   Anxiety disorder-specific measures used in IAPT

For the NHS Digital defined outcomes, the first and last available depression and anxiety symptom severity scores are used. The measure of depression used is the Patient Health Questionnaire 9-items (PHQ-9),[3] but the anxiety-related measure used depends on the clinical disorder being treated.[4]

If people are treated for depression or generalised anxiety disorder, the Generalized Anxiety Disorder scale 7-items (GAD-7)[5] is used. However, anxiety disorder-specific measures are recommended when treating specific disorders due to the increased sensitivity of these scales to measure symptoms of specific anxiety disorders.

Table 5 presents the anxiety disorder-specific measures recommended for anxiety disorders treated by IAPT services.

Table 5: Anxiety disorder-specific measures used in IAPT by disorder (adapted from NHS Digital)

Anxiety disorder	Recommended measure	Threshold for caseness	Threshold for reliable improvement
Agoraphobia	Mobility Inventory[6]	2.3	0.73
Health anxiety	Health Anxiety Inventory[7]	18	4
Obsessive-compulsive disorder	Obsessive-Compulsive Inventory[8]	40	32
Panic disorder	Panic Disorder Severity Scale[9]	-	-
Post-traumatic stress disorder	Impact of Events Scale (IES-R)[10]	33	9
Social anxiety disorder	Social Phobia Inventory[11]	19	10

1.5.2. IAPT outcome definitions

Table 6: IAPT outcome definitions

IAPT outcomes	Definitions
Moving to recovery*	This is defined as scoring above the threshold for 'caseness' (clinical threshold) for either depression or/and anxiety (using the GAD-7 or appropriate anxiety disorder specific measure) at assessment, and the scoring below caseness on both measures at the end of treatment (last contact). The threshold for caseness on the PHQ-9 is a score of 10 or above, and on the GAD-7 it is 8 or above (thresholds for individual anxiety disorder specific measures are presented in [Table 5](#)).
Reliable improvement*	Defined as a change in symptom severity score that is above the 'error of measurement' for a scale (which means that the change is unlikely to be chance error in repeated measurement) between first and last timepoints. This change can be on either the depression or anxiety measure, and does not have to be on both.
Reliable recovery*	Combines the first 2 outcomes, so individuals have to meet criteria for recovery but also must have reliable improvement on at least 1 of the measures used in calculations.
Reliable deterioration*	An increase in scores above the error of measurement on that scale (worsening of symptoms).
Dropout**	Defined as clinician-reported 'reason for end of episode' being 'dropped out'.
Proportion of sessions attended**	The proportion of all sessions offered that were attended by the patient (that is, not coded as 'did not attend' or cancelled).

* Defined by NHS Digital in national reports.
** Used by the research team in previous studies.[12,13]

1.5.3.   Changes in recovery rate (national data)

Figure 5 (a–e) presents the recovery rates by ethnicity groups, using the detailed ONS categories, compared with the rates for 'White British' groups, which are also presented for comparison. Recovery rates by the high-level ONS ethnicity categories can be found in *Section 3.4.* of the report.

Figure 5: IAPT recovery rates by detailed ONS categories of ethnicity

Figure 5 (a): IAPT recovery rate ('Asian' ethnic groups)
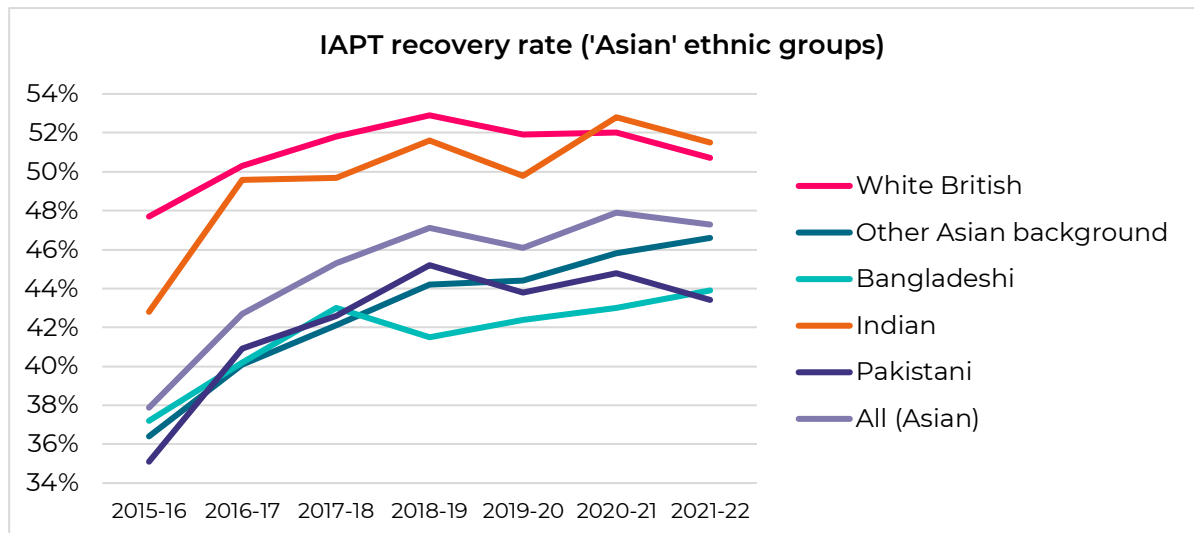
Figure 5 (b): IAPT recovery rate ('Black' ethnic groups)

Figure 5 (c): IAPT recovery rate ('Mixed' ethnic groups)

IAPT recovery rate ('Mixed' ethnic groups)

Legend: White British, Other Mixed background, White & Asian, White & Black African, White & Black Caribbean, All (Mixed)
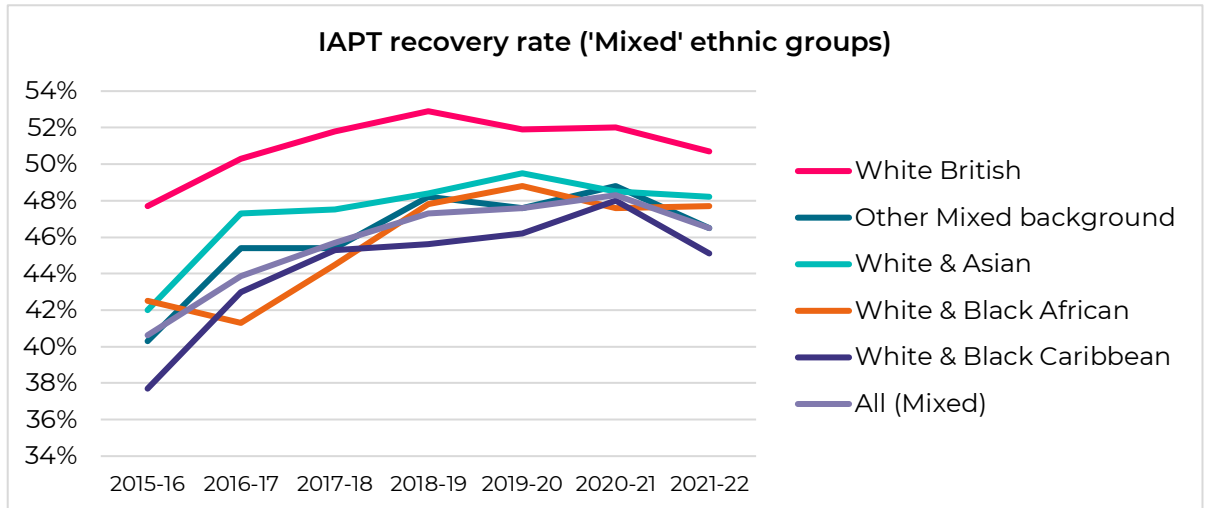
Figure 5 (d): IAPT recovery rate ('Other' ethnic groups)

IAPT recovery rate ('Other' ethnic groups)

Legend: White British, Any other Ethnic Groups, Chinese, All (Other)
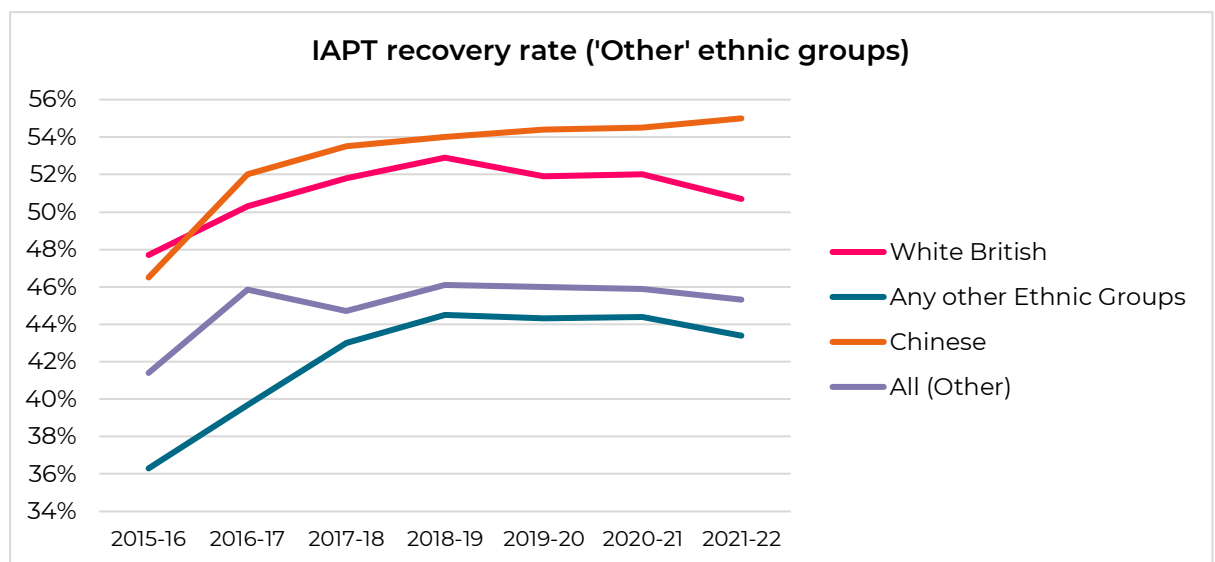
Figure 5 (e): IAPT recovery rate ('White' ethnic groups)

IAPT recovery rate ('White' ethnic groups)

Legend: All (White)*, Other White background, White Irish, White British
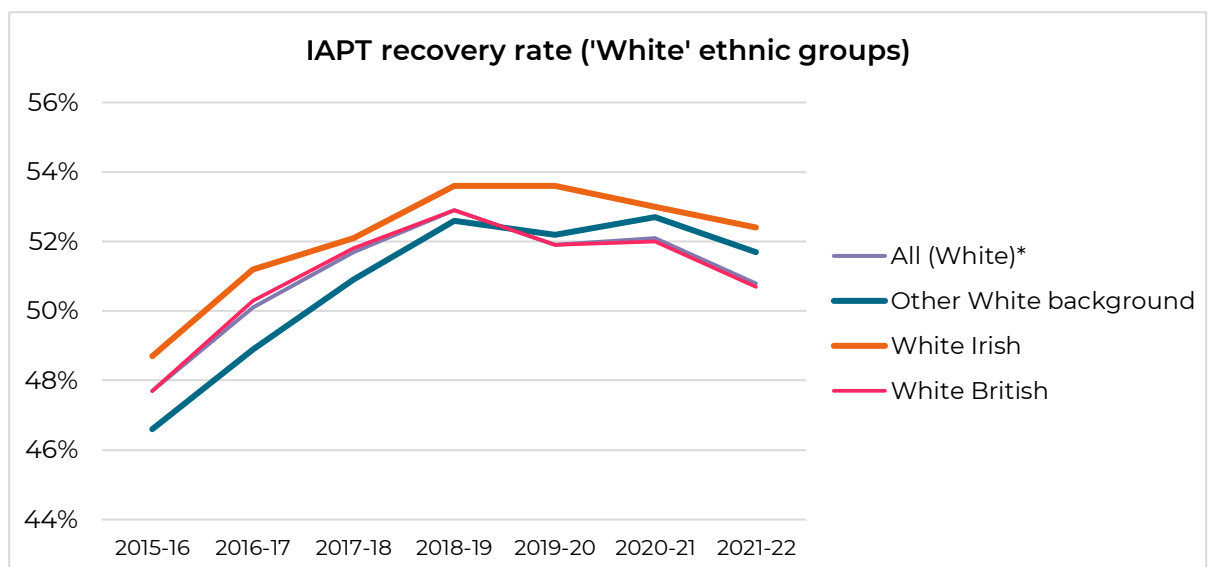
* 'All (White)' is partially obscured by the line for 'White British' data

1.5.4. Changes in reliable improvement rate (national data)

Figure 6 (a–e) presents the reliable improvement rates by ethnicity groups by the detailed ONS ethnicity categories compared with the rates for 'White British' groups, which are also presented for comparison. Reliable improvement rates by the high-level categories can be found in *Section 3.4.* of the report.

Figure 6: IAPT reliable improvement rates by detailed ONS categories of ethnicity

Figure 6 (a): IAPT reliable improvement rate ('Asian' ethnic groups)
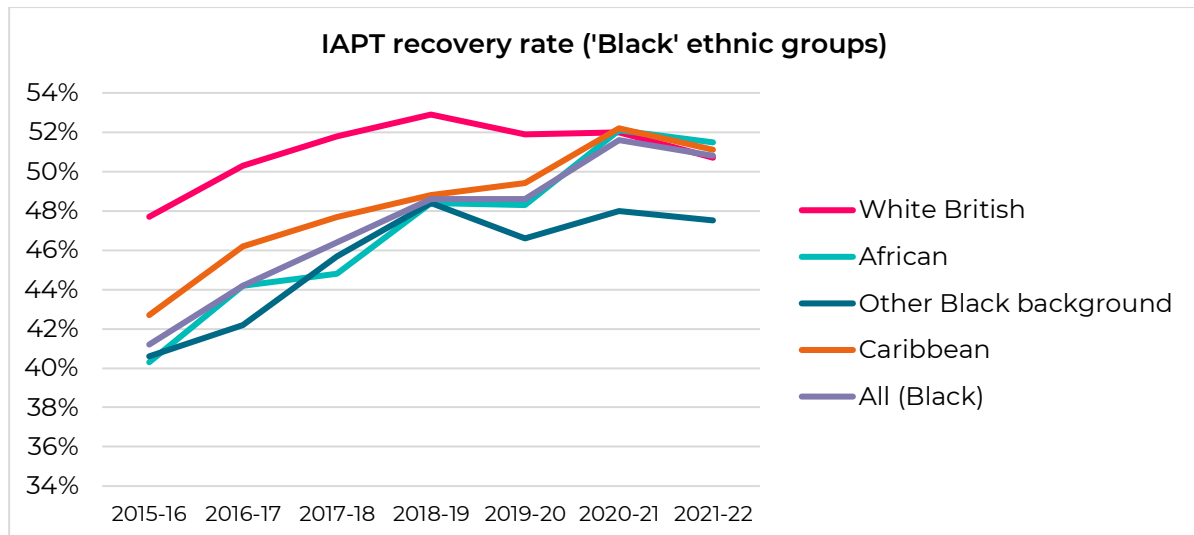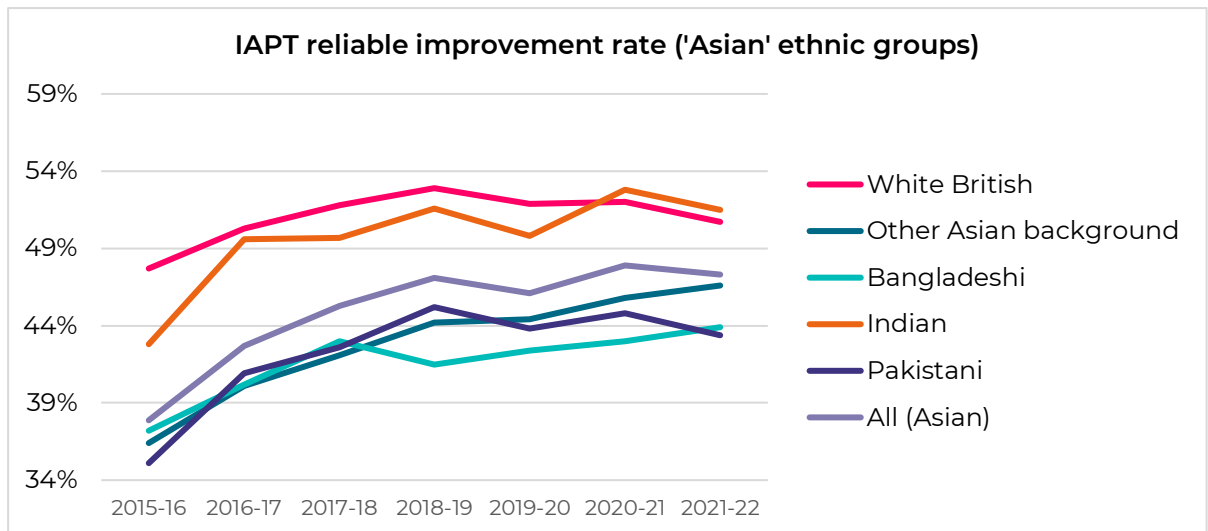

Figure 6 (b): IAPT reliable improvement rate ('Black' ethnic groups)

Figure 6 (c): IAPT reliable improvement rate ('Mixed' ethnic groups)

IAPT reliable improvement rate ('Mixed' ethnic groups)

Legend:
- White British
- Other Mixed background
- White & Asian
- White & Black African
- White & Black Caribbean
- All (Mixed)
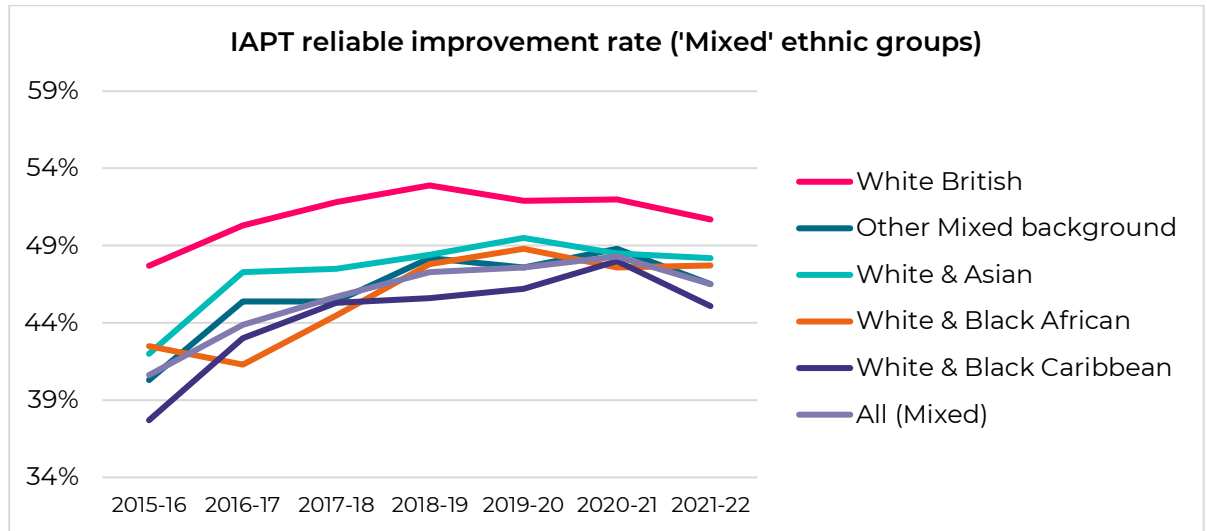
Figure 6 (d): IAPT reliable improvement rate ('Other' ethnic groups)

IAPT reliable improvement rate ('Other' ethnic groups)

Legend:
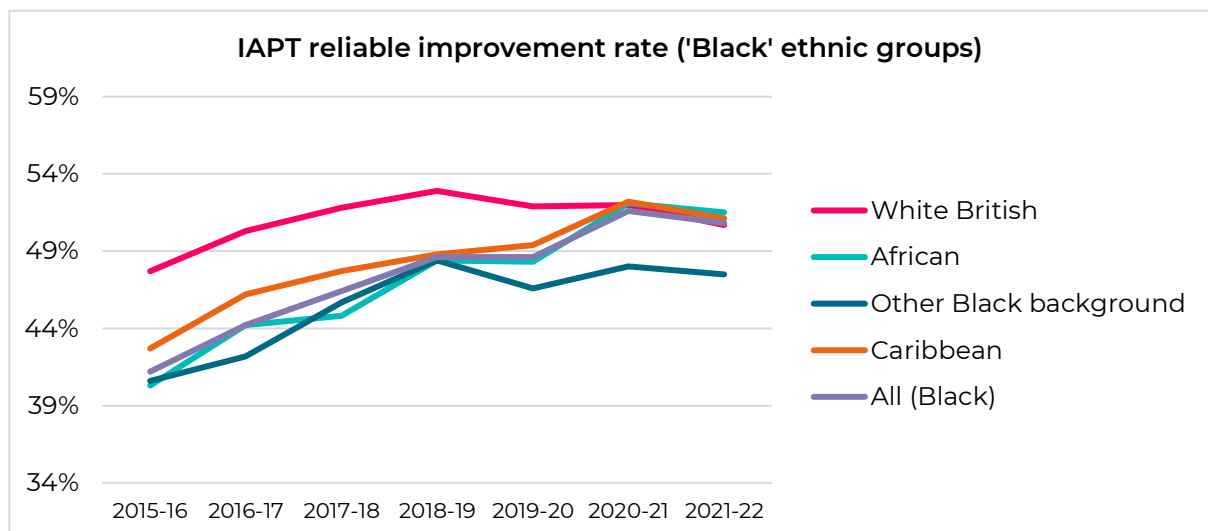- White British
- Any other Ethnic Groups
- Chinese
- All (Other)
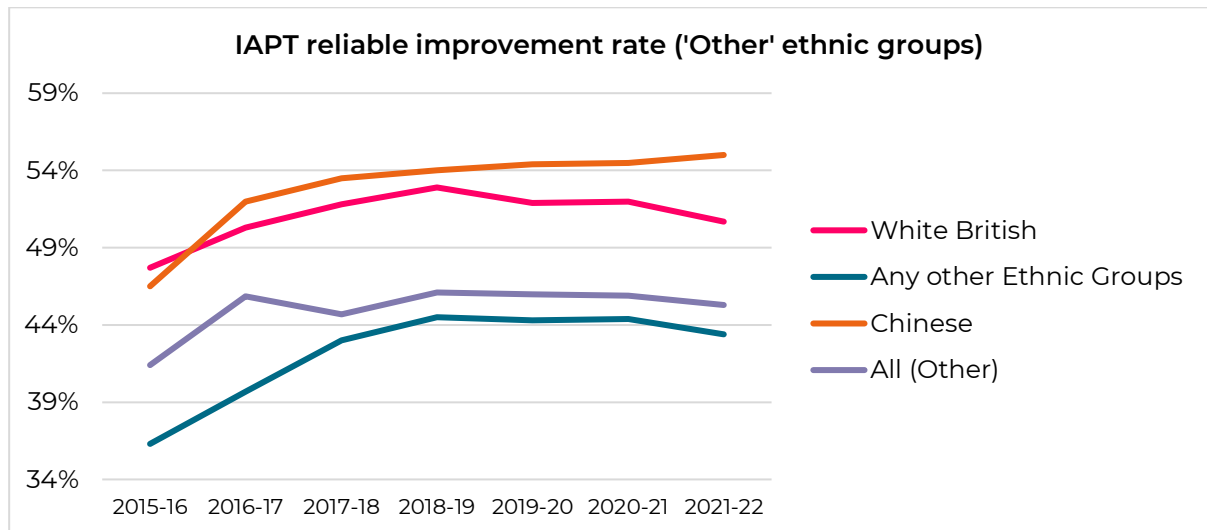
Figure 6 (e): IAPT reliable improvement rate ('White' ethnic groups)

IAPT reliable improvement rate ('White' ethnic groups)

Legend:
- White British
- White Irish
- Other White background
- All (White)
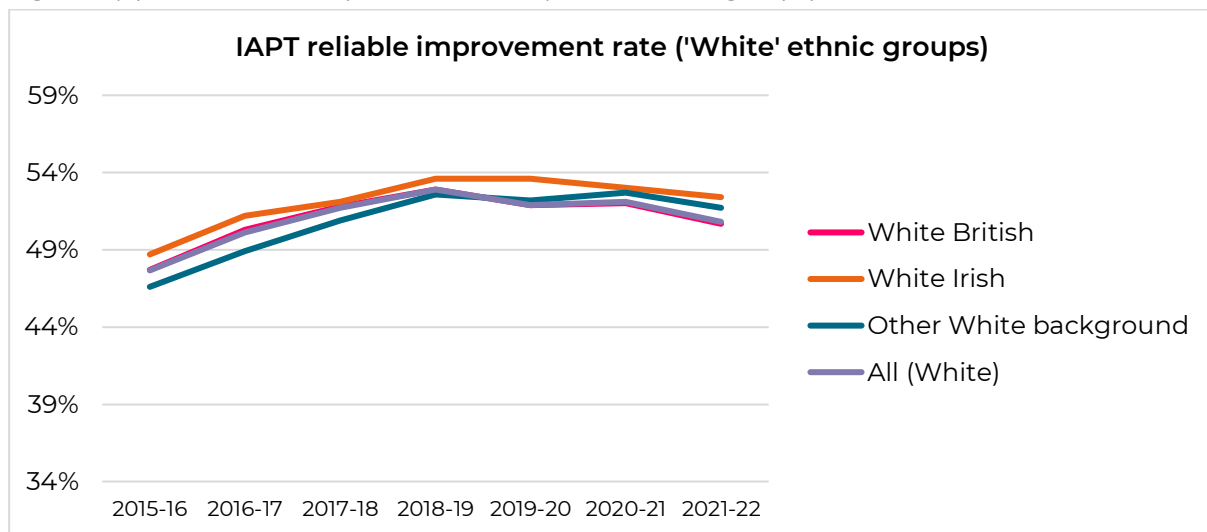
1.5.5. Changes in reliable recovery rate (national data)

Figure 7 (a–e) presents the reliable recovery rates by ethnicity groups at both the high-level ONS categories and by the detailed categories, compared with the rates for 'White British' groups.

Figure 7: IAPT reliable recovery rates by high-level and detailed ONS ethnicity categories

Figure 7 (a): IAPT reliable recovery rate (high-level ethnic categories)

IAPT reliable recovery rate

Legend: White, Asian or Asian British, Black or Black British, Mixed, Other Ethnic Groups
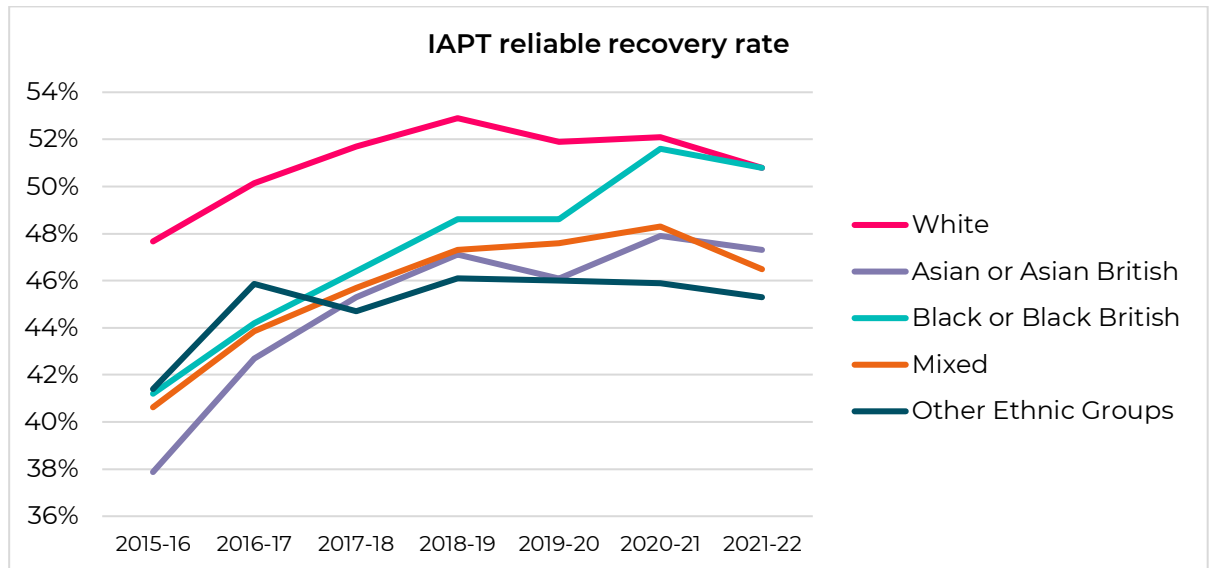
Figure 7 (b): IAPT reliable recovery rate ('Asian' ethnic groups)

IAPT reliable recovery rate ('Asian' ethnic groups)

Legend: White British, Other Asian background, Bangladeshi, Indian, Pakistani, All (Asian)
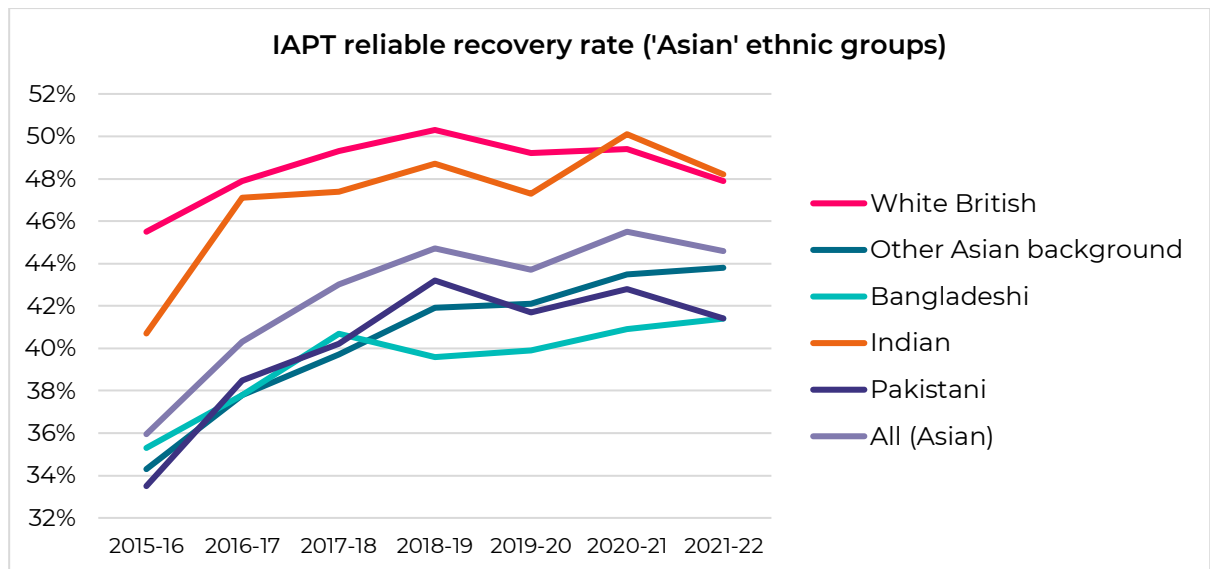
Figure 7 (c): IAPT reliable recovery rate ('Black' ethnic groups)

IAPT reliable recovery rate ('Black' ethnic groups)

Legend: White British, African, Other Black background, Caribbean, All (Black)
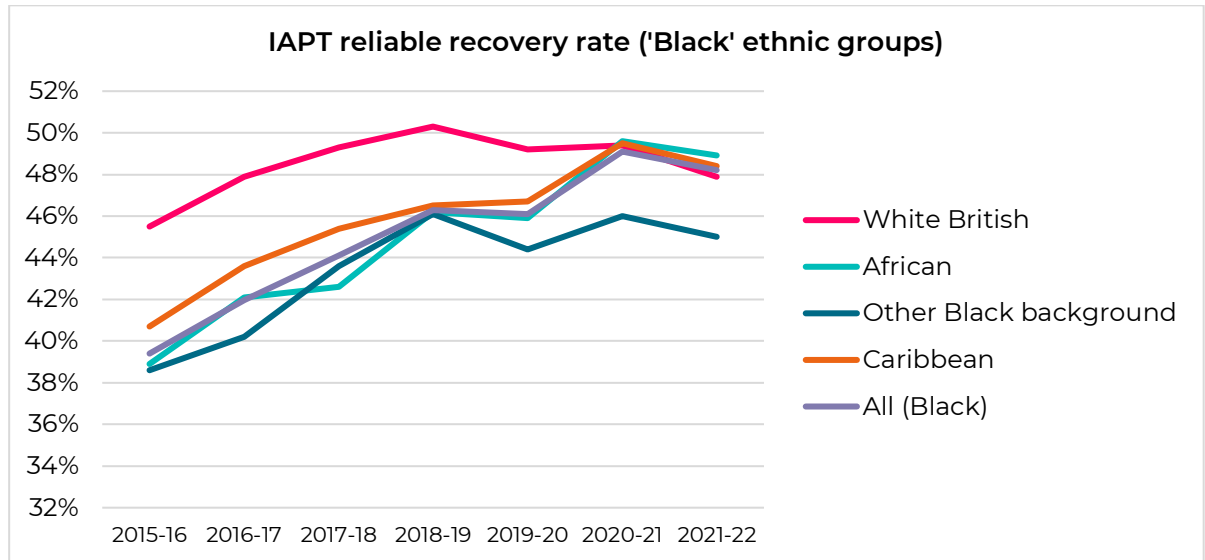
Figure 7 (d): IAPT reliable recovery rate (Mixed ethnic groups)

IAPT reliable recovery rate ('Mixed' ethnic groups)

Legend: White British, Other Mixed background, White & Asian, White & Black African, White & Black Caribbean, All (Mixed)
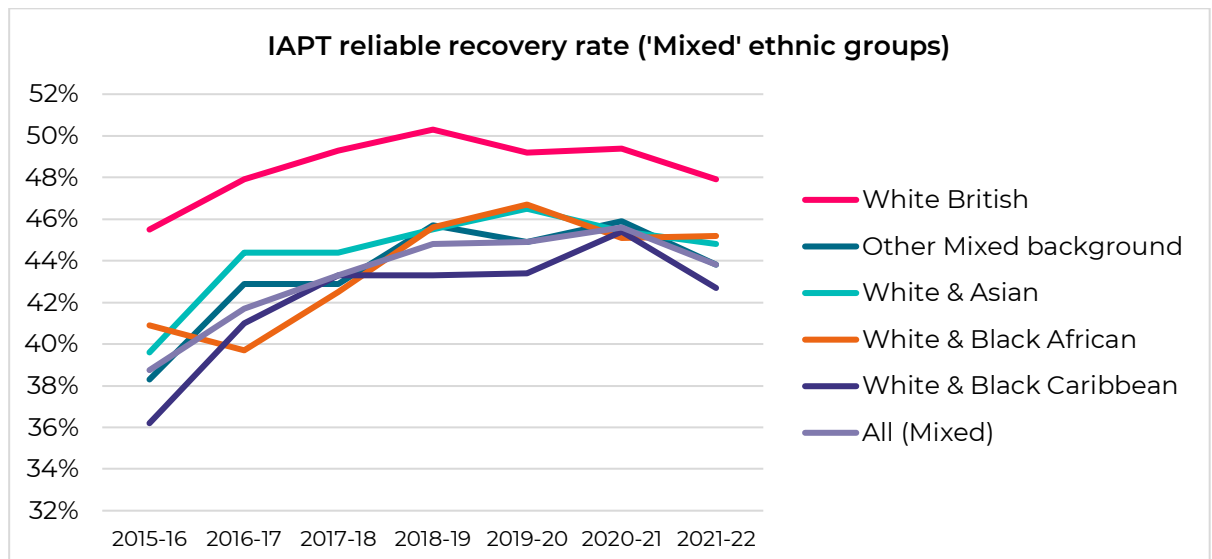
Figure 7 (e): IAPT reliable recovery rate ('Other' ethnic groups)

IAPT reliable recovery rate ('Other' ethnic groups)

Legend: White British, Any other Ethnic Groups, Chinese, All (Other)
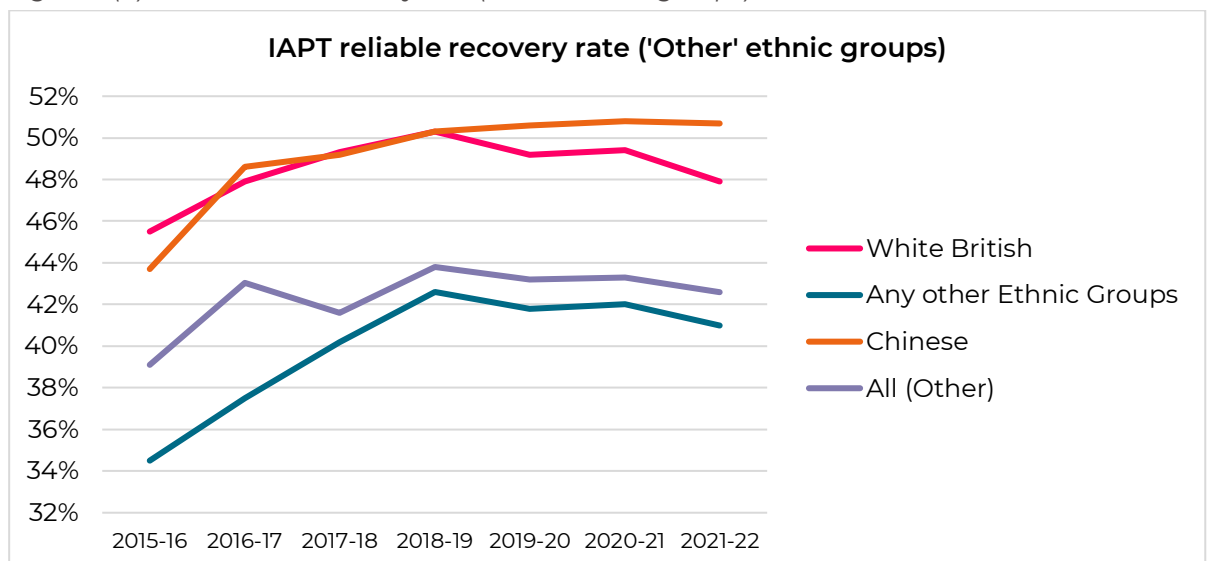
Figure 7 (f): IAPT reliable recovery rate ('White' ethnic groups)

IAPT reliable recovery rate ('White' ethnic groups)

Legend:
- White British
- White Irish
- Other White background
- All (White)
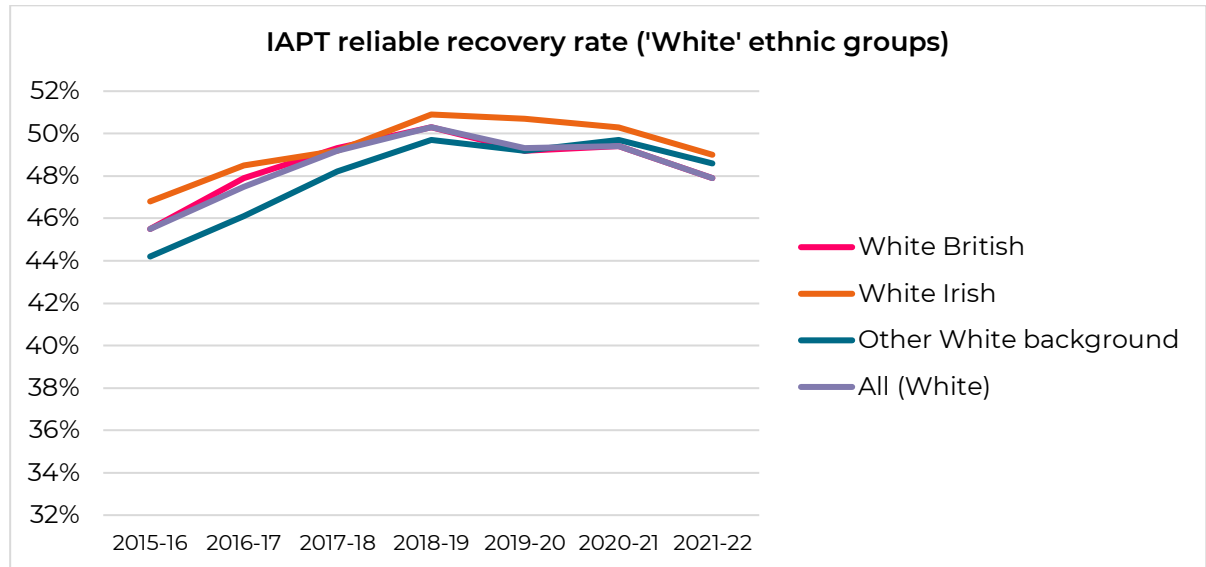
1.5.6. Odds ratios comparing each ethnic group with the 'White: British' group

The following tables present the ORs for:

- recovery (Table 7)
- reliable improvement (Table 8)
- reliable recovery (Table 9)
- reliable deterioration (Table 10)
- dropout (Table 11)
- proportion of sessions attended (Table 12).

Table 7: **Recovery** ORs

Ethnic group	Model 1		Model 2		Model 3		Model 4		Model 5	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
White – British	*	*	*	*	*	*	*	*	*	*
White – Irish	1.02	(0.98; 1.06)	0.97	(0.94; 1.01)	0.95	(0.91; 0.99)	0.96	(0.92; 1)	0.94	(0.9; 0.98)
White – Other White Background	0.95	(0.94; 0.97)	0.98	(0.97; 1)	0.95	(0.93; 0.97)	0.95	(0.93; 0.96)	0.92	(0.9; 0.93)
Mixed – White and Black Caribbean	0.72	(0.7; 0.75)	0.79	(0.77; 0.82)	0.84	(0.81; 0.87)	0.89	(0.85; 0.93)	0.90	(0.86; 0.94)
Mixed – White and Black African	0.77	(0.72; 0.83)	0.83	(0.78; 0.89)	0.85	(0.78; 0.92)	0.89	(0.82; 0.97)	0.91	(0.83; 0.99)
Mixed – White and Asian	0.82	(0.78; 0.86)	0.89	(0.85; 0.94)	0.89	(0.84; 0.95)	0.91	(0.86; 0.96)	0.89	(0.84; 0.95)
Mixed – Other Mixed Background	0.80	(0.78; 0.83)	0.86	(0.83; 0.89)	0.87	(0.84; 0.91)	0.91	(0.87; 0.94)	0.89	(0.85; 0.93)
Asian – Indian	0.93	(0.91; 0.95)	0.94	(0.92; 0.96)	0.98	(0.95; 1)	0.98	(0.96; 1.01)	0.98	(0.95; 1.01)
Asian – Pakistani	0.67	(0.65; 0.69)	0.71	(0.69; 0.73)	0.85	(0.83; 0.88)	0.94	(0.9; 0.97)	0.95	(0.92; 0.99)
Asian – Bangladeshi	0.64	(0.61; 0.67)	0.69	(0.66; 0.72)	0.79	(0.75; 0.84)	0.86	(0.81; 0.92)	0.85	(0.8; 0.91)
Asian – Other Asian Background	0.69	(0.66; 0.71)	0.71	(0.68; 0.73)	0.79	(0.76; 0.82)	0.84	(0.81; 0.87)	0.84	(0.81; 0.87)
Black – Caribbean	0.84	(0.82; 0.87)	0.85	(0.83; 0.87)	0.91	(0.89; 0.95)	0.99	(0.96; 1.03)	0.99	(0.96; 1.03)
Black – African	0.78	(0.76; 0.81)	0.82	(0.79; 0.84)	0.94	(0.91; 0.98)	1.02	(0.98; 1.06)	1.04	(0.99; 1.08)
Black – Other Black Background	0.77	(0.73; 0.8)	0.79	(0.75; 0.83)	0.85	(0.8; 0.9)	0.93	(0.87; 0.98)	0.94	(0.89; 1.01)
Other – Chinese	1.05	(0.98; 1.12)	1.11	(1.04; 1.19)	1.05	(0.97; 1.14)	1.06	(0.98; 1.14)	1.04	(0.96; 1.13)
Other – Any Other Ethnic Group	0.69	(0.67; 0.71)	0.70	(0.68; 0.72)	0.78	(0.76; 0.81)	0.84	(0.81; 0.87)	0.84	(0.81; 0.88)

Table 8: **Reliable improvement** ORs

Ethnic group	Model 1		Model 2		Model 3		Model 4		Model 5	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
White – British	*	*	*	*	*	*	*	*	*	*
White – Irish	0.96	(0.93; 1)	0.94	(0.9; 0.97)	0.94	(0.9; 0.98)	0.94	(0.9; 0.99)	0.93	(0.88; 0.97)
White – Other White Background	0.95	(0.94; 0.97)	0.97	(0.95; 0.98)	0.97	(0.96; 0.99)	0.97	(0.95; 0.99)	0.94	(0.92; 0.96)
Mixed – White and Black Caribbean	0.78	(0.75; 0.81)	0.83	(0.8; 0.86)	0.86	(0.82; 0.89)	0.91	(0.87; 0.95)	0.93	(0.88; 0.97)
Mixed – White and Black African	0.84	(0.78; 0.91)	0.88	(0.82; 0.95)	0.92	(0.84; 1)	0.97	(0.89; 1.06)	0.96	(0.88; 1.06)
Mixed – White and Asian	0.81	(0.76; 0.85)	0.85	(0.81; 0.9)	0.87	(0.82; 0.93)	0.88	(0.83; 0.93)	0.84	(0.79; 0.9)
Mixed – Other Mixed Background	0.84	(0.81; 0.87)	0.87	(0.84; 0.91)	0.89	(0.86; 0.93)	0.93	(0.89; 0.97)	0.92	(0.88; 0.96)
Asian – Indian	0.92	(0.9; 0.94)	0.93	(0.9; 0.95)	0.92	(0.89; 0.94)	0.92	(0.89; 0.94)	0.92	(0.89; 0.95)
Asian – Pakistani	0.72	(0.7; 0.74)	0.74	(0.72; 0.76)	0.79	(0.76; 0.81)	0.87	(0.84; 0.9)	0.89	(0.86; 0.92)
Asian – Bangladeshi	0.70	(0.67; 0.74)	0.74	(0.7; 0.78)	0.79	(0.74; 0.84)	0.87	(0.81; 0.92)	0.85	(0.8; 0.91)
Asian – Other Asian Background	0.73	(0.7; 0.75)	0.74	(0.72; 0.76)	0.77	(0.74; 0.8)	0.82	(0.79; 0.85)	0.82	(0.78; 0.85)
Black – Caribbean	0.88	(0.86; 0.91)	0.88	(0.86; 0.91)	0.94	(0.91; 0.97)	1.03	(1; 1.07)	1.02	(0.99; 1.06)
Black – African	0.85	(0.82; 0.88)	0.87	(0.84; 0.9)	0.95	(0.91; 0.99)	1.03	(0.99; 1.07)	1.05	(1.01; 1.1)
Black – Other Black Background	0.83	(0.79; 0.87)	0.84	(0.8; 0.89)	0.89	(0.84; 0.95)	0.98	(0.93; 1.05)	1.01	(0.94; 1.08)
Other – Chinese	0.99	(0.91; 1.06)	1.02	(0.94; 1.1)	1.06	(0.97; 1.15)	1.06	(0.97; 1.15)	1.03	(0.94; 1.13)
Other – Any Other Ethnic Group	0.74	(0.72; 0.76)	0.75	(0.72; 0.77)	0.76	(0.73; 0.79)	0.82	(0.79; 0.85)	0.82	(0.79; 0.85)

Table 9: **Reliable recovery** ORs

Ethnic group	Model 1		Model 2		Model 3		Model 4		Model 5	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
White – British	*	*	*	*	*	*	*	*	*	*
White – Irish	1.01	(0.97; 1.05)	0.96	(0.93; 1)	0.95	(0.91; 0.99)	0.96	(0.92; 1)	0.95	(0.9; 0.99)
White – Other White Background	0.95	(0.93; 0.96)	0.97	(0.96; 0.99)	0.95	(0.93; 0.97)	0.95	(0.93; 0.97)	0.92	(0.9; 0.94)
Mixed – White and Black Caribbean	0.73	(0.71; 0.76)	0.80	(0.77; 0.83)	0.85	(0.81; 0.88)	0.90	(0.86; 0.93)	0.91	(0.87; 0.95)
Mixed – White and Black African	0.79	(0.74; 0.85)	0.85	(0.79; 0.91)	0.88	(0.82; 0.96)	0.93	(0.86; 1.01)	0.95	(0.87; 1.03)
Mixed – White and Asian	0.81	(0.77; 0.85)	0.88	(0.83; 0.92)	0.89	(0.84; 0.94)	0.90	(0.85; 0.95)	0.88	(0.82; 0.93)
Mixed – Other Mixed Background	0.80	(0.78; 0.83)	0.85	(0.82; 0.88)	0.88	(0.84; 0.91)	0.91	(0.87; 0.95)	0.90	(0.86; 0.94)
Asian – Indian	0.93	(0.91; 0.96)	0.94	(0.92; 0.97)	0.97	(0.95; 1)	0.98	(0.95; 1)	0.98	(0.95; 1)
Asian – Pakistani	0.68	(0.66; 0.7)	0.72	(0.7; 0.74)	0.84	(0.82; 0.87)	0.92	(0.89; 0.96)	0.94	(0.91; 0.98)
Asian – Bangladeshi	0.65	(0.62; 0.68)	0.70	(0.66; 0.73)	0.80	(0.75; 0.85)	0.87	(0.82; 0.92)	0.86	(0.81; 0.92)
Asian – Other Asian Background	0.69	(0.67; 0.71)	0.71	(0.69; 0.73)	0.78	(0.76; 0.81)	0.84	(0.81; 0.87)	0.84	(0.81; 0.87)
Black – Caribbean	0.85	(0.82; 0.87)	0.85	(0.83; 0.88)	0.93	(0.9; 0.96)	1.01	(0.97; 1.04)	1.01	(0.97; 1.04)
Black – African	0.80	(0.77; 0.82)	0.83	(0.8; 0.86)	0.95	(0.91; 0.98)	1.02	(0.98; 1.06)	1.04	(1; 1.08)
Black – Other Black Background	0.77	(0.74; 0.81)	0.80	(0.76; 0.84)	0.86	(0.81; 0.91)	0.94	(0.88; 0.99)	0.95	(0.9; 1.02)
Other – Chinese	1.00	(0.93; 1.07)	1.05	(0.98; 1.13)	1.03	(0.95; 1.11)	1.03	(0.96; 1.12)	1.02	(0.94; 1.1)
Other – Any Other Ethnic Group	0.69	(0.67; 0.71)	0.70	(0.68; 0.73)	0.77	(0.75; 0.8)	0.83	(0.81; 0.86)	0.84	(0.81; 0.87)

Table 10: **Reliable deterioration** ORs

Ethnic group	Model 1		Model 2		Model 3		Model 4		Model 5	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
White – British	*	*	*	*	*	*	*	*	*	*
White – Irish	1.16	(1.08; 1.24)	1.18	(1.1; 1.26)	1.18	(1.09; 1.28)	1.17	(1.08; 1.26)	1.16	(1.07; 1.26)
White – Other White Background	1.13	(1.1; 1.17)	1.12	(1.09; 1.16)	1.10	(1.06; 1.14)	1.09	(1.05; 1.13)	1.10	(1.06; 1.14)
Mixed – White and Black Caribbean	1.28	(1.19; 1.37)	1.24	(1.16; 1.32)	1.22	(1.14; 1.32)	1.13	(1.05; 1.21)	1.12	(1.04; 1.22)
Mixed – White and Black African	1.31	(1.15; 1.49)	1.28	(1.12; 1.45)	1.27	(1.1; 1.47)	1.20	(1.04; 1.39)	1.14	(0.97; 1.34)
Mixed – White and Asian	1.21	(1.09; 1.33)	1.17	(1.06; 1.29)	1.14	(1.03; 1.28)	1.14	(1.02; 1.27)	1.15	(1.02; 1.29)
Mixed – Other Mixed Background	1.25	(1.17; 1.34)	1.22	(1.14; 1.31)	1.24	(1.15; 1.34)	1.18	(1.1; 1.27)	1.18	(1.09; 1.27)
Asian – Indian	1.18	(1.12; 1.23)	1.17	(1.12; 1.23)	1.25	(1.19; 1.31)	1.24	(1.18; 1.3)	1.22	(1.16; 1.29)
Asian – Pakistani	1.46	(1.39; 1.53)	1.43	(1.36; 1.5)	1.56	(1.48; 1.66)	1.37	(1.29; 1.45)	1.34	(1.25; 1.42)
Asian – Bangladeshi	1.73	(1.59; 1.88)	1.68	(1.55; 1.83)	1.77	(1.61; 1.95)	1.56	(1.42; 1.72)	1.57	(1.41; 1.73)
Asian – Other Asian Background	1.47	(1.39; 1.55)	1.45	(1.37; 1.54)	1.53	(1.44; 1.63)	1.42	(1.34; 1.52)	1.40	(1.3; 1.5)
Black – Caribbean	1.27	(1.21; 1.34)	1.27	(1.2; 1.33)	1.23	(1.16; 1.31)	1.08	(1.02; 1.15)	1.09	(1.02; 1.16)
Black – African	1.36	(1.28; 1.44)	1.34	(1.26; 1.42)	1.28	(1.2; 1.37)	1.15	(1.07; 1.23)	1.11	(1.03; 1.2)
Black – Other Black Background	1.29	(1.18; 1.41)	1.27	(1.16; 1.4)	1.27	(1.14; 1.41)	1.11	(1; 1.24)	1.10	(0.98; 1.23)
Other – Chinese	1.10	(0.96; 1.26)	1.08	(0.94; 1.24)	0.99	(0.85; 1.15)	1.00	(0.85; 1.16)	1.02	(0.87; 1.2)
Other – Any Other Ethnic Group	1.46	(1.39; 1.54)	1.45	(1.38; 1.53)	1.56	(1.47; 1.65)	1.41	(1.33; 1.5)	1.41	(1.33; 1.51)

*Table 11: **Dropout** ORs*

Ethnic group	Model 1		Model 2		Model 3		Model 4		Model 5	
	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI	OR	95% CI
White – British	*	*	*	*	*	*	*	*	*	*
White – Irish	0.93	(0.89; 0.97)	1.00	(0.95; 1.04)	1.00	(0.96; 1.05)	0.99	(0.94; 1.03)	0.97	(0.93; 1.02)
White – Other White Background	0.90	(0.88; 0.91)	0.86	(0.85; 0.88)	0.87	(0.85; 0.89)	0.85	(0.83; 0.87)	0.84	(0.82; 0.86)
Mixed – White and Black Caribbean	1.40	(1.35; 1.46)	1.22	(1.17; 1.27)	1.17	(1.12; 1.22)	1.09	(1.04; 1.14)	1.07	(1.03; 1.12)
Mixed – White and Black African	1.25	(1.16; 1.35)	1.11	(1.03; 1.2)	1.04	(0.95; 1.13)	0.97	(0.89; 1.06)	0.97	(0.88; 1.06)
Mixed – White and Asian	1.08	(1.02; 1.15)	0.95	(0.89; 1)	0.94	(0.88; 1)	0.94	(0.88; 1)	0.92	(0.86; 0.99)
Mixed – Other Mixed Background	1.12	(1.08; 1.17)	1.02	(0.98; 1.06)	0.99	(0.95; 1.04)	0.96	(0.91; 1)	0.93	(0.89; 0.98)
Asian – Indian	0.91	(0.88; 0.93)	0.89	(0.87; 0.91)	0.87	(0.84; 0.9)	0.86	(0.83; 0.89)	0.86	(0.83; 0.89)
Asian – Pakistani	1.38	(1.34; 1.43)	1.28	(1.24; 1.32)	1.10	(1.06; 1.14)	0.98	(0.95; 1.02)	0.98	(0.94; 1.02)
Asian – Bangladeshi	1.25	(1.18; 1.32)	1.10	(1.04; 1.17)	0.99	(0.93; 1.06)	0.88	(0.82; 0.94)	0.88	(0.82; 0.94)
Asian – Other Asian Background	1.07	(1.03; 1.11)	1.02	(0.98; 1.06)	0.96	(0.92; 1)	0.91	(0.87; 0.95)	0.88	(0.84; 0.92)
Black – Caribbean	1.11	(1.08; 1.15)	1.10	(1.07; 1.14)	1.06	(1.02; 1.1)	0.95	(0.91; 0.98)	0.92	(0.89; 0.96)
Black – African	1.30	(1.25; 1.35)	1.21	(1.17; 1.26)	1.15	(1.1; 1.2)	1.04	(1; 1.09)	1.03	(0.99; 1.08)
Black – Other Black Background	1.25	(1.18; 1.32)	1.20	(1.13; 1.27)	1.14	(1.07; 1.22)	1.04	(0.97; 1.1)	1.03	(0.96; 1.1)
Other – Chinese	0.83	(0.77; 0.9)	0.76	(0.7; 0.83)	0.80	(0.73; 0.88)	0.79	(0.73; 0.87)	0.78	(0.71; 0.86)
Other – Any Other Ethnic Group	1.06	(1.02; 1.09)	1.03	(0.99; 1.06)	0.97	(0.93; 1)	0.89	(0.86; 0.93)	0.88	(0.84; 0.91)

Table 12: **Proportion of sessions attended** ORs

Ethnic group	Model 1		Model 2		Model 3		Model 4		Model 5	
	β	95% CI	β	95% CI	β	95% CI	β	95% CI	β	95% CI
White – British	*	*	*	*	*	*	*	*	*	*
White – Irish	0.00	(0; 0)	-0.01	(-0.01; 0)	-0.01	(-0.01; -0.01)	-0.01	(-0.01; 0)	-0.01	(-0.01; -0.01)
White – Other White Background	0.01	(0.01; 0.01)	0.02	(0.02; 0.02)	0.02	(0.01; 0.02)	0.02	(0.02; 0.02)	0.01	(0.01; 0.01)
Mixed – White and Black Caribbean	-0.04	(-0.04; -0.04)	-0.03	(-0.03; -0.02)	-0.03	(-0.03; -0.02)	-0.02	(-0.03; -0.02)	-0.02	(-0.02; -0.02)
Mixed – White and Black African	-0.02	(-0.03; -0.02)	-0.01	(-0.02; 0)	-0.01	(-0.02; -0.01)	-0.01	(-0.02; 0)	-0.01	(-0.02; 0)
Mixed – White and Asian	-0.01	(-0.01; 0)	0.01	(0; 0.01)	0.01	(0; 0.01)	0.00	(0; 0.01)	0.00	(0; 0.01)
Mixed – Other Mixed Background	-0.01	(-0.02; -0.01)	0.00	(-0.01; 0)	-0.01	(-0.01; 0)	0.00	(-0.01; 0)	-0.01	(-0.01; 0)
Asian – Indian	0.00	(0; 0)	0.00	(0; 0)	0.00	(0; 0)	0.00	(0; 0)	0.00	(0; 0)
Asian – Pakistani	-0.04	(-0.04; -0.03)	-0.03	(-0.03; -0.02)	-0.03	(-0.04; -0.03)	-0.02	(-0.03; -0.02)	-0.02	(-0.02; -0.02)
Asian – Bangladeshi	-0.03	(-0.03; -0.02)	-0.02	(-0.02; -0.01)	-0.02	(-0.02; -0.01)	-0.01	(-0.01; 0)	0.00	(-0.01; 0)
Asian – Other Asian Background	0.00	(-0.01; 0)	0.00	(0; 0)	0.00	(0; 0.01)	0.01	(0; 0.01)	0.01	(0; 0.01)
Black – Caribbean	-0.02	(-0.03; -0.02)	-0.02	(-0.02; -0.02)	-0.03	(-0.03; -0.02)	-0.02	(-0.02; -0.01)	-0.02	(-0.02; -0.02)
Black – African	-0.03	(-0.03; -0.03)	-0.02	(-0.03; -0.02)	-0.03	(-0.03; -0.02)	-0.02	(-0.02; -0.02)	-0.02	(-0.02; -0.01)
Black – Other Black Background	-0.03	(-0.03; -0.02)	-0.02	(-0.03; -0.02)	-0.03	(-0.03; -0.02)	-0.02	(-0.02; -0.01)	-0.02	(-0.02; -0.01)
Other – Chinese	0.04	(0.03; 0.04)	0.05	(0.04; 0.05)	0.04	(0.03; 0.05)	0.04	(0.03; 0.04)	0.03	(0.03; 0.04)
Other – Any Other Ethnic Group	-0.01	(-0.01; 0)	0.00	(-0.01; 0)	0.00	(0; 0)	0.01	(0; 0.01)	0.01	(0.01; 0.01)

1.6.   Results of multilevel models

The following tables present the results of the multilevel models for:

- recovery ([Table 13](#))
- reliable improvement ([Table 14](#))
- reliable recovery ([Table 15](#))
- reliable deterioration ([Table 16](#))
- dropout ([Table 17](#))
- proportion of sessions attended ([Table 18](#))

*Table 13: Results of multilevel models for **recovery***

Ethnic group	Model 1		Model 5	
	OR	95% CI	OR	95% CI
White – British	*	*	*	*
White – Irish	1.02	(0.98; 1.05)	0.99	(0.95; 1.04)
White – Other White Background	0.94	(0.93; 0.96)	0.99	(0.97; 1.01)
Mixed – White and Black Caribbean	0.71	(0.69; 0.74)	0.93	(0.89; 0.97)
Mixed – White and Black African	0.77	(0.72; 0.83)	0.97	(0.89; 1.06)
Mixed – White and Asian	0.81	(0.77; 0.85)	0.93	(0.87; 0.99)
Mixed – Other Mixed Background	0.80	(0.77; 0.83)	0.94	(0.9; 0.98)
Asian – Indian	0.89	(0.86; 0.91)	0.97	(0.94; 1)
Asian – Pakistani	0.64	(0.63; 0.66)	0.94	(0.9; 0.97)
Asian – Bangladeshi	0.62	(0.59; 0.65)	0.91	(0.85; 0.97)
Asian – Other Asian Background	0.66	(0.64; 0.69)	0.88	(0.84; 0.92)
Black – Caribbean	0.81	(0.79; 0.83)	1.03	(1; 1.07)
Black – African	0.77	(0.75; 0.8)	1.12	(1.07; 1.17)
Black – Other Black Background	0.76	(0.72; 0.8)	1.00	(0.93; 1.06)
Other – Chinese	1.04	(0.97; 1.12)	1.09	(1; 1.18)
Other – Any Other Ethnic Group	0.67	(0.65; 0.69)	0.88	(0.85; 0.91)

*Table 14: Results of multilevel models for **reliable improvement***

Ethnic group	Model 1		Model 5	
	OR	95% CI	OR	95% CI
White – British	*	*	*	*
White – Irish	0.99	(0.95; 1.03)	0.96	(0.91; 1.01)
White – Other White Background	0.96	(0.95; 0.98)	0.98	(0.96; 1)
Mixed – White and Black Caribbean	0.79	(0.76; 0.82)	0.95	(0.91; 0.99)
Mixed – White and Black African	0.86	(0.8; 0.92)	1.00	(0.91; 1.1)
Mixed – White and Asian	0.81	(0.77; 0.86)	0.87	(0.81; 0.92)
Mixed – Other Mixed Background	0.86	(0.83; 0.89)	0.95	(0.91; 1)
Asian – Indian	0.93	(0.91; 0.96)	0.94	(0.91; 0.97)
Asian – Pakistani	0.73	(0.71; 0.76)	0.89	(0.86; 0.93)
Asian – Bangladeshi	0.72	(0.69; 0.76)	0.90	(0.84; 0.96)
Asian – Other Asian Background	0.74	(0.71; 0.76)	0.85	(0.82; 0.89)
Black – Caribbean	0.89	(0.87; 0.92)	1.07	(1.02; 1.11)
Black – African	0.87	(0.84; 0.9)	1.12	(1.07; 1.17)
Black – Other Black Background	0.85	(0.81; 0.9)	1.04	(0.98; 1.12)
Other – Chinese	1.00	(0.93; 1.08)	1.06	(0.97; 1.16)
Other – Any Other Ethnic Group	0.74	(0.72; 0.77)	0.84	(0.81; 0.88)

*Table 15: Results of multilevel models for **reliable recovery***

Ethnic group	Model 1		Model 5	
	OR	95% CI	OR	95% CI
White – British	*	*	*	*
White – Irish	1.02	(0.98; 1.05)	1.00	(0.95; 1.04)
White – Other White Background	0.95	(0.93; 0.96)	0.98	(0.96; 1)
Mixed – White and Black Caribbean	0.73	(0.71; 0.76)	0.94	(0.9; 0.98)
Mixed – White and Black African	0.80	(0.74; 0.86)	1.01	(0.92; 1.1)
Mixed – White and Asian	0.81	(0.77; 0.85)	0.91	(0.86; 0.97)
Mixed – Other Mixed Background	0.81	(0.78; 0.84)	0.94	(0.9; 0.98)
Asian – Indian	0.90	(0.88; 0.92)	0.97	(0.94; 1)
Asian – Pakistani	0.66	(0.64; 0.68)	0.92	(0.89; 0.96)
Asian – Bangladeshi	0.63	(0.6; 0.67)	0.91	(0.85; 0.97)
Asian – Other Asian Background	0.68	(0.66; 0.7)	0.88	(0.84; 0.92)
Black – Caribbean	0.83	(0.8; 0.85)	1.05	(1.01; 1.08)
Black – African	0.79	(0.77; 0.82)	1.12	(1.07; 1.17)
Black – Other Black Background	0.78	(0.74; 0.82)	1.01	(0.94; 1.07)
Other – Chinese	1.01	(0.94; 1.08)	1.06	(0.98; 1.16)
Other – Any Other Ethnic Group	0.69	(0.66; 0.71)	0.87	(0.84; 0.9)

*Table 16: Results of multilevel models for **reliable deterioration***

Ethnic group	Model 1		Model 5	
	OR	95% CI	OR	95% CI
White – British	*	*	*	*
White – Irish	1.14	(1.06; 1.22)	1.17	(1.07; 1.27)
White – Other White Background	1.11	(1.08; 1.15)	1.10	(1.06; 1.15)
Mixed – White and Black Caribbean	1.27	(1.19; 1.36)	1.14	(1.05; 1.23)
Mixed – White and Black African	1.27	(1.11; 1.44)	1.14	(0.97; 1.34)
Mixed – White and Asian	1.20	(1.08; 1.32)	1.15	(1.03; 1.3)
Mixed – Other Mixed Background	1.22	(1.14; 1.31)	1.18	(1.09; 1.28)
Asian – Indian	1.18	(1.13; 1.24)	1.25	(1.18; 1.32)
Asian – Pakistani	1.40	(1.33; 1.47)	1.34	(1.26; 1.44)
Asian – Bangladeshi	1.61	(1.48; 1.75)	1.57	(1.41; 1.74)
Asian – Other Asian Background	1.44	(1.36; 1.53)	1.40	(1.3; 1.5)
Black – Caribbean	1.26	(1.19; 1.33)	1.11	(1.04; 1.19)
Black – African	1.29	(1.22; 1.37)	1.10	(1.01; 1.18)
Black – Other Black Background	1.24	(1.13; 1.36)	1.11	(0.98; 1.25)
Other – Chinese	1.07	(0.93; 1.23)	1.03	(0.87; 1.21)
Other – Any Other Ethnic Group	1.45	(1.37; 1.52)	1.44	(1.35; 1.53)

*Table 17: Results of multilevel models for **dropout***

Ethnic group	Model 1		Model 5	
	OR	95% CI	OR	95% CI
White – British	*	*	*	*
White – Irish	0.95	(0.91; 0.99)	1.02	(0.97; 1.07)
White – Other White Background	0.93	(0.91; 0.95)	0.87	(0.85; 0.89)
Mixed – White and Black Caribbean	1.51	(1.45; 1.57)	1.18	(1.13; 1.24)
Mixed – White and Black African	1.30	(1.2; 1.41)	1.03	(0.94; 1.14)
Mixed – White and Asian	1.15	(1.08; 1.22)	0.96	(0.89; 1.03)
Mixed – Other Mixed Background	1.22	(1.17; 1.27)	1.02	(0.97; 1.07)
Asian – Indian	0.95	(0.93; 0.98)	0.91	(0.88; 0.94)
Asian – Pakistani	1.39	(1.34; 1.43)	1.07	(1.02; 1.11)
Asian – Bangladeshi	1.31	(1.23; 1.38)	1.01	(0.94; 1.09)
Asian – Other Asian Background	1.14	(1.1; 1.18)	0.95	(0.91; 0.99)
Black – Caribbean	1.19	(1.15; 1.23)	1.06	(1.02; 1.11)
Black – African	1.29	(1.24; 1.34)	1.05	(1; 1.1)
Black – Other Black Background	1.31	(1.24; 1.39)	1.13	(1.05; 1.21)
Other – Chinese	0.85	(0.78; 0.92)	0.80	(0.72; 0.88)
Other – Any Other Ethnic Group	1.13	(1.09; 1.17)	0.96	(0.92; 1)

*Table 18: Results of multilevel models for **proportion of sessions attended***

Ethnic group	Model 1		Model 5	
	Beta	95% CI	Beta	95% CI
White – British	*	*	*	*
White – Irish	-0.01	(-0.01; 0)	-0.01	(-0.02; -0.01)
White – Other White Background	0.01	(0.01; 0.01)	0.01	(0.01; 0.01)
Mixed – White and Black Caribbean	0.04	(-0.05; -0.04)	-0.02	(-0.03; -0.02)
Mixed – White and Black African	0.03	(-0.04; -0.02)	-0.01	(-0.02; 0)
Mixed – White and Asian	-0.01	(-0.01; 0)	0.00	(0; 0.01)
Mixed – Other Mixed Background	-0.02	(-0.02; -0.02)	-0.01	(-0.01; 0)
Asian – Indian	-0.01	(-0.01; -0.01)	-0.01	(-0.01; 0)
Asian – Pakistani	-0.04	(-0.04; -0.03)	-0.02	(-0.02; -0.01)
Asian – Bangladeshi	-0.03	(-0.04; -0.03)	-0.01	(-0.01; 0)
Asian – Other Asian Background	-0.01	(-0.01; -0.01)	0.00	(0; 0.01)
Black – Caribbean	-0.03	(-0.04; -0.03)	-0.02	(-0.03; -0.02)
Black – African	-0.04	(-0.04; -0.03)	-0.02	(-0.02; -0.01)
Black – Other Black Background	-0.03	(-0.04; -0.03)	-0.02	(-0.03; -0.02)
Other – Chinese	0.03	(0.03; 0.04)	0.04	(0.03; 0.04)
Other – Any Other Ethnic Group	-0.01	(-0.01; -0.01)	0.01	(0; 0.01)

1.7.   Impact of own group ethnic density

The individual patient IAPT dataset includes Lower Layer Super Output Area (LSOA) for each person. This provides information about each local area covering 400–1,200 households. These data can be combined with a number of datasets commonly collected by the ONS, including local area deprivation (measured from the indices of multiple deprivation [IMD]) as well as the proportion of people of different ethnicities living in each LSOA.

Exploratory analyses were conducted to examine the impact of 'own group ethnicity density'; that is, the proportion of people living in an LSOA who were of the same ethnicity as the person using IAPT services, to consider exploring whether this was associated with individual outcomes.

Data were not available for every ethnicity category in the IAPT MDS, and notably all 'Mixed' ethnicity categories are not available in ONS tables on this metric.

Figure 8 presents the average own group ethnic density for each ethnic group for whom there were data. The 'White: British' group were very likely to live in local areas with a high density of 'White: British' people, whereas the average own group ethnic density for other groups was much lower (around just 2% for 'White: Irish', 'Black: Any Other Black Background' and 'Other: Chinese' groups).

Figure 8: Own group ethnic density
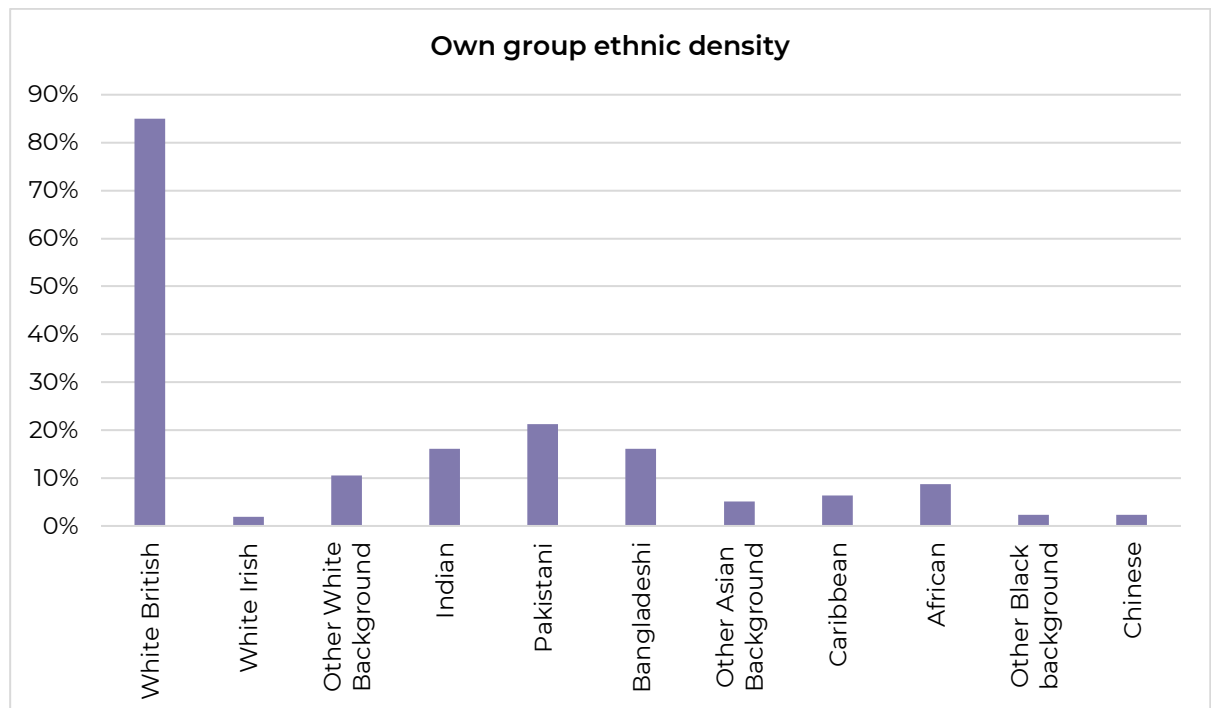
Logistic regression models were constructed to assess the impact of own group ethnicity on the likelihood of having a course of treatment for those assessed by services, and also for the four treatment outcomes indicating biggest differences (recovery, reliable improvement, reliable recovery and dropout) that are

examined in *Section 3.6.* of the report and in this appendix. There were differences between the 'White: British' group and all other ethnicity groups on treatment outcomes, and for people who had a course of treatment. Analyses were conducted with both unadjusted models, and adjusting for the IMD, also provided at the LSOA level.

The analyses of own group ethnic density were considered exploratory in nature, and are presented in full in:

- course of treatment ([Table 19](#))
- recovery ([Table 20](#))
- reliable improvement ([Table 21](#))
- reliable recovery ([Table 22](#))
- dropout ([Table 23](#)).

For the 'White: British', 'White: Any Other White Background' and 'Black: Caribbean' ethnicity groups, when adjusting for IMD it was found that higher own group ethnic density was associated with a higher likelihood of receiving treatment after initial assessment. For people of 'White: Irish', 'Asian: Indian', 'Asian: Bangladeshi', 'Asian: Any Other Asian Background', and 'Other: Chinese' ethnicity, the opposite association was observed.

The 'White: British' group had a greater likelihood of reliable improvement, reliable recovery and also dropout when living in a higher area with a higher own group ethnic density, after adjusting for IMD (recovery was associated with higher ethnic density in the unadjusted model only). The 'White: Irish' group were more likely to recover and reliably recovery with higher own group ethnic density, and people from 'White: Any Other White Background' were more likely to recover, reliably improve, reliable recover and less likely to drop out when living in areas of higher own group ethnic density.

People of 'Asian: Pakistani' ethnicity were more likely to recovery, reliably improve and reliably recover when living in areas of higher own group ethnic density. However, ethnic density was not associated with differences in treatment outcomes for any other ethnicity group.

More associations were observed when exploring dropout, with people of 'Asian: Indian' and 'Black: Caribbean' ethnicities less likely to drop out in areas of higher own group ethnic density, whereas people of 'Asian: Other Asian Background' and 'Black: African' backgrounds were more likely to drop out when in areas of higher own group ethnic density.

Table 19: Own group ethnic density: Course of treatment

	Unadjusted		Adjusted for IMD	
	OR	95% CI	OR	95% CI
White – British	1.004	(1.004; 1.004)	1.002	(1.002; 1.002)
White – Irish	0.966	(0.95; 0.982)	0.979	(0.963; 0.995)
White – Other White Background	1.000	(0.999; 1.002)	1.003	(1.001; 1.004)
Asian – Indian	0.994	(0.993; 0.995)	0.995	(0.994; 0.996)
Asian – Pakistani	0.998	(0.997; 0.999)	1.001	(1; 1.002)
Asian – Bangladeshi	0.980	(0.978; 0.982)	0.982	(0.98; 0.984)
Asian – Other Asian Background	0.993	(0.989; 0.998)	0.994	(0.99; 0.999)
Black – Caribbean	1.008	(1.004; 1.011)	1.016	(1.012; 1.02)
Black – African	0.996	(0.993; 0.998)	1.002	(0.999; 1.005)
Black – Other Black Background	0.990	(0.976; 1.003)	1.010	(0.995; 1.026)
Other – Chinese	0.964	(0.949; 0.98)	0.968	(0.953; 0.983)

Table 20: Own group ethnic density: Recovery

	Unadjusted		Adjusted for IMD	
	OR	95% CI	OR	95% CI
White – British	1.003	(1.003; 1.003)	1.000	(1; 1)
White – Irish	1.043	(1.018; 1.069)	1.059	(1.033; 1.086)
White – Other White Background	1.001	(0.999; 1.003)	1.004	(1.002; 1.006)
Asian – Indian	1.000	(0.999; 1.001)	1.001	(0.999; 1.002)
Asian – Pakistani	1.003	(1.002; 1.004)	1.006	(1.004; 1.007)
Asian – Bangladeshi	0.998	(0.995; 1.002)	0.999	(0.995; 1.003)
Asian – Other Asian Background	0.997	(0.99; 1.004)	0.999	(0.992; 1.006)
Black – Caribbean	0.996	(0.991; 1.001)	1.002	(0.996; 1.007)
Black – African	0.997	(0.993; 1.001)	1.001	(0.996; 1.005)
Black – Other Black Background	0.992	(0.971; 1.013)	1.012	(0.988; 1.035)
Other – Chinese	0.983	(0.961; 1.007)	0.985	(0.962; 1.008)

Table 21: Own group ethnic density: Reliable improvement

	Unadjusted		Adjusted for IMD	
	OR	95% CI	OR	95% CI
White – British	1.003	(1.003; 1.004)	1.001	(1.001; 1.002)
White – Irish	1.012	(0.985; 1.04)	1.025	(0.998; 1.054)
White – Other White Background	1.000	(0.998; 1.002)	1.002	(1; 1.004)
Asian – Indian	0.998	(0.996; 1)	0.998	(0.997; 1)
Asian – Pakistani	1.000	(0.999; 1.001)	1.002	(1.001; 1.004)
Asian – Bangladeshi	1.000	(0.997; 1.003)	0.999	(0.996; 1.003)
Asian – Other Asian Background	0.995	(0.988; 1.002)	0.996	(0.989; 1.003)
Black – Caribbean	0.999	(0.994; 1.005)	1.005	(0.999; 1.011)
Black – African	0.995	(0.991; 0.999)	0.999	(0.994; 1.003)
Black – Other Black Background	0.993	(0.972; 1.016)	1.010	(0.985; 1.035)
Other – Chinese	0.997	(0.972; 1.023)	0.999	(0.974; 1.025)

Table 22: Own group ethnic density: Reliable recovery

	Unadjusted		Adjusted for IMD	
	OR	95% CI	OR	95% CI
White – British	1.003	(1.003; 1.003)	1.001	(1; 1.001)
White – Irish	1.030	(1.005; 1.056)	1.045	(1.02; 1.071)
White – Other White Background	1.000	(0.998; 1.002)	1.002	(1; 1.004)
Asian – Indian	1.000	(0.998; 1.001)	1.000	(0.999; 1.002)
Asian – Pakistani	1.003	(1.001; 1.004)	1.005	(1.004; 1.006)
Asian – Bangladeshi	0.999	(0.995; 1.002)	0.999	(0.995; 1.003)
Asian – Other Asian Background	0.997	(0.991; 1.004)	0.999	(0.993; 1.006)
Black – Caribbean	0.995	(0.99; 1.001)	1.001	(0.996; 1.007)
Black – African	0.996	(0.992; 1)	1.000	(0.996; 1.005)
Black – Other Black Background	0.991	(0.971; 1.013)	1.014	(0.991; 1.038)
Other – Chinese	0.988	(0.965; 1.012)	0.989	(0.966; 1.013)

Table 23: Own group ethnic density: Dropout

	Unadjusted		Adjusted for IMD	
	OR	95% CI	OR	95% CI
White – British	1.000	(1; 1.001)	1.004	(1.003; 1.004)
White – Irish	0.988	(0.96; 1.017)	0.977	(0.949; 1.006)
White – Other White Background	0.995	(0.993; 0.997)	0.993	(0.99; 0.995)
Asian – Indian	0.998	(0.996; 0.999)	0.997	(0.995; 0.999)
Asian – Pakistani	1.003	(1.002; 1.004)	1.001	(0.999; 1.003)
Asian – Bangladeshi	1.003	(1; 1.007)	1.003	(0.999; 1.007)
Asian – Other Asian Background	1.013	(1.006; 1.021)	1.012	(1.004; 1.02)
Black – Caribbean	0.995	(0.99; 1.001)	0.989	(0.983; 0.995)
Black – African	1.024	(1.02; 1.029)	1.025	(1.02; 1.031)
Black – Other Black Background	1.028	(1.004; 1.052)	1.017	(0.99; 1.043)
Other – Chinese	1.016	(0.989; 1.044)	1.013	(0.986; 1.041)

1.8. Patient Experience Questionnaire

Table 24: PEQ questions and scoring

Patient Experience Questionnaire – Assessment (PEQ-A)					
1. Were you given information about options for choosing a treatment that is appropriate for your problems?	Yes	No			
2. Do you prefer any of the treatments among the options available?	Yes	No			
3. Have you been offered your preference?	Yes	No	N/A		
Patient Experience Questionnaire – Treatment (PEQ-T)					
1. Did staff listen to you and treat your concerns seriously?	At All Times	Most of the Time	Sometimes	Rarely	Never
2. Do you feel that the service has helped you to better understand and address your difficulties?	At All Times	Most of the Time	Sometimes	Rarely	Never
3. Did you feel involved in making choices about your treatment and care?	At All Times	Most of the Time	Sometimes	Rarely	Never
4. On reflection, did you get the help that mattered to you?	At All Times	Most of the Time	Sometimes	Rarely	Never
5. Did you have confidence in your therapist and his/her skills and techniques?	At All Times	Most of the Time	Sometimes	Rarely	Never

1.8.1. PEQ – Assessment

Table 25: Proportion endorsing PEQ-A questions, by ethnicity group

Group	% = Yes to Question 1	% = Yes to Question 2	% = Yes to Question 3
British	96.0%*	82.4%*	97.0%
Irish	94.7%	81.8%	96.3%
Other White Background	93.1%	79.6%	95.8%
White and Black Caribbean	94.3%	79.2%	96.0%
White and Black African	92.5%	78.9%	95.3%

White and Asian	94.2%	81.2%	97.2%*
Other Mixed Background	93.8%	80.8%	96.2%
Indian	92.9%	81.3%	96.0%
Pakistani	92.6%	81.0%	97.1%
Bangladeshi	89.5%**	78.1%	97.0%
Other Asian Background	92.5%	79.2%	96.8%
Caribbean	90.9%	79.0%	95.5%
African	90.5%	77.9%**	95.4%
Other Black Background	92.2%	79.5%	95.8%
Chinese	93.8%	80.3%	94.9%**
Other Ethnic Group	94.8%	80.3%	96.4%
Missing	93.8%	78.1%	95.7%

* = largest proportion of 'Yes' responses to each question.
** = smallest proportion of 'Yes' responses to each question.

Figure 9, Figure 10 and Figure 11 present the proportion of individuals reporting 'Yes' to each PEQ-A question, by ethnicity group. Table 26 presents the ORs from logistic regression models for each PEQ-A question by ethnicity, compared with the 'White: British' group.

Figure 9: Proportion of individuals reporting 'Yes' to PEQ-A item 1 ('Given information')
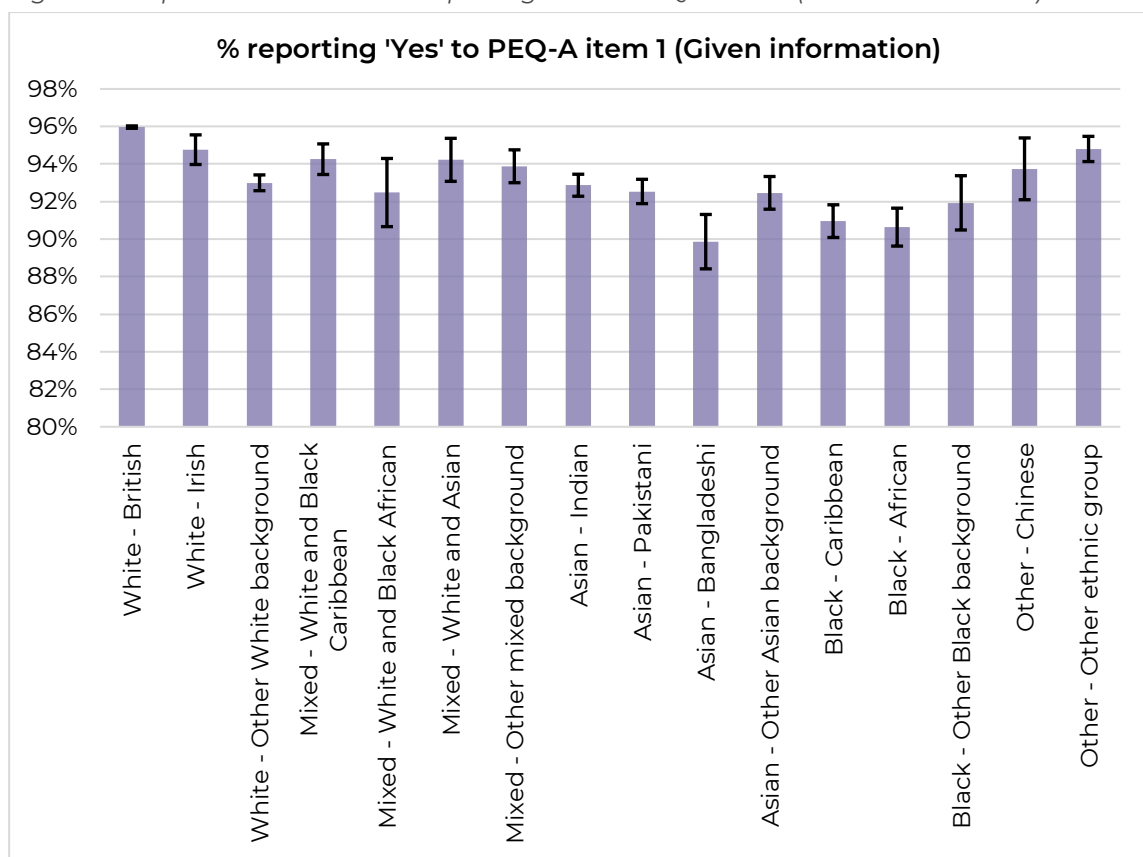
Figure 10: Proportion of individuals reporting 'Yes' to PEQ-A item 2 ('Have preference')

% reporting 'Yes' to PEQ-A item 2 (have preference)
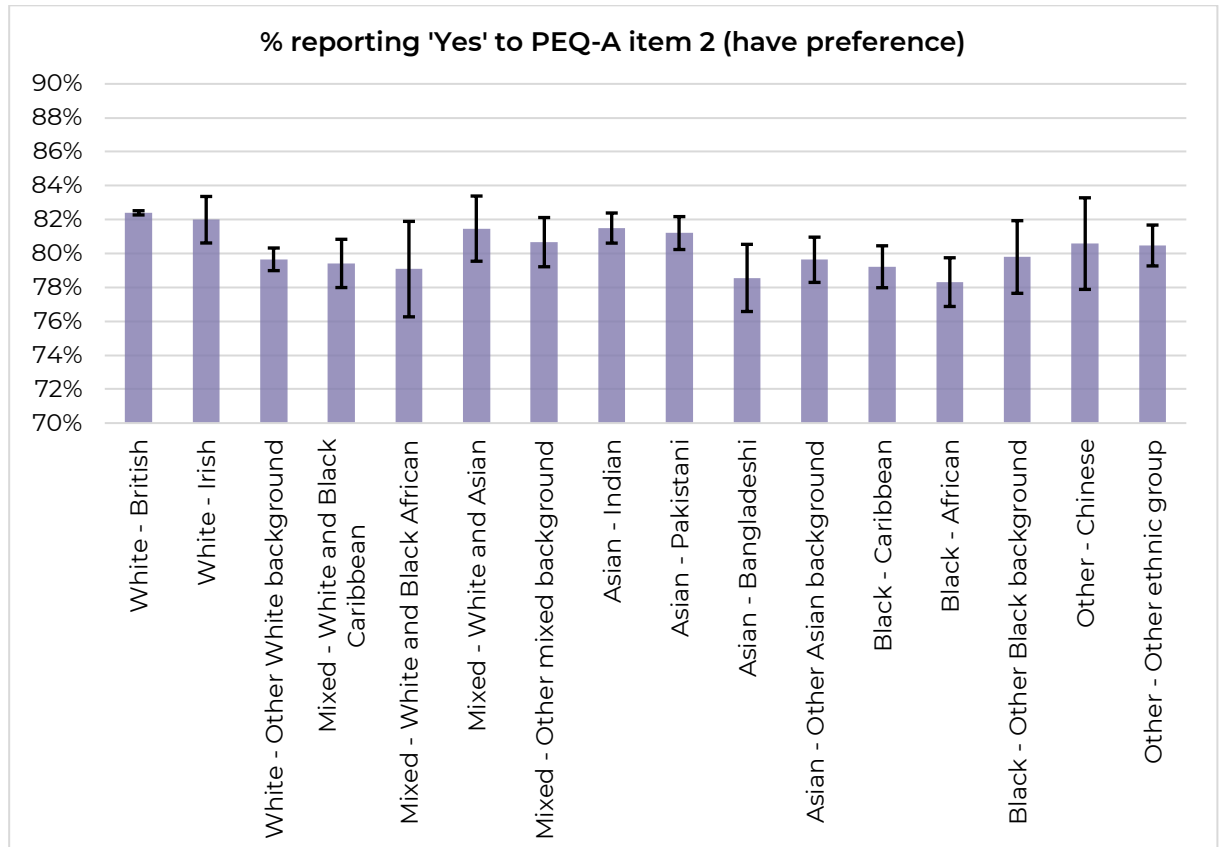
Figure 11: Proportion of individuals reporting 'Yes' to PEQ-A item 3 ('Received preference')

% reporting 'Yes' to PEQ-A item 3 (received preference)
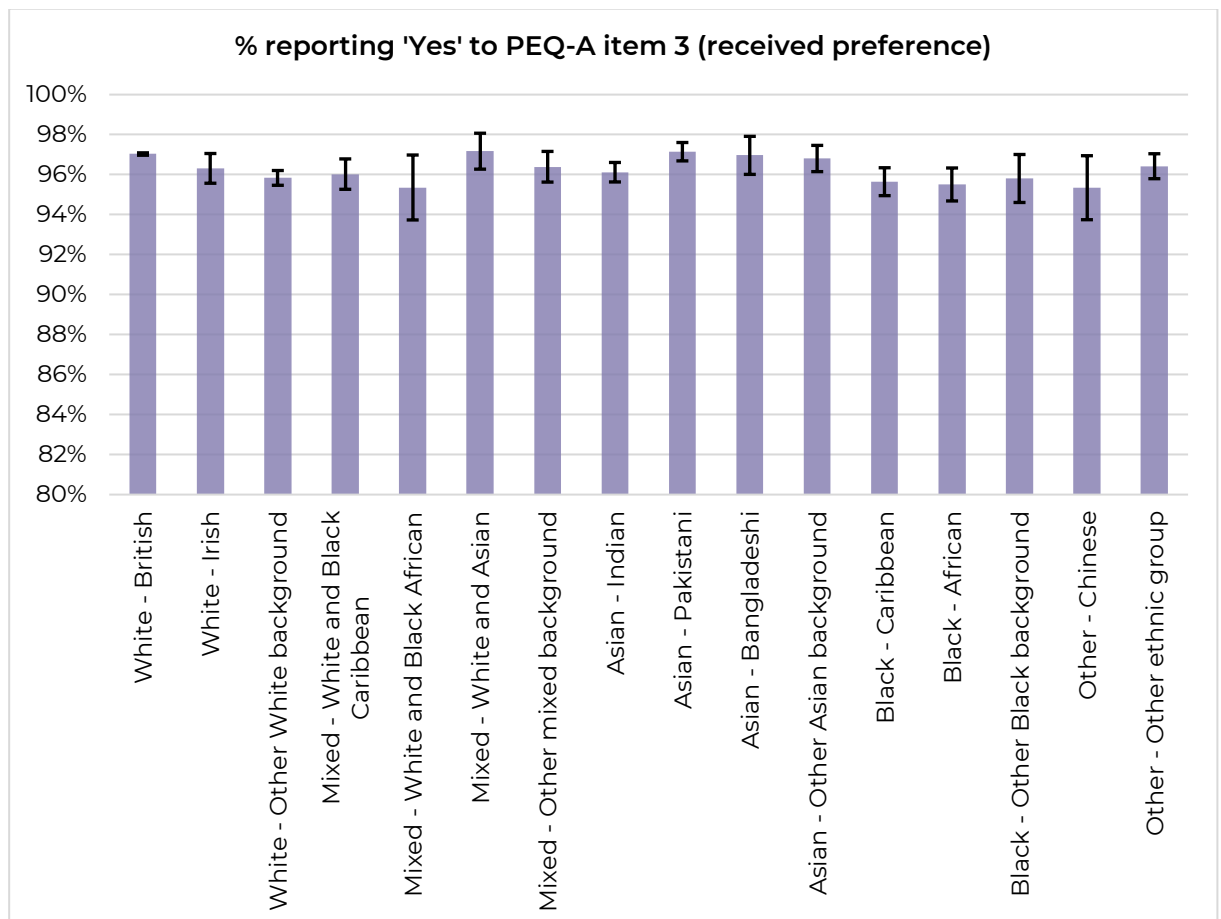
Table 26: ORs (from logistic regression models) for each PEQ-A question by ethnicity (compared with the 'White: British' group)

Group	PEQ-A Q1		PEQ-A Q2		PEQ-A Q3	
	OR	95% CI	OR	95% CI	OR	95% CI
White – British	Ref	Ref	Ref	Ref	Ref	Ref
White – Irish	0.76	(0.65; 0.89)	0.97	(0.89; 1.07)	0.65	(0.65; 0.99)
White – Other White Background	0.56	(0.52; 0.6)	0.84	(0.8; 0.87)	0.52	(0.64; 0.77)
Mixed – White and Black Caribbean	0.69	(0.59; 0.8)	0.82	(0.76; 0.9)	0.59	(0.61; 0.9)
Mixed – White and Black African	0.52	(0.4; 0.67)	0.81	(0.68; 0.96)	0.40	(0.44; 0.91)
Mixed – White and Asian	0.69	(0.55; 0.85)	0.94	(0.83; 1.07)	0.55	(0.76; 1.46)
Mixed – Other Mixed Background	0.64	(0.55; 0.75)	0.89	(0.81; 0.98)	0.55	(0.66; 1.02)
Asian – Indian	0.55	(0.5; 0.6)	0.94	(0.89; 1)	0.50	(0.66; 0.87)
Asian – Pakistani	0.52	(0.47; 0.57)	0.92	(0.87; 0.98)	0.47	(0.88; 1.23)
Asian – Bangladeshi	0.37	(0.32; 0.44)	0.78	(0.7; 0.88)	0.32	(0.71; 1.35)
Asian – Other Asian Background	0.52	(0.45; 0.58)	0.84	(0.77; 0.91)	0.45	(0.75; 1.15)
Black – Caribbean	0.42	(0.38; 0.47)	0.81	(0.76; 0.88)	0.38	(0.57; 0.8)
Black – African	0.41	(0.36; 0.46)	0.77	(0.71; 0.84)	0.36	(0.54; 0.79)
Black – Other Black Background	0.48	(0.39; 0.58)	0.84	(0.74; 0.96)	0.39	(0.52; 0.94)
Other – Chinese	0.63	(0.48; 0.83)	0.89	(0.75; 1.05)	0.48	(0.44; 0.9)
Other – Other Ethnic Group	0.77	(0.67; 0.88)	0.88	(0.82; 0.95)	0.67	(0.69; 0.99)
Missing	0.65	(0.61; 0.69)	0.77	(0.74; 0.8)	0.61	(0.66; 0.78)

Notes: Ref = reference category

1.8.2.   PEQ – Treatment

Table 27: Mean score (and SD) for each PEQ-T question (Q) by ethnicity group

	PEQ-T Q1: Mean (SD)	PEQ-T Q2: Mean (SD)	PEQ-T Q3: Mean (SD)	PEQ-T Q4: Mean (SD)	PEQ-T Q5: Mean (SD)
White – British	3.93 (0.35)	3.64 (0.67)	3.76 (0.6)	3.68 (0.69)	3.88 (0.44)
White – Irish	3.92 (0.39)	3.65 (0.65)	3.75 (0.64)	3.69 (0.67)	3.88 (0.45)
White – Other White Background	3.92 (0.35)	3.59 (0.68)	3.7 (0.65)	3.59 (0.73)	3.84 (0.48)
Mixed – White and Black Caribbean	3.94 (0.31)	3.64 (0.66)	3.78 (0.55)	3.69 (0.65)	3.88 (0.42)
Mixed – White and Black African	3.94 (0.27)	3.65 (0.65)	3.78 (0.55)	3.67 (0.66)	3.87 (0.43)
Mixed – White and Asian	3.92 (0.39)	3.6 (0.7)	3.71 (0.67)	3.62 (0.72)	3.84 (0.51)
Mixed – Other Mixed Background	3.92 (0.36)	3.61 (0.69)	3.74 (0.61)	3.63 (0.72)	3.86 (0.44)
Asian – Indian	3.89 (0.42)	3.6 (0.69)	3.68 (0.67)	3.62 (0.71)	3.83 (0.52)
Asian – Pakistani	3.88 (0.51)	3.63 (0.73)	3.69 (0.71)	3.63 (0.75)	3.84 (0.54)
Asian – Bangladeshi	3.87 (0.45)	3.59 (0.73)	3.69 (0.66)	3.6 (0.73)	3.82 (0.51)
Asian – Other Asian Background	3.91 (0.35)	3.62 (0.66)	3.68 (0.63)	3.6 (0.71)	3.84 (0.47)
Black – Caribbean	3.92 (0.37)	3.63 (0.65)	3.75 (0.6)	3.67 (0.65)	3.86 (0.45)
Black – African	3.91 (0.34)	3.66 (0.61)	3.76 (0.57)	3.67 (0.64)	3.87 (0.42)
Black – Other Black Background	3.92 (0.34)	3.65 (0.63)	3.74 (0.61)	3.66 (0.66)	3.87 (0.41)
Other – Chinese	3.87 (0.42)	3.53 (0.68)	3.64 (0.65)	3.55 (0.72)	3.76 (0.54)
Other – Other Ethnic Group	3.91 (0.34)	3.65 (0.64)	3.72 (0.61)	3.64 (0.69)	3.86 (0.44)
Missing	3.93 (0.34)	3.64 (0.67)	3.74 (0.63)	3.67 (0.69)	3.87 (0.43)

PEQ-T question 1

For the item asking whether 'staff listened and treated concerns seriously' (PEQ-T question 1), average scores ranged from 3.87 ('Other: Chinese') to 3.94 ('Mixed: White and Black African').

Compared with the 'White: British' group, it was observed that the following ethnic groups had significantly lower scores:

- 'White: Irish'
- 'Asian: Indian'
- 'Asian: Pakistani'

- 'Asian: Bangladeshi'
- 'Asian: Any Other Asian Background'
- 'Black: Caribbean'
- 'Black: African',
- 'Other: Chinese'
- 'Other: Any Other Ethnic Group' .

Cohen's d is a measure of the difference in means between groups which can be derived using a simple mathematical formula.[14] Applying this formula, the biggest difference in responses to PEQ-T, question 1, was found between the 'White: British' and 'Asian: Bangladeshi' ethnic groups, with a Cohen's d of 0.18. In accordance with the conventional interpretation of Cohen's d effect sizes (Cohen's d between 0.2-0.5 is considered 'small' and anything below is considered 'negligible'), this was a negligible difference.

PEQ-T question 2

The range in average scores between ethnicity groups for the item 'Do you feel the service has helped' (PEQ-T question 2) was from 3.53 ('Other: Chinese') to 3.66 ('Black: African').

Compared with the 'White: British' group, people from the following groups reported significantly lower average scores on this item:

- 'White: Any Other White Background'
- 'Mixed: White and Asian'
- 'Mixed: Any Other Mixed Background'
- 'Asian: Indian'
- 'Asian: Bangladeshi'
- 'Other: Chinese'.

Cohen's d was estimated to be 0.17 between the 'White: British' group and the group with the lowest average score ('Other: Chinese') indicating a negligible effect, whereas the was a 'small' effect difference (d=0.21) between the group with the highest score on this item ('Black: African') compared with the group with the lowest average score ('Other: Chinese').

PEQ-T question 3

For the question about whether people 'felt involved in making choices' (PEQ-T question 3), average scores ranged from 3.64 ('Other: Chinese') to 3.78 ('Mixed: White and Black Caribbean').

Compared with the 'White: British' group, average scores for this item were statistically lower for:

- 'Other White Background'
- 'Mixed: White and Asian'
- 'Asian: Indian'
- 'Asian: Pakistani'
- 'Asian: Bangladeshi'
- 'Asian: Other Asian Background'
- 'Other: Chinese'
- 'Other: Any Other Ethnic Group'.

Cohen's d was 0.19 between the 'White: British' group and the group with the lowest average score ('Other: Chinese'), whereas d=0.25 between the mean score for 'Other: Chinese' and 'Mixed: White and Black Caribbean' (the group with the highest average score).

PEQ-T question 4

PEQ-T question 4 asks whether people 'got the help that mattered to them' and average scores ranged from 3.55 ('Other: Chinese') to 3.69 ('Mixed: White and Black Caribbean').

Compared with the 'White: British' ethnicity group, average scores for this item were significantly lower for all ethnicity groups except:

- 'White: Irish'
- 'Mixed: White and Black Caribbean'
- 'Mixed: White and Black African'
- 'Black: Caribbean'
- 'Black: African'
- 'Black: Any Other Black Background'.

Cohen's d was 0.19 between the 'White: British' and group with the lowest average score ('Other: Chinese'), whereas the effect size was considered small (d=0.21) between the 'Other: Chinese' group and the 'Mixed: White and Black Caribbean' group.

PEQ-T question 5

Lastly, scores on the question about whether people felt 'confident in their therapist' (PEQ-T, question 5) were compared, with averages ranging from 3.76 ('Other: Chinese') to 3.88 ('White: British' and 'Mixed: White and Black Caribbean').

All ethnicities had significantly lower average scores than the 'White: British' group except for:

- 'White: Irish'
- 'Mixed: White and Black Caribbean'
- 'Mixed: White and Black African'
- 'Black: African'
- 'Black: Any Other Black Background'.

The effect size between the 'White: British' and 'Other: Chinese' groups was 0.28, indicating a small effect observed on mean differences.

PEQ-T data 2019–23

Unfortunately, the national IAPT patient-level data available to the research team did not include data after March 2019 and therefore we could not assess changes to patient experience following introduction of the updated IAPT Black, Asian and Minority Ethnic Service User Positive Practice Guide (PPG).[15] It is important for future research to assess how the PPG has changed patient experience.

PEQ-T mean scores and beta coefficients

Below, we present the mean scores for each PEQ-T question, by ethnicity group.

- Item 1 ('Listened to') – Figure 12
- Item 2 ('Service helped') – Figure 13
- Item 3 ('Involved in decisions') – Figure 14
- Item 4 ('Got help that mattered') – Figure 15
- Item 5 ('Confidence in therapist') – Figure 16

These are followed by Table 28, which presents beta coefficients (from linear regression models) for each PEQ-T question by ethnicity (compared with the 'White: British' group).

Figure 12: Average score PEQ-T item 1 ('Listened to')

Average score PEQ-T item 1 (Listened to)
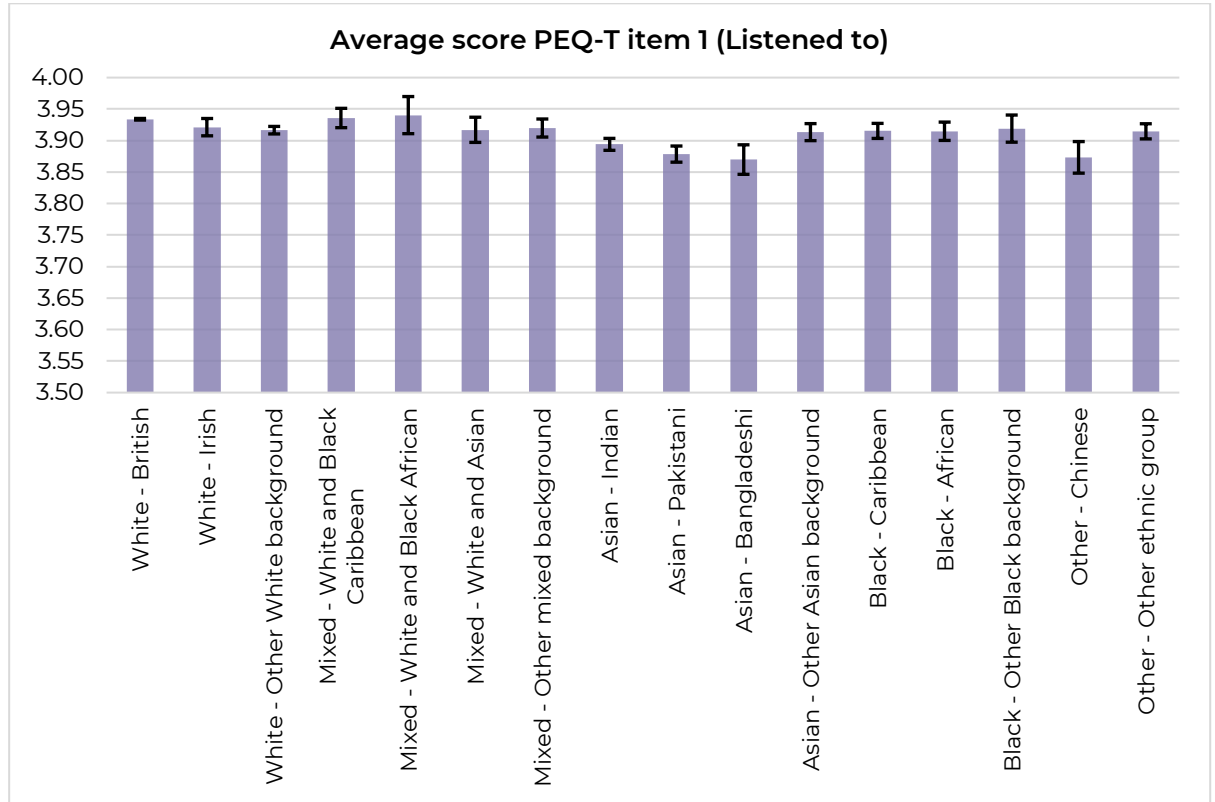
Figure 13: Average score PEQ-T item 2 ('Service helped')

Average score PEQ-T item 2 (Service helped)
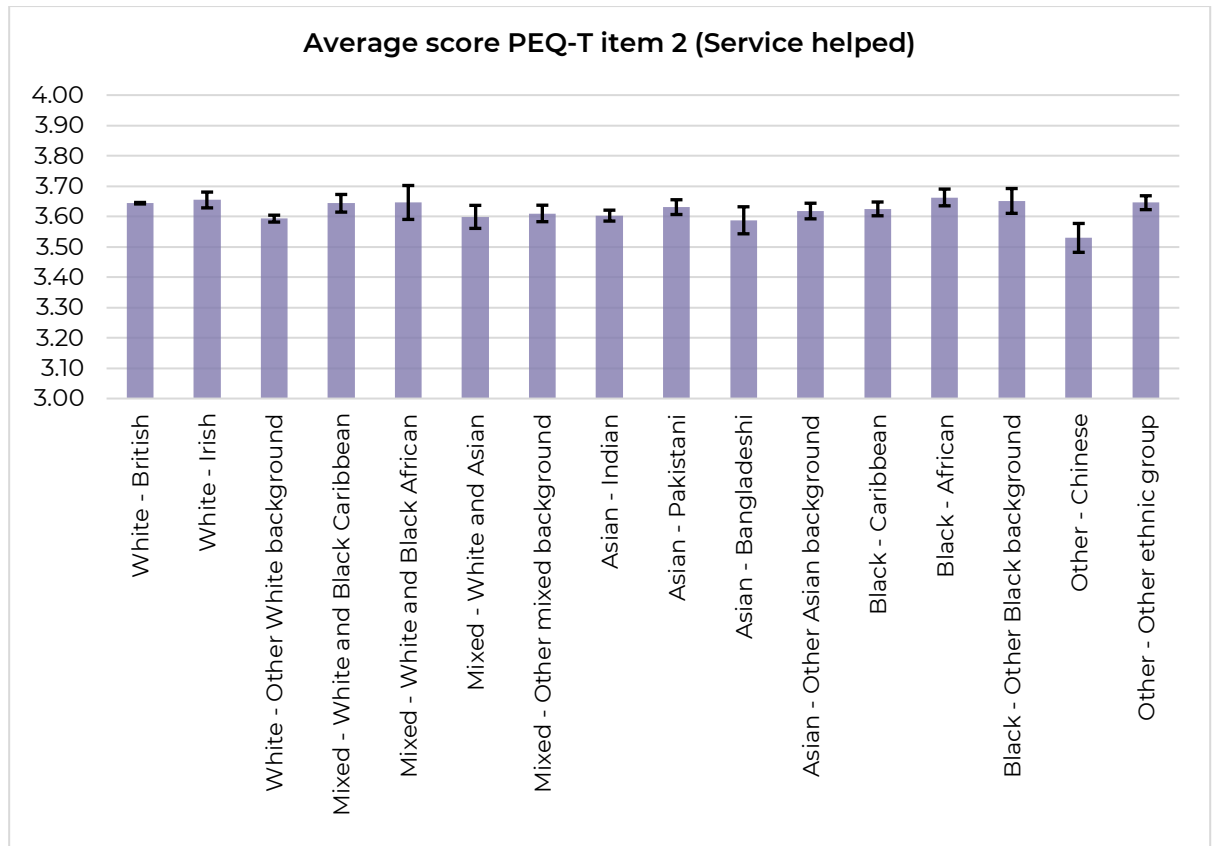
Figure 14: Average score PEQ-T item 3 ('Involved in decisions')

Average score PEQ-T item 3 (involved in decisions)
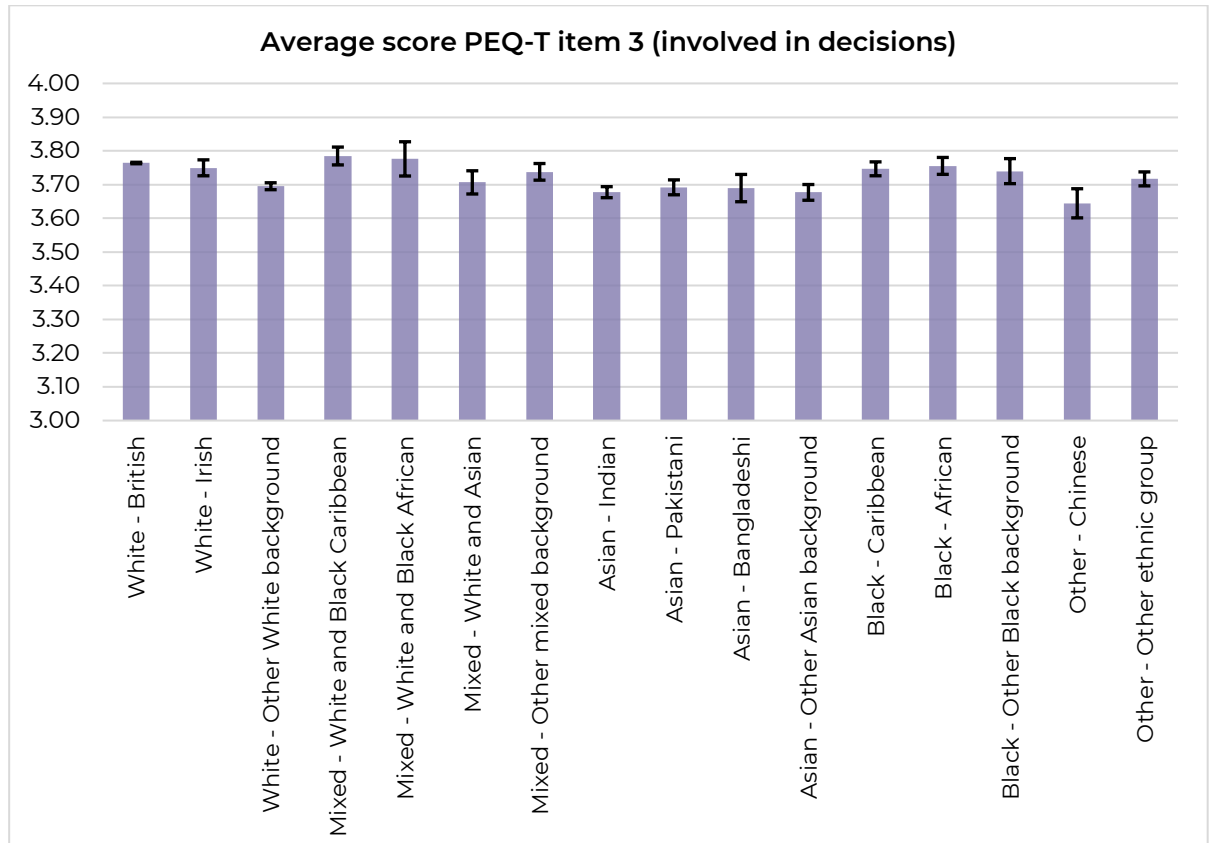
Figure 15: Average score PEQ-T item 4 ('Got help that mattered')

Average score PEQ-T item 4 (Got help that mattered)
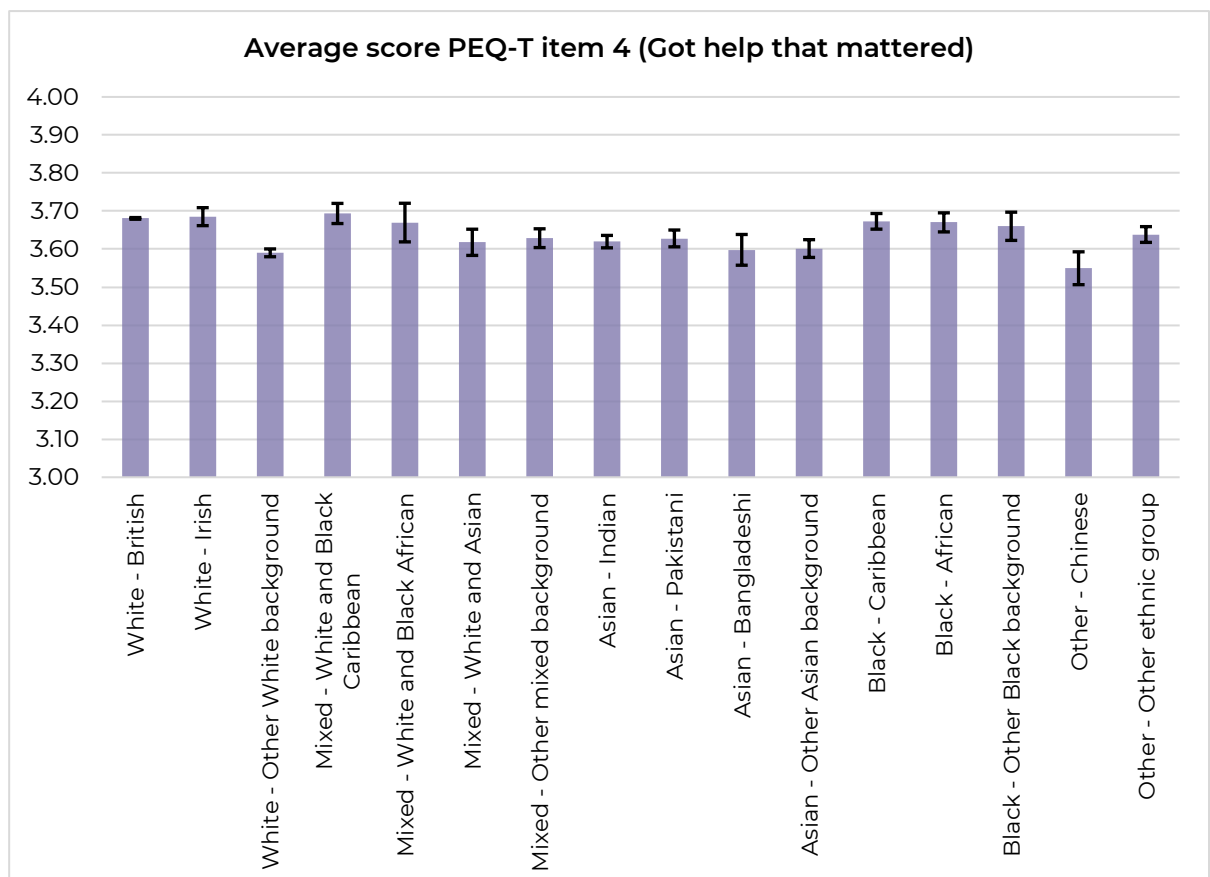
Figure 16: Average score PEQ-T item 5 ('Confidence in therapist')

Average score PEQ-T item 5 (Confidence in therapist)
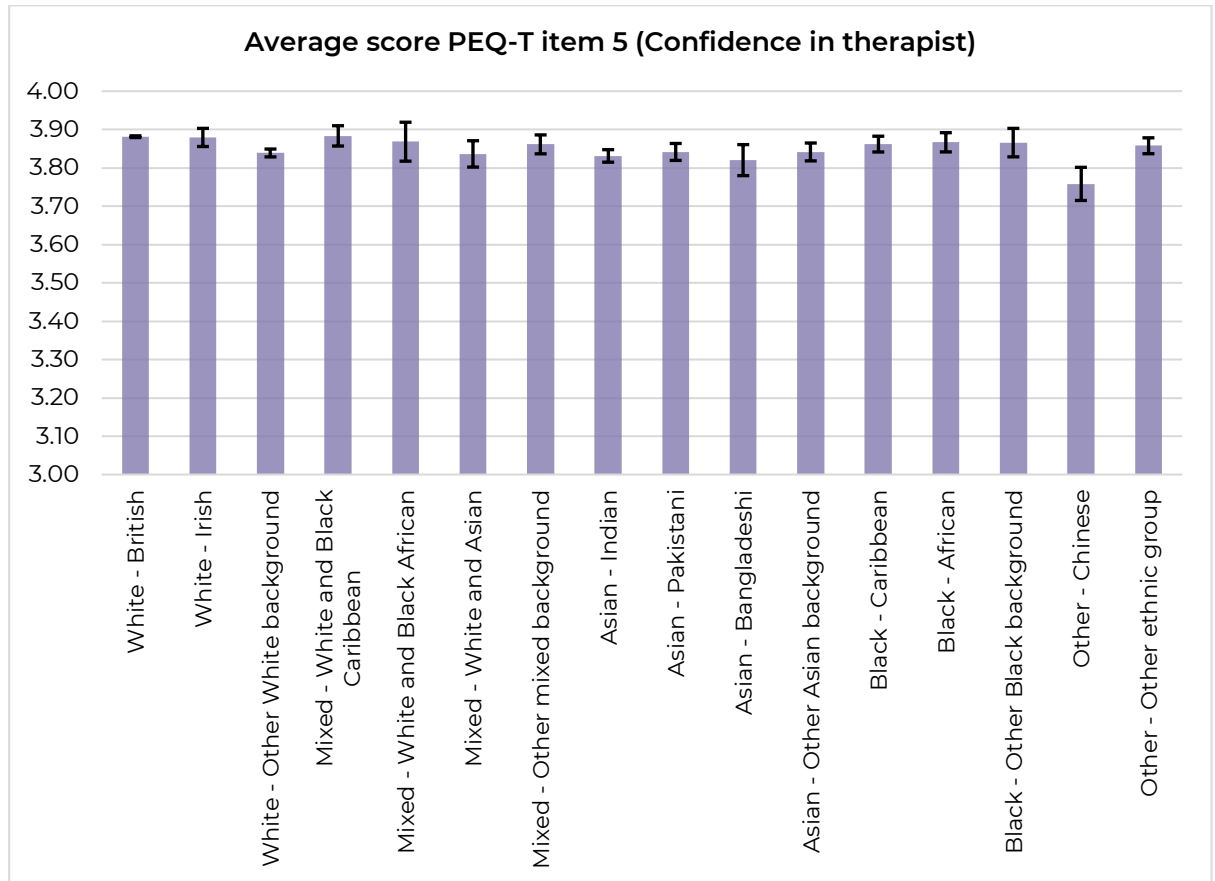
Table 28: Beta coefficients (from linear regression models) for each PEQ-T question by ethnicity (compared with the 'White: British' group)

Group	PEQ-T Q1		PEQ-T Q2		PEQ-T Q3		PEQ-T Q4		PEQ-T Q5	
	β	95% CI	β	95% CI	β	95% CI	β	95% CI	β	95% CI
White – British	*	*	*	*	*	*	*	*	*	*
White – Irish	-0.01	(-0.02; 0)	0.01	(-0.01; 0.04)	-0.02	(-0.04; 0.01)	0.00	(-0.02; 0.03)	0.00	(-0.02; 0.01)
White – Other White Background	-0.02	(-0.02; -0.01)	-0.05	(-0.06; -0.04)	-0.02	(-0.08; -0.06)	-0.09	(-0.1; -0.08)	-0.04	(-0.05; -0.04)
Mixed – White and Black Caribbean	0.00	(-0.01; 0.02)	0.00	(-0.03; 0.03)	-0.01	(0; 0.05)	0.01	(-0.02; 0.04)	0.00	(-0.02; 0.02)
Mixed – White and Black African	0.01	(-0.02; 0.04)	0.01	(-0.05; 0.07)	-0.02	(-0.03; 0.07)	0.00	(-0.06; 0.05)	-0.01	(-0.05; 0.03)
Mixed – White and Asian	-0.02	(-0.04; 0)	-0.05	(-0.08; -0.01)	-0.04	(-0.09; -0.02)	-0.06	(-0.1; -0.02)	-0.04	(-0.07; -0.02)
Mixed – Other Mixed Background	-0.01	(-0.03; 0)	-0.03	(-0.06; 0)	-0.03	(-0.05; 0)	-0.05	(-0.08; -0.02)	-0.02	(-0.04; 0)
Asian – Indian	-0.04	(-0.05; -0.03)	-0.04	(-0.06; -0.02)	-0.05	(-0.1; -0.07)	-0.06	(-0.08; -0.04)	-0.05	(-0.06; -0.04)
Asian – Pakistani	-0.05	(-0.06; -0.04)	0.00	(-0.02; 0.02)	-0.06	(-0.09; -0.04)	-0.04	(-0.06; -0.01)	-0.03	(-0.05; -0.02)
Asian – Bangladeshi	-0.06	(-0.09; -0.04)	-0.05	(-0.09; -0.01)	-0.09	(-0.11; -0.03)	-0.07	(-0.12; -0.03)	-0.06	(-0.09; -0.03)
Asian – Other Asian Background	-0.02	(-0.03; -0.01)	-0.02	(-0.05; 0.01)	-0.03	(-0.1; -0.06)	-0.07	(-0.1; -0.05)	-0.04	(-0.06; -0.02)
Black – Caribbean	-0.02	(-0.03; -0.01)	-0.02	(-0.04; 0)	-0.03	(-0.04; 0)	-0.01	(-0.03; 0.02)	-0.02	(-0.04; -0.01)

Black – African	-0.02	(-0.04; -0.01)	0.02	(-0.01; 0.04)	-0.04	(-0.04; 0.01)	-0.01	(-0.04; 0.02)	-0.02	(-0.04; 0)
Black – Other Black background	-0.02	(-0.04; 0)	0.01	(-0.03; 0.05)	-0.04	(-0.06; 0.01)	-0.02	(-0.06; 0.02)	-0.02	(-0.05; 0.01)
Other – Chinese	-0.07	(-0.09; -0.04)	-0.12	(-0.17; -0.07)	-0.09	(-0.17; -0.08)	-0.13	(-0.18; -0.08)	-0.12	(-0.16; -0.09)
Other – Any Other Ethnic Group	-0.02	(-0.03; -0.01)	0.00	(-0.02; 0.02)	-0.03	(-0.07; -0.03)	-0.04	(-0.06; -0.02)	-0.02	(-0.04; -0.01)
Missing	0.00	(-0.01; 0)	-0.01	(-0.02; 0)	-0.01	(-0.03; -0.01)	-0.02	(-0.03; -0.01)	-0.01	(-0.02; 0)

Appendix 2: Focus groups for people using IAPT services and IAPT therapists

2.1.   Focus group development and recruitment

Topic schedules for all focus groups were developed in consultation and co-production with lived experience advisers. They were based on literature on cultural adaptations including questions on service- and organisational-level adaptations based on the findings of a systematic review.[16]

Questions were used by the group facilitators (who were both National Advisers and lived experience experts) to explore the five areas (listed in *Section 4.* of the report). Researchers from the project team gave prompts when necessary.

All focus group events were transcribed verbatim. Directed content analysis,[17] a deductive approach based on the topic schedule, was used to thematically analyse the data. Codes were created based on the topic schedule.

Focus group materials were created in co-production with the patient and carer representatives, in a series of MS Teams meetings with the Lead Researcher and Developer.

2.1.1.   Eligibility

Criteria for focus group members were that they were:

- over 18 years old
- a user of IAPT services **or** a practitioner in IAPT in England, currently or within the last 6 months
- able to engage in an online event (to be held on Zoom).

2.1.2.   Focus group recruitment

The focus groups were advertised:

- on the NCCMH website
- in a mailing to IAPT services
- in a mailing to IAPT Café (past and current IAPT therapists who meet bimonthly)
- by practitioners who took part in focus groups, to colleagues and people using services
- by word of mouth.

2.1.3. Focus group demographics

The tables below contain anonymised information about the demographics of the focus group participants, presenting therapist demographics followed by demographics of people using IAPT services.

People using IAPT services

Table 29: Living location (N=19)

Region	n (%)
London	8 (42.1%)
North East and Yorkshire	4 (21.1%)
Midlands	4 (21.1%)
East of England	1 (5.3%)
North West	1 (5.3%)
South West	1 (5.3%)

Table 30: Ethnicity (N=19)

Ethnicity	n (%)
Asian or Asian British – Any Other Asian Background	5 (26.3%)
Asian or Asian British – Bangladeshi	3 (15.8%)
Asian or Asian British – Indian	2 (10.5%)
Asian or Asian British – Pakistani	2 (10.5%)
Prefer to self-describe	2 (10.5%)
White – British	1 (5.3%)
Black or Black British – African	1 (5.3%)
Black or Black British – Caribbean	1 (5.3%)
Black – Any Other Black or Black British Background	1 (5.3%)
Mixed/multiple Ethnic Groups – White and Asian	1 (5.3%)

Table 31: Age range (N=19)

Age range	n (%)
25–34	7 (36.8%)
35–44	6 (31.6%)
45–54	2 (10.5%)
65–74	2 (10.5%)
55–64	1 (5.3%)
18–24	1 (5.3%)

Table 32: Gender identity (N=19)

Gender identity	n (%)
Woman	8 (42.1%)
Man	7 (36.8%)
Cis man (identifies with the same gender assigned at birth)	2 (10.5%)
Cis woman (identifies with the same gender assigned at birth)	1 (5.3%)
Prefer not to say	1 (5.3%)

Table 33: Sexual orientation (N=19)

Sexual orientation	n (%)
Heterosexual woman	7 (36.8%)
Heterosexual man	4 (22.2%)
Homosexual/gay man	4 (22.2%)
Prefer not to say	3 (15.8%)
Asexual	1 (5.3%)

Table 34: Disability (N=19)

Disability	n (%)
No	10 (52.6%)
Yes (e.g. physical disability)	9 (47.4%)

IAPT therapists

Table 35: Location of the work as a practitioner (N=21)

Region	n (%)
London	5 (23.8%)
Midlands	4 (19.0%)
South East	3 (14.3%)
East of England	3 (14.3%)
North West	3 (14.3%)
North East and Yorkshire	2 (9.5%)
South West	1 (4.8%)

Table 36: Professional role (N=21)

Role	n (%)
High-intensity practitioner	12 (57.1%)
Psychological wellbeing practitioner (PWP)	5 (23.8%)
Clinical psychologist	2 (9.5%)
Other (e.g. deputy clinical lead, senior psychotherapist)	2 (9.5%)

Table 37: Ethnicity (N=21)

Ethnicity	n (%)
Asian or Asian British – Indian	6 (28.6%)
White – British	5 (23.8%)
Black or Black British – African	2 (9.5%)
Black or Black British – Caribbean	2 (9.5%)
Asian or Asian British – East Asian	1 (4.8%)
Asian or Asian British – Any Other Asian background	1 (4.8%)
Mixed/multiple Ethnic Groups – White and Black African	1 (4.8%)
Mixed/multiple Ethnic Groups – White and Black Caribbean	1 (4.8%)
White – European	1 (4.8%)
White – Irish	1 (4.8%)

Table 38: Age range (N=21)

Age range	n (%)
25–34	7 (33.3%)
35–44	6 (28.6%)
45–54	4 (19.0%)
55–64	2 (9.5%)
65–74	2 (9.5%)

Table 39: Gender identity (N=21)

Gender identity	n (%)
Cis woman (identifies with the same gender assigned at birth)	9 (42.9%)
Woman	9 (42.9%)
Cis man (identifies with the same gender assigned at birth)	2 (9.5%)
Man	1 (4.8%)

Table 40: Sexual orientation (N=21)

Sexual orientation	n (%)
Heterosexual woman	17 (81.0%)
Heterosexual man	3 (14.3%)
Bisexual	1 (4.8%)

Table 41: Disability (N=21)

Disability	n (%)
No	18 (85.7%)
Yes (e.g. hearing)	3 (14.3%)

2.2. Findings from focus groups with people from minoritised ethnic groups using IAPT services

2.2.1. Access to IAPT

Information about IAPT

Before accessing IAPT services, focus group participants said they had received little to no information about the service. Some had just received a flyer from the service through their door, and others were told about the service by their GP.

Some people went into treatment with expectations that were not met; for example, expecting to have more sessions than were offered. Before accessing IAPT people wanted information from services about what to expect at each stage of the process, for example what the assessment or treatment would be, or what their options were.

Overall, participants agreed that there was not enough information provided by the IAPT service that (a) they could access easily and (b) was in the languages they spoke about: the service, accessing IAPT and the treatment IAPT could offer. This was seen as particularly important due to the stigma around mental health problems in some communities and a lack of terms in some dialects about mental health:

> *'This is what clinicians need to be aware of. You think you got a professional interpreter, but mental health is not talked about in the minorities, minority communities with them words don't actually exist…' (Focus group participant)*

See also Appendix 2.3.1. on findings from focus groups with IAPT therapists under the heading 'Language and access'.

Participants expressed a wish for information that explained what the service could offer. Some said they had been asked by IAPT therapists what help they needed, but had not felt able to answer fully or state their preferences without

knowing what support and choices were available. This was more difficult if they lacked experience or knowledge of IAPT, and if mental health was not discussed within their families and communities.

Also see [Appendix 2.6.](#) for comparisons between focus group findings and the qualitative literature.

Barriers to accessing IAPT services

Barriers faced by people from minoritised ethnic groups accessing IAPT services included difficulties in getting referrals. Some participants said that GPs of the same ethnicity had said they did not need treatment and should try praying or 'just getting on with it':

> *'I went to my GP, and the main GP – they're Muslim like myself, and I were trying to tell them about what was going on and depression … because I recognised that, at that point, that I did need some sort of medication for the depression. And they turned around and said to me that "You don't need any medication, you just need to go home and pray and you'll be fine". And I just thought, that is so wrong for a GP to say' (Focus group participant)*

Participants spoke of struggles in accessing the services because of stigma around mental health. They described not being able to risk family members such as parents finding out they wanted to access IAPT services because they may be perceived as 'going mad':

> *'…it's a taboo subject. You just don't seek mental health. It must mean there's something wrong with you which made makes it difficult for [them] to have a conversation about it in the house because, you know, the people always around' (Focus group participant)*

This led to them not feeling able or supported to access IAPT; or, if they did, having to find somewhere private (such as in their car) for phone appointments.

Some people who had used IAPT services said they were afraid that they would be discrimination, that they thought they might be judged or treated differently by service staff based on their ethnicity. Fear of bias and discrimination is often described by people from minoritised ethnic communities as a challenge when it comes to accessing help

Assessment

After referral, language was seen as a barrier to accessing IAPT services, particularly for older people who might have limited English or not know how to ask for the support that they need:

> *'How you ask a question in English, it's very different to how you ask the question to somebody in our language, and some of the questions become quite inappropriate' (Focus group participant)*

Participants talked about not being able to find an IAPT therapist who spoke their language. If they found someone who spoke a similar dialect (for example, Punjabi instead of Urdu), they spoke of feeling that they were in a 'take it or leave it' situation. Dialect differences and a lack of mental health terminology in some languages could lead people to feel confused and overwhelmed during assessment. Participants spoke of therapists trying to overcome this by, for example, explaining mental health concepts in more simple and longer terms, but to do this was time consuming.

Participants discussed the importance of cultural sensitivity in IAPT staff when it came to the language used in assessments, saying that the way questions are phrased does not always make sense and is not necessarily appropriate to people from all cultures, for example questions about being married or in a sexual relationship.

Also see Appendix 2.6. for comparisons between focus group findings and the qualitative literature.

2.2.2. Treatment delivery

Therapist characteristics

Therapists talking about themselves was seen as integral to people's experience of IAPT. Some felt more comfortable speaking to a therapist of the same gender, and some preferred to have a therapist from a similar ethnic background because they felt they would not have to explain cultural issues:

> *'Just having that representation within the counselling service that IAPT offers, it's always wonderful to see somebody like yourself represented in the person that you're speaking to, just because you don't need to explain all the nuances. It's not that the therapist might not understand. It's just you feel as though you have to explain lots of different things and it becomes a teaching session rather than a counselling session.' (Focus group participant)*

Other participants preferred a therapist from a different ethnic background, because they would worry about talking to someone from their own community. Past experience of therapy also influenced this preference. One participant said that speaking to someone from outside their ethnicity and feeling like their mental health was understood by them was a very positive experience, though they noted that building this trusting relationship took time.

Therapist approach

Participants discussed the importance of the therapist treating them as an individual. This could include giving them the time to discuss issues that are important to them (such as their faith or job), not discussing topics they did not

want to talk about or did not feel were relevant, and asking questions in a way that they could relate to:

> *'[...] my therapist was so understanding of my faith as a Christian. I was given the platform to speak a lot about how my faith impacts on my depression, and on my life, and the importance of me personally believing in God [...] And the interest that she took in something that was so significant in my life was immensely touching.'* (Focus group participant)

It was also seen as important for therapists to understand and integrate into therapy issues relevant to the person, or be receptive to learning about them. Some participants had negative past experience of therapists' assumptions about their culture or religion, so called for more appreciation and understanding of differences between cultures. Participants wanted time and space for people's cultural backgrounds to be appreciated, to bring their different experiences to therapy and to feel listened to, saying that training could help bring this into services.

2.2.3.   The service

Practical aspects of the service

Participants noted issues that were important to them, including changing the time of the session if the person was unavoidably running late and the option of early morning or evening appointments.

Participants talked about where the appointment was held. Some people preferred to have their appointment at a GP surgery because it was familiar and they felt comfortable there. Others preferred a community centre, finding it more relaxed and convenient. Providing people with a choice about location of treatment and services adapting and accommodating these preferences was seen as positive for the treatment experience – and, therefore, treatment outcomes:

> *'[...] even if you ask someone, "Does this location work for you? Does this time work for you?" [...] a lot of the time, especially with mental health, it's in giving those answers and having that conversation that you can find out some of the things that are contributing to the mental health problems in the first place.'* (Focus group participant)

Participants also discussed remote versus face-to-face therapy. For example, some participants reported finding remote therapy (by phone) impersonal. Others added that the experience of therapy over video conferencing was more personal than by phone because they could see the therapist's facial expressions and see that they were listening.

2.2.4.   Changes and improvements to IAPT

Participants perceived inequalities in access to and receipt of IAPT therapy for people from minoritised ethnic groups, and that they affected their experience of IAPT:

> *'[…] there is a lot of inequalities, there is a lot of gaps. Not intentional inequalities, but unintentional inequalities that IAPT services need to really address when it comes to minoritised ethnic communities. From language, culture, […] Eurocentric models of mental health that don't fit well with the way we, in certain cultures, see mental health. So […] at some point, [it would] be nice if we can look at some of those issues.' (Focus group participant)*

Participants suggested changes and improvements to IAPT services to help engage people from minoritised ethnic groups and remove gaps in accessing services, summarised below.

Also see Appendix 2.6. for comparisons between focus group findings and the qualitative literature.

Education and training

Staff could be given extra education and training to improve their understanding of the needs of the local population, and treatment could be adapted based on it. This points to the potential for building on the national IAPT training programme and replicating learning at the local level based on population needs. There may be people from a range of minoritised ethnic groups and, given the variation in language, dialect, tradition and religion, an understanding and awareness of the local population's demographics could help with meeting cultural needs. The training could be specialised or delivered by a lived experience adviser.

> *'There's not much element or focus on cultural competency, and the complex needs of communities. […] for example, if I say I'm South Asian, it's not simple as that. Then you'll have micro-communities, microaggressions, and things like that… you won't understand, and all the forms and the assessments and the therapies are technically White Eurocentric. So you're like, how does that apply to me?' (Focus group participant)*

Education and training were felt to be particularly important because some people noted that their therapists seemed less comfortable discussing certain topics, such as disability. Others spoke of not feeling understood, having to justify or explain at depth their struggles, or having to educate their therapists about their disability.

In the therapist focus groups, there was also discussion about therapists shying away from topics they felt uncomfortable with or untrained to discuss.

Therapist characteristics

A means of indicating the ethnicity, religion and sexual orientation of therapists was suggested as a way to make people feel more comfortable in therapy.

Participants felt that, wherever possible, individual preferences should be taken into account when choosing a therapist.

Information provision

As outlined above, participants suggested that improvements should be made to the quality of information about services (what they offer and what to expect from treatment).

Language used to describe the service

Participants discussed the term 'IAPT' and the language used to describe the service. For some people the word 'psychological' sounded frightening, carrying negative connotations of 'madness' or 'insanity', making people feel that the service is not for them. Participants acknowledged that there is still a taboo around mental health and therapy in some cultures.

It was suggested that promoting IAPT services as being intended to 'improve wellbeing' may make it more accessible for people from some minoritised ethnic backgrounds.

Lived experience advisers

Some people suggested that having lived experience advisers to help co-produce, co-facilitate or inform the development of the service would be helpful. Many services have processes in place to co-produce, but methods for meaningfully involving people with lived experience may be limited by time and funding or the processes may not be well-publicised or known.

Links with community partners

The benefits of making connections with community partners or organisations was highlighted, including that it can promote the service to underrepresented or less-engaged communities and let them know how the service could support them. Many services do have connections with local community partners (such as religious organisations), but therapists in our focus groups and survey respondents both said that the impact of the COVID-19 pandemic, staffing constraints and time have limited their work.

2.3. Findings from focus groups with IAPT therapists

From the 21 participants, the most reported ethnicity was 'Asian or Asian British – Indian' (n=6, 28.6%) followed by 'White – British' (n=5, 23/8%). Each other ethnicity category was selected by one or two participants, and full information can be found in Table 37.

2.3.1. Access to IAPT

Service promotion and outreach work

Outreach activities

Therapists discussed access beginning before people set foot in the service and the importance of promoting the service in the community:

> *'One of the things we did was to go into the community to attract them. Not relying on them coming forward, because that has been a problem, because within the community itself, there are barriers.' (Focus group participant)*

When reaching out to people first accessing IAPT services, therapists emphasised the importance of being clear and thorough, and of explaining to people what the service can provide and addressing any misconceptions they may have.

Some therapists talked about members of staff, including patient liaison officers, who are responsible for outreach and service promotion, but some said that the responsibility of outreach work fell on all staff and took time away from treatment delivery and other duties:

> *'[…] we're using constantly our own pool of staff, a clinician to go and […] promote their service, to go into communities. So we're not using other members of staff to go and do that. So, constantly, you're digging from the same pool of the clinicians you have.' (Focus group participant)*

Other promotional strategies aimed to normalise discussion of mental health problems and raise awareness. They included making links with community partners (such as places of worship or community centres) or delivering workshops rather than relying on people to come forward. However, many therapists said that the COVID-19 pandemic had impeded progress in this area and that outreach work was not yet back to pre-pandemic levels.

Information about IAPT services

Therapists discussed the merits of different methods to promote and provide information about IAPT services. They thought that some people did not have an awareness or understanding of what IAPT is and can offer. Possible ways to improve this included getting information into the communities (which could then be translated into different languages), using social media to raise

awareness and sending texts/emails. However, the last two points rely on Internet access and competence in using it, which could be a barrier for some people.

Other sources of information include IAPT services' websites. Participants talked about trying to make websites as easy to access, navigate and understand as possible for people from different minoritised ethnic backgrounds, especially if English was their second language. Having culturally accessible videos about anxiety, depression and cognitive behavioural therapy (CBT) on websites could help introduce people to what the service can offer.

Therapists noted that it is important for people using IAPT to understand what the service does and why there are waiting times. They recognised that waiting times are difficult for people and wanted to prevent them from dropping out of treatment if there were long waiting times.

Language and access

Language was a common theme that arose during all discussions, and was important throughout the entire IAPT process, including access to services.

Therapists said language barriers can affect how assessment questionnaires and quality of life scales are completed. These measures can be subjective and interpreted differently in different languages. They can also take longer to complete if English is not the person's first language, in which case their interpretation of the questions could lead to inaccurate answers – which could affect the measures' validity, utility and comparability.

Participants emphasised the importance of providing all written information and forms in the person's preferred language if possible (see also Appendix 2.1.1., findings from focus groups with people using IAPT services, under the heading 'Information about IAPT'). Therapists discussed other strategies to overcome language barriers, suggesting that instead of asking people who need an interpreter to call the service to tell them, they could ask an interpreter to phone the person. This would actively bring people into the service rather than waiting for them to respond to a translated letter. Other strategies included audio interpretation.

> *'I think there's a big […] disconnect between us, both the language and our own awareness of what we offer as services, and what is known in the communities. And I think overcoming some of those cultural barriers […] is something that's really key, because of all the attitudes, and different languages that are […] used around mental illness. So, one, we are quite lucky in our service, that we have got a fairly diverse workforce where we've had the idea that maybe the representation from our workforce can go into those communities to promote, do a lot of service promotion and things like workshops.' (Focus group participant)*

Therapists highlighted the importance of using the right language and terminology, because in some languages mental health terminology does not exist.

> *'Language is a big barrier when you expect people to do self-referral and they can't even speak or read English. How do they do that, and how do they express their mental health issues?' (Focus group participant)*

Cultural barriers

Therapists discussed cultural barriers that can prevent people from minoritised ethnic groups from accessing IAPT services.

Reflecting on feedback from people using services, therapists recognised that some people will have had previous experiences of IAPT that were difficult. Therapists recognised that some people may have felt that their culture, an integral part of their lives, was often not discussed or integrated into assessment and treatment. Some therapists expressed understanding that people using IAPT services might not feel understood, or that it unintentionally became the person's responsibility to educate therapists about their cultural backgrounds or needs.

> *'[…] even before coming through the gates of IAPT treatment, stigma […] stops people from accessing it to begin with. Which is something we need to look at, to improve access by […] normalising the fact that it's OK to seek support. Some cultures […] don't see mental health as a thing, it's something that doesn't happen to us. You just get on with life […] and it gets pushed to the side until it's a bit too late or you're further down that patient's journey and the mental health has deteriorated even more.' (Focus group participant)*

> *'[For] young Black men in our localities, it's more difficult […] for them to access the service. We have found that they have the lowest referrals into the service. So I think that we need to do some work. Sometimes we get bogged down with languages and people from minoritised ethnic groups, but there are quite a lot of English-speaking ethnic minorities who we then failed to access.' (Focus group participant)*

> *'People don't trust IAPT services. They don't see this service representing them, they feel that they have to explain their culture during sessions, and they kind of waste their time. Their job feels that they're educating the therapist.'*

2.3.2. Treatment delivery

Treatment offered

Some therapists raised concerns about the evidence-base behind therapies offered in IAPT, such as CBT. Some expressed a view of CBT as a 'White middle class' therapy and argued that this may mean that it does not always serve the needs of a diverse population from minoritised ethnic groups. They expressed the view that the level of knowledge and understanding required to engage with, and benefit from CBT could serve as a barrier to some people from minoritised

ethnic communities, or could make it difficult if English was their second language.

'There's a lot of emphasis on CBT courses, and sometimes people don't feel like they have the permission to focus on the really important validation side. If patients are talking about experiences of feeling alienated or of discrimination, sometimes practitioners don't feel like they've got permission to spend time talking about it and validating that. Whereas that's a really important part of the treatment, because the evidence repeatedly says is, people want to be understood and listened to, and have their experiences acknowledged' (Focus group participant)

Adapting treatment

Service adaptations

Therapists discussed aspects of the service that work well and that need to be changed to better support people from minoritised ethnic groups accessing IAPT. These included structural adaptations, such as offering earlier or later appointments. The therapists did acknowledge that not all IAPT services are set up to do this, and this adaptation is not possible for all stages of the process. For example, assessments always need to be carried out in core working hours so that risk can be managed.

Changing where the therapy appointment was held was also discussed by therapists, for example the appropriateness and proximity of the venue to the person.

Therapists also discussed remote therapy, and that they had been surprised by the positive feedback they received from people attending IAPT services. During the pandemic, they found that attendance and recovery rates increased while using remote therapy. Returning to face-to-face sessions after the easing of COVID-19 restrictions had been difficult for some people, but they explained that while remote therapy works well for some it does not work as well for others. Also, some therapists noted that offering a choice of therapy medium is not always possible.

'I think it's about matching the service to people's availability, and particularly when you think about the socioeconomic roles of some of the clients from minority backgrounds, that they're not always able to adjust their shifts in the same way.' (Focus group participant)

'It's really about flexibility and reaching out, and to make it as accessible as possible. That's what we were saying: use all resources we have to help people engage.' (Focus group participant)

Adaptations made by therapists

As discussed under 'Access', therapists recognised that despite improvements in cultural competence training for therapists, it is still sometimes the case that the burden falls on the person using IAPT services to bring up cultural issues rather than the therapist asking about the person's background and what culturally sensitive adaptations they might need. This might mean that important considerations that are integral to the therapeutic process or formulation are missed. Therapists said that it is important to make sure that therapists are asking the right questions at each stage of the process, so that people feel comfortable in bringing up experiences relevant to their culture or ethnicity.

> *'As a White therapist, if I actually invite people and ask them explicitly about experiences of racism, they will almost inevitably tell me about their experiences and they're almost always intrinsically linked to the formulation, and we wouldn't have been able to proceed with therapy in an effective way. … That's not something that standard training has ever included.' (Focus group participant)*

Language and diversity

Therapists discussed delivering therapy in multiple languages, and the benefits that this can bring to people using IAPT services. They reported that to deliver treatment in other languages removed the need for an interpreter, and having an interpreter in the session can change the dynamic of the therapeutic relationship. However, recruiting therapists who speak languages additional to English in an already depleted workforce was acknowledged as being difficult.

> *'I deliver therapy in a different language, and can do assessments in a different language. And my own experience is, people have a better experience in their own language.' (Focus group participant)*

Therapists noted that some **people may have complex needs** (for example, resulting from trauma associated with refugee status), and spoke about not assigning people who have had the same experiences to the same therapist just because they can speak a certain language. Therapists in the focus groups noted that the background of staff does not dictate their ability to work with clients from different backgrounds, and not to make assumptions about therapist/client suitability.

> *'[…] sometimes we can easily slip into the expectation […] that staff […] from a BAME [Black, Asian and minority ethnic] background can be more inclusive of such populations. For example, if you're an Indian staff member you might be more suitable to work with such populations because of similar backgrounds. But actually this may not be true.' (Focus group participant)*

One therapist described a person who did not want to admit they spoke a certain language because of worry about being assigned an interpreter from the same culture, and that their treatment would be spoken about in the community. This

relates to discussion in the focus groups with people using IAPT services, who spoke about seeking mental health support being seen negatively, or feeling unable to discuss mental health with family members. They felt that the risk of their treatment being spoken about negatively in the community could outweigh the benefits of receiving treatment.

Therapists spoke about the **diversity of the workforce reflecting the communities** that they serve. Therapists discussed that sometimes diversity is reflected well, but often is more visible in the psychological wellbeing practitioner (PWP) or high-intensity therapist workforce, as opposed to in senior leadership and management. As senior leaders are often responsible for implementing change, they emphasised the importance of diversity in these positions. They thought that some staff from minoritised ethnic groups were not being given equal promotion opportunities. They suggested embedding diversity into the structures of IAPT, for example making sure that staff diversity reflects the community that it services – including senior leadership, and creating specific positions focusing on equality and diversity could help create both equal opportunities and change in the service's work to increase access for minoritised ethnic communities.

> *'On an IAPT level, definitely senior management – there's a scarcity of staff from the BAME backgrounds. Shall we say it's really, really noticeable' (Focus group participant)*

> *'We're not going to fundamentally change services until we fundamentally change the leadership' (Focus group participant)*

Interpreters

The usefulness of interpreters (plus associated issues and limitations) formed a large part of the discussion around treatment delivery. As mentioned above, having a third person in the room can affect the therapeutic dynamic and this is compounded by rarely having the same interpreter for a person's full course of treatment. When treatment takes place online, therapists said there could be a different interpreter every week – and if the Internet connection was lost during the session, they might be reconnected with a different interpreter. To help prevent this, it was suggested that the same interpreter could be booked for all sessions.

> *'The problem with COVID is that everything has gone remote. And sometimes, because nowadays the interpreting service we're using have gone worldwide …. So you might then be cut off and then somebody else picks up the phone. So that's where the discontinuity of care happens.' (Focus group participant)*

Therapists emphasised that the need for extra time to work with interpreters was not always met. Services need to be mindful that these longer appointments may reduce a practitioner's caseload, and targets may need to be revised based on the complexity of therapists' caseloads. Training is also needed on how best to work

with interpreters. Therapists described the need for this provision to be standardised and commonplace, or more consistently provided.

> *'We are more flexible. But I know it does impact on clinicians as well, because…that session might not necessarily count as two contacts. So I think this is a question that might need addressing more, finding out what also exists. We often support therapy if the session needs to take longer. But I guess that might have clinical implications elsewhere, around targets for those individuals.' (Focus group participant)*

However, therapists explained that adaptations such as these can lead to much longer waiting times when an interpreter is needed This can be frustrating for the person using IAPT services as well as the therapist. Therapists acknowledged that increased waiting times risk disengagement and dropout. Also, because there are not interpreters for all languages, therapists have needed to find some language interpreters privately.

Translation of information and documents for people using IAPT services

Therapists said that there were stages of the IAPT process when translation was important but also at times problematic, and the effect that this had on people from minoritised ethnic groups using the service.

For example, when having letters translated for people using IAPT services whose first language was not English, therapists described having to weigh up whether to arrange for a good quality but more time-consuming translation against a more rapid but lower quality translation. Therapists spoke of using Google Translate and of reusing translated letters by changing the names on them, leading to the letter not accurately reflecting the current person using the service. Giving enough time and resources for translations is also needed. There are central banks of translated materials, but they may not be in all of the languages needed and they may not have all of the resources needed. Knowledge of these resources may also be inadequate. Participants said it would be helpful to standardise these banks of translated materials across England.

Aspects of the IAPT treatment pathways, such as the online SilverCloud platform, are only in a few languages and so are not accessible for people who do not speak those languages (especially English). Therapists recognised that this meant that there was not equal access to the IAPT service and treatment pathways.

Training and supervision

Any training should increase IAPT staff's knowledge, so they can make necessary adaptations for people using the service. Not all therapists knew that such training opportunities are part of national training programmes. It may be that national programmes do not always reach individual services.

Both focus groups discussed the lack of training in working with people from minoritised ethnic groups. IAPT therapists expressed concern that feeling like

they lacked appropriate skills and training could lead to reluctance to work with people from minoritised ethnic groups or bring up their experiences.

> *'It's a systemic issue, and without any open discussion of social inequalities and racialised inequalities in training, then that will remain outside the radar of a lot of practitioners. And so the onus can't be on individual practitioners if any of this isn't being addressed openly at systemic level within services and within training.' (Focus group participant)*

Therapists said that when people know there is a lack of cultural competence in an IAPT service, it can affect their trust in the service. Training by experts with lived experience and in cultural competence were felt to be of benefit.

Other training topics that were raised were racism, discrimination, social and racialised inequalities, and cultural competence. Therapists wanted diverse staff to contribute to training provision and development.

The need for senior leadership to attend training opportunities, discussion groups and events beyond the mandatory requirements was discussed:

> *'I wonder how often these things [focus groups, conferences aimed at promoting access to IAPT] happen at [CEO and] management level, even just to understand what's going on' (Focus group participant)*

'There's a lot of pressure from my seniors to push that agenda [PPG], to do that almost sort of annoyingly, feeling like it's a very tokenistic gesture' (Focus group participant)

Supervision can help reduce ethnic inequalities when therapists can reflect on their own racialised identity, talk about adapting interventions for people from minoritised ethnic backgrounds, consider the person's background in the context of the work, and discuss complex cases. Discussing their own ethnic or racial identity encourages therapists to talk to people in therapy about their own identities.

2.3.3. The service

Resources

Time

Lack of time is likely to impede making adaptations within the services. For example, busy caseloads and schedules often meant that their time could not be allocated for reading and engaging with resources such as the PPG, which then needed to be done outside of working hours. As mentioned above, translating letters and phoning people using services also takes extra time.

Staffing

As mentioned above, staff are sometimes expected to undertake outreach work on top of their usual caseloads. If there are no specific members of staff and no dedicated time, resource or funding for outreach work, it is much harder to undertake successfully.

Promotions and opportunities

Therapists discussed the importance of making the recruitment process fair and unbiased, and ensuring that there was equal access to opportunities. Therapists talked about their general thoughts of what unequal access looked like. Some recalled hearing people talk about not being told about promotion opportunities, unequal access to involvement with projects, or not enough opportunities to undertake secondments. Therapists discussed these as examples of microaggressions of subtle or indirect discrimination. Other examples in the PPG are staff from minoritised ethnic backgrounds being less likely to be consulted when decisions are being made and more likely to undergo disciplinary procedures. Therapists noted that they wanted equality in opportunities as opposed to promotions based on the fulfilment of diversity criteria (see also the previous paragraph, on staffing)

> *'It's not just direct discrimination. It's people not being given the opportunity to take on projects to stretch themselves. It's about not being given chance to do secondments. It's about been more likely to be discriminate against disciplinaries once you are in post. I mean, I guess there's a lot we can learn from outside IAPT that probably applies equally in IAPT. This is something we've got to address before we can make that change.' (Focus group participant)*

2.3.4. Changes and improvements to IAPT

Targets and key performance indicators (KPIs)

Therapists discussed the pressures that targets and KPIs can bring to practice. While necessary, and sometimes realistic and achievable, therapists said they are less achievable when making certain adaptations to treatment for people from minoritised ethnic groups. This is because working with interpreters takes extra time, so targets may need to be re-evaluated in the context of the complexity of their caseload, to make them more achievable.

Diversity monitoring

Participants discussed IAPT outcome data, noting that vastly different minoritised ethnic groups are combined in the database and only overall outcomes for these large and diverse populations are looked at. This means that nuances and differences between minoritised ethnic groups are missed.

'Using that "BAME" label encapsulates such a large population and diversity. So it almost puts it into either you're BAME or non-BAME, creating those two categories. We're not actually – there's such diversity in that label' (Focus group participant)

Integrating feedback

Therapists said that collecting and integrating feedback from people using IAPT services was vital, especially because feedback is often more negative from people of minoritised ethnic backgrounds than other backgrounds. Therapists discussed the importance of continually gathering feedback from people using services and discussing areas of the service with them, to help make improvements. They said it was important to have the time to analyse and act on this data. Unfortunately, methods for data collection and analysis were not discussed by focus group participants.

'Patient satisfaction tends to be lower [in] racialised minority people. And so I was thinking something about... cultural safety and cultural humility are very much dependent upon more information from the patient, more feedback from the patient about the quality of the care.' (Focus group participant)

'Getting the service user voice to understand what is working, what's not working, how would they like to see … because they also own the service.' (Focus group participant)

2.4.   Findings from all focus groups on treatment delivery

Table 42: What works well and what can be improved in IAPT treatment delivery

Focus group theme: Treatment delivery	Similar issues raised by both therapists and people using IAPT services	Differences In issues raised between therapists and people using IAPT services
Therapist characteristics and cultural sensitivity of the therapist	• IAPT therapists displaying **cultural awareness and sensitivity** by attending **training** when necessary, including: o having a **deeper understanding of the individual needs** of people from different minoritised ethnic groups o being **comfortable discussing issues around ethnicity** and disability o knowing about the factors and **issues that are important to people** from local minoritised ethnic populations, for example aspects of culture, discrimination and religion	**People using IAPT services** • Accommodation of **preferences for a therapist with certain characteristics** **Therapists** • Proactively **discussing cultural issues** with people who use IAPT services, so they can be integrated with the formulation and therapeutic process • Receiving **regular supervision** to discuss topics such as cultural sensitivity • Wanting service leads to ensure that the **workforce reflects the ethnic diversity** of the local population
Language that therapy is delivered in	• Offering therapy in **multiple languages**	**Therapists** • Translation services being slow and the availability of interpreters can be inconsistent and changeable, thus disrupting therapy, can serve as barriers

Table 43: What works well and what can be improved in IAPT services

Focus group theme: The service	Similar issues raised by both therapists and people using IAPT services	Differences In issues raised between therapists and people using IAPT services
Resource/ practical aspects of the service	• **Flexibility over session timings** (for example, morning or evening appointments) • Offering **locations that suit the preferences** of the person • Choice of **in-person or digital treatment delivery**	**Therapists** • **Adequate staffing and funding**, which would give services the time and flexibility to deliver those 'practical aspects of the service' • There are barriers to some of these service adaptations, such as that not all IAPT services can offer **earlier or later appointments,** or some people not responding well to treatment **online**

Table 44: Focus group suggestions for changes and improvements to IAPT services

Focus group	Changes and improvements to IAPT services
Similar issues raised by both therapists and people using IAPT services	• **Educating and training IAPT therapists** to better understand the needs of minoritised ethnic groups • **Lived experience/advisory input** to support service development and education • **Types of information** provided (for language, format and when/how that information is received) • Creating more **connections with community partners** or organisations.
Issues raised only by people using IAPT services	• **Preference for therapist with certain characteristics** (for example, their gender, ethnicity, religion or sexual orientation/allyship)
Issues raised only by IAPT therapists	• **Re-evaluating targets and KPIs** in light of heavy caseloads (for example, if interpreters are needed), to make them more achievable • Enabling **more granular diversity monitoring** within different minoritised ethnic groups and using this to improve service delivery • Using more methods such as surveys, focus groups and workshops to **collect feedback from people from minoritised ethnic groups who use the service,** and integrating it into services

2.5. Comparisons between focus group findings and the qualitative literature

2.5.1. Information, health promotion, mental health awareness and stigma

Both the focus groups and qualitative studies in the literature review highlighted the importance of information provision to promote mental health and the services, increase awareness and help combat mental health stigma:

- Jackson-Blott2015[18] showed that information to promote health can be shared through posters or letters, and that targeting underserved communities can be beneficial. Running courses to raise awareness is also helpful.

- Jackson-Blott2015,[18] Loewenthal2012[19] and Yasmin-Qureshi2021[20] discussed mental health stigma in minoritised ethnic communities. They highlighted that when men are seen as strong, it can create a barrier to help-seeking. Mind2013[21] reported that stigma can create a barrier to accessing mental health services because of the shame associated with it. Information and psychoeducation to combat stigma and raise awareness is therefore important, as is offering culturally adapted treatment to make it easier for people from communities with high levels of mental health stigma to access services.

2.5.2. Access

The focus groups and some qualitative studies from the literature review highlighted barriers to access to IAPT services, including in referrals, waiting times and treatment attendance:

- Yasmin-Qureshi2021[20] highlighted that South Asian women perceived that their GPs had been reluctant to refer them for psychological therapy. Parry2011[22] found that people from Black and Asian ethnic groups were more likely to self-refer to services than be referred, though this difference was reduced when diagnosis was more recent. People in our focus groups also spoke of GPs reluctance to refer them for treatment, suggesting that instead they prayed or 'got over it'.

- Yasmin-Qureshi2021[20] demonstrated the negative impact of long waiting times for treatment. They also found that non-attendance could be linked to people thinking that others need the appointment more than they do. People in our focus groups agreed with this, but highlighted the benefit of therapy once they received it. This shows the need to keep people engaged when they are on waiting lists and to keep the waiting times to a minimum.

Table 45: What works well and can be improved in IAPT access

Theme: Access	Similarities across focus groups	Differences between therapists and people using IAPT services focus groups
Information about the service and waiting times	• **Explaining clearly what the service can offer**, including who it is for, any wait times and the reason for them. • **Digital communication can be challenging** for people without mobile phone or Internet access, and those who are not computer literate.	**People using IAPT services** o Services to provide **clear, accessible and up-to-date information** **Therapists** o **Promoting the IAPT service in the community** through outreach work. This has been affected by lack of resource to carry out this work and the pandemic.
Languages and terminology used in information and assessments	• **Information and therapy sessions in languages used by the local population.** • Clinical terminology related to mental health is different or non-existent in some languages. **Services must therefore use accessible language.**	**Therapists** • Being **proactive about providing interpreters** and asking about language needs, rather than asking people to opt in.
Discussing culture in assessment	• **Discuss and integrate a person's culture and religion** into assessment and treatment, when appropriate.	**People using IAPT services** • Being **mindful of culture when asking questions** (how the questions are phrased).

2.5.3. Adapting treatment and services

Findings from the focus groups and qualitative studies in the literature review both agreed that the following adaptations to treatments and services can help increase access:

• Jackson-Blott2015[18] and Yasmin-Qureshi2021[20] found that the location of therapy was important, for example having familiar, local and multiple options.

• Yasmin-Qureshi2021[20] highlighted the importance of including culture and religion in the therapeutic process and showed that a therapists' poor understanding can impact patient experience. Mind2013[21] showed that people felt that IAPT services were not meeting the needs of people from minoritised ethnic backgrounds.

• Yasmin-Qureshi2021[20] and three qualitative grey literature studies (Buffin2009,[23] Mind2013,[21] NICE2017[24] [National Institute for Health and Care

Excellence]) showed the benefits that translations and interpreters can bring, especially in reducing language barriers. However, as in the focus groups, the studies showed how hard it can be to find suitable interpreters, and highlighted the benefit of bilingual therapists to people using IAPT services.

2.6. Topic guide – people using IAPT services

2.6.1. Topic schedule

Access to IAPT

1. Please talk to us about your experiences of first accessing IAPT services

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail, or use as prompts to further the conversation about these topics

- Talk to us about the referral process (self-referral, GP?)
- What (if anything) did you know about IAPT before you were referred? Information provided?
- Did you find it easy or hard to access to the service? Why?
- Did you experience any challenges or difficulties in starting treatment?

If challenges accessing treatment are discussed, follow up with:

- What are some of the reasons you might **not have wanted** to access treatment?

If not mentioned above, ask:

- What about waiting times?
- Referral to assessment versus assessment to first treatment

2. Please talk to us about the assessment process

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail, or use as prompts to further the conversation about these topics

- How did the assessment make you feel?
- How did you feel about what was offered to you? (number of sessions, frequency of sessions, type of support [group, 1:1] etc.)
- Satisfaction with what was offered?

Treatment delivery

3. **What things about the therapist providing your treatment do/did you value the most i.e. what are some of the things they do or say that are most helpful?**

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail, or use as prompts to further the conversation about these topics

- Are there any characteristics (e.g. gender, age, ethnicity) of your therapist that you find makes it easier or more challenging to talk with them?

4. **Can you talk about any things that your therapist does/did in order to meet your individual needs in treatment and make it suitable for you?**

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail, or use as prompts to further the conversation about these topics

- If applicable, how does/did your therapist consider any language translation or interpretation needs?
- What things do you feel that they do to make sure treatment reflects your cultural needs?
- If applicable, what things do you feel that they do to take into account your spiritual and/or religious beliefs?
- If applicable, did you feel comfortable talking to the therapist about things you feel they may not have understood about you?
- Have you and your therapist discussed making your treatment suitable in any of your treatment sessions? (e.g., changing or adapting elements of treatment?)

5. **What additional things do you think the therapist could have done/could do to make sure that the treatment is suitable for you?**

The service

6. What things does/did the IAPT service do to make sure you can attend your treatment sessions?

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail, or use as prompts to further the conversation about these topics

- Did they change anything about the time, day or regularity of sessions for you?
- Did they change anything about the way treatment is delivered (face-to-face, telephone or video call)?

NOTE: likely to have responses relating to the COVID-19 pandemic.

Changes and improvements to IAPT

7. How should IAPT provide a better service to people from minoritised ethnic communities?

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail, or use as prompts to further the conversation about these topics

- What do you think could be done to encourage IAPT use in diverse communities? Would you like to see more people from within your communities accessing IAPT?
- What should change about what IAPT provides?
- How can we better support people to understand their mental health?
- What about the language used to describe IAPT itself (Improving Access to Psychological Therapies)?

General experience

8. Is there anything else people would like to talk about regarding their experiences?

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail, or use as prompts to further the conversation about these topics

- Anything in particular that was negative/challenging about your experience?
- Anything in particular that was positive/good about your experience?

2.7.   Topic guide – IAPT therapists

2.7.1.   Topic schedule

Access to IAPT

1.   Please tell us your thoughts about access to IAPT treatment

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail or use as prompts to further the conversation about these topics.

- What things do you think make it easy or hard for people to access IAPT care? Why?
- What are the challenges people might have in starting treatment?
- If not mentioned above, ask:
    - What about waiting times? – Referral to assessment versus assessment to first treatment
    - What about other barriers to access?

2.   Please talk to us about the assessment process

Prompt questions: Ask the following questions if responses to the question above do not lead to this organically, do not provide enough detail, or use as prompts to further the conversation about these topics

- How do you feel about the assessment process as a practitioner? Challenges, advantages?
- Can you talk to us about the training you received about conducting assessments?
- Further prompt: What about any training you received to support assessment of people from different cultures?

Treatment delivery

3.   How do you feel about the treatment you're able to offer people after they've been assessed?

Prompt questions: Ask the following questions if responses to the question above do not lead to this organically, do not provide enough detail, or use as prompts to further the conversation about these topics

- Talk about the confidence you have in the treatment that you are able to offer.
- How well-equipped do you feel in meeting the needs of people from diverse backgrounds?

- Can you talk about things you have done to make sure treatment reflects an individual's cultural needs? (for example, considering spiritual and/or religious beliefs?)
- If applicable, how have you managed any language translation or interpretation needs?
- What additional things do you think you could do to make sure that the treatment is suitable for your clients?

If not mentioned above, ask:

- What is your experience of using the IAPT Black, Asian and Minority Ethnic Positive Practice Guide?
    - What has been helpful about this? What has been challenging?

The service

4. Can you talk about some things that the service you work in has one to make sure clients can attend their treatment sessions

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail, or use as prompts to further the conversation about these topics

- Are you able to change anything about the time, day or regularity of sessions for people?
- What about changes to the way treatment is delivered (face-to-face, telephone or video call)?

*NOTE: Likely to have responses relating to the COVID-19 pandemic.

Changes and improvements to IAPT

5. How should IAPT provide a better service to people from minoritised ethnic communities?

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail, or use as prompts to further the conversation about these topics

- What do you think could be done to encourage IAPT use in diverse communities?
    - What can be done or is already being done to promote IAPT service use?
- What should change about what IAPT provides?
- How can we better support people to understand their mental health?
- What about the language used to describe IAPT itself (Improving Access to Psychological Therapies)?

General experience

6. Is there anything else people would like to talk about regarding their experiences providing IAPT treatment?

Prompt questions: Ask the following questions if responses to the question above either do not provide enough detail, or use as prompts to further the conversation about these topics

- Can you talk about anything in particular that you think is more negative/challenging about providing IAPT care as a practitioner?
- Can you talk about anything in particular that is positive/good about providing IAPT care as a practitioner?

Other prompts

Prompt about being able to access adapted treatment such as language, access to later appointments etc. Barriers exist and it can be a long-winded task and difficult for the therapist to navigate and make adaptations decisions.

People mentioned at various times the importance of recognising positive practice and learning from colleagues/other practitioners. Is there anything anyone would like to share (similarly to James about using supervision constructively) what other positive experiences of providing care for people from diverse communities? Things that work well or things you find positive or helpful in your practice?

2.8. Demonstrative quotes from the focus groups

Selected quotes from focus group participants organised by theme.

2.8.1. Focus groups with people using IAPT services

Theme	Quote
Information about IAPT	• *'So where I am in [place name], lots of people speak Urdu, Gujarati. Those are languages that you can put in the leaflet and maybe a little footnote to say if you would like this leaflet in another language like Somali, please contact this number. That way, at least you can have it in your own language… So that would be my first thing, that language is needed to be considered 'cause it's not always accessible, particularly for the older community.'* • *'It needs to be easy to find rather than you sat on Google trying to find is there something out there that's gonna help you. Because often you don't know what you need and counselling is not a word that resonates in the South Asian community. Mental health. Those are things that people don't*

Theme	Quote
	really talk about, it doesn't happen. But it does. And wording kind of needs to be looked at, cause often mental health is like, "Oh no, no, someone else is mentally unwell, I'm not".'
	• *'This is what clinicians need to be aware of. You think you got a professional interpreter, but mental health is not talked about in the minorities, minority communities with them words don't actually exist. And in order to get that message across, you probably have to give them an analogy and you probably take 5 minutes to get to that point where that other person understands'.*
	• *'In African Caribbean communities, mental health sometimes is considered... well, you just need to pull yourself together and, you know, we don't really need mental health support, we don't need to see psychiatrists, psychologists and so forth. And so I think what we can do is share our lived experience with your friends, with your colleagues, with your family, and say, "This is my experience" – particularly someone like me, who's had a really great experience with the service, it's nothing to be afraid of, it's nothing to be ashamed of. This is about wellbeing. This is about wellness, and really promoting what the service can offer.'*
Access	• *'I do remember at one point and I went to my GP, and the main GP – they're Muslim like myself, and I were trying to tell them about what was going on and depression, and that I needed medication to help with it because I recognised that, at that point, that I did need some sort of medication for the depression. And they turned around and said to me that "You don't need any medication, you just need to go home and pray and you'll be fine." And I just thought, that is so wrong for a GP to say, like I understand that I'm Muslim as well and praying and all that is a massive part of our lives. But when someone is telling you, you need medication, you cannot turn around and tell them that no, you don't, you need to go home and pray that it doesn't work like that. You can't mix your religion with profession, you can't do that. I just thought that was really wrong.'*
	• *'Some people might not access the service even if they might need it made me think of someone in my family who couldn't access this service because he lived with his parents. And, like [participant name] mentioned it's a taboo subject. You just don't seek mental health. It must mean there's something wrong with you which makes it difficult for [them] to have a conversation about it in the house because, you know, the people always around, and that makes you think, that's one reason, that a lot of people, I'm Indian, so I don't think any of*

Theme	Quote
	my friends, even if they need to would access the service it's just not an option.'
	• *'I found that like for a lot of my male friends, again, that men of Caribbean and African heritage, it's been a lot of negative experiences. I've only had one that's, you know, said that they've been OK with their experiences. And they struggled to access IAPT because it's like, you know, the talking therapies and stuff because it seems to always be kind of picked to a higher stage because they're perceived as a threat, even if they are approaching with a similar thing to what it is that I may be saying, it's taken differently.'*
Assessment	• *'How you ask a question in English, it's very different to how you ask the question to somebody in our language, and some of the questions become quite inappropriate, you know. And my mum really struggled with that like...[an] example would be if you say to somebody, Are you in certain cultures? Are you married, and they say "No". Now we know you don't have to be married, to be in a sexual relationship. But some people get very frustrated when you say to them, "Are you in a sexual relationship?" Have you not heard what I just said – I'm not married, how can I be in a sexual relationship? And they forget that she will live in a society where you don't have to be married to be in that scenario.'*
Therapists' characteristics	• *'In my case it was helpful that I met a person who was from a different ethnic [minority], like, ethnicity. I think there was that kind of cultural competency that I felt that maybe wasn't there in terms of mental health. So I felt that I could potentially confide in somebody and talk about the challenges with regard to mental health, because it was from [someone] outside of my ethnicity. So, and I think the more we did that we kind of built some kind of relationship. So you know in a way it was kind of a bit unsure to begin with, but I think it was just about learning to trust and just take it like one step at the time.'*
	• *'Just having that representation within the counselling service that IAPT offers, it's always wonderful to see somebody like yourself represented in the person that you're speaking to, just because you don't need to explain all the nuances. It's not that the therapist might not understand. It's just you feel as though you have to explain lots of different things and it becomes a teaching session rather than a counselling session.'*
	• *'If there was some sort of [...] diverse and equal opportunities kind of advocate or adviser or officer, someone that's easily accessible where if you feel that the therapist has misunderstood something and you're coming from a diverse*

Theme	Quote
	background, whether it's an ethnicity, neurodiversity, sexuality, religion, whatever. Someone specifically trained on different approaches and different interpretations and mental health. That could benefit one most. And help explain, or help the therapist understand the context or whatever you're experiencing, whether it's on the assessment process or it's during the therapy, you know the patient feels that something been misunderstood or misconstrued. This person can come in and maybe even also provide the training. So that therapists are aware of different interpretations and mental health, that when someone from a different background, a different sexuality, different ethnicity, comes in, they generally feel more understood because there's been adequate training.'
	• *'I think what would be really nice to see [is] how IAPT services can be modelled and developed or re-tweaked to suit different, cultural communities. I've got a good example to share: there was a family intervention therapy that's been adapted, and it's called culturally adapted time intervention for African Caribbean men, and it works really well....We need something like that in IAPT, that is modelled and defined or refined according to different communities, so that that cultural backgrounds and experiences are not ignored or not validated.'*
Therapists' approach	• *'I was quite taken aback that my therapist was so understanding of my faith as a Christian. I was given the platform to speak a lot about how my faith impacts on my depression, and on my life, and the importance of me personally believing in God. I believe in The Bible, and I thought she was gonna think I was a complete wacko, and that this was all weird. I would [have thought] she [would] kind of avoid those subjects, but she didn't. I was allowed to speak what I felt and some of her questions, you know... I really struggled with going to church, and she would ask, you know, "Were you able to get to church on Sunday?", and "How did you find the sermon?" And the interest that she took in something that was so significant in my life was immensely touching.'*
	• *'I felt there was a need to constantly tell them a bit more about the struggles, and I felt that I had to justify as well and explain myself again. So I found that a bit of a challenge, and then I felt maybe not understood. It was kind of a bit of a barrier to maybe not say more, because that shared understanding might not be there.'*
	• *'We really need to understand that when we talk about minoritised ethnic communities we're not all one. We're all*

Theme	Quote
	very different in the big world. And she [another participant] sometimes gets very frustrated that she dresses, yes, as an Asian female – very similar to an Indian, Hindu, Sikh […], but […] sometimes [it's] assumed, because she's Muslim that she must have a full Arab culture, and she doesn't.'
Practical aspects of the service	• *'You know, even if you ask someone, "Does this location work for you? Does this time work for you?", it doesn't mean that you're gonna be able to give them the ideal time or the ideal location. But then, just in asking that question, if they're saying, "No, this time doesn't work for me" or "This location doesn't work for me", a lot of the time, especially with mental health, it's in giving those answers and having that conversation that, actually, you can even find out some of the things that are contributing to the mental health problems in the first place.'*
Changes and improvements to IAPT	• *'I think she [the therapist] struggled with the disability, aspect and so if they could be [understanding] on those kind of things it would be really helpful.'* • *'I think it's something that we should really deeply reflect upon, because there is a lot of inequalities, there is a lot of gaps. Not intentional inequalities, but unintentional inequalities that IAPT services need to really address when it comes to minoritised ethnic communities. From language, culture [inaudible], Eurocentric models of mental health that don't fit well with the way we, in certain cultures, see mental health. So I think slowly, at some point, [it would] be nice if we can spend a little bit time on this looking at some of those issues.'* • *'There's not much element or focus on cultural competency, and the complex needs of communities. Because like, for example, if I say I'm South Asian, it's not simple as that. Then you'll have micro-communities, microaggressions, and things like that... you won't understand, and all the forms and the assessments and the therapies are technically White Eurocentric. So you're like, how does that apply to me?'* • *'It [therapy] falls under what we call a "tree of wellness"... we have a really big wellness program, you know, spearheaded from the US [United States] and it's very, very popular. And under that wellness program are therapy services, psychologists, psychiatrists, and so forth. And that's kind of removed the taboo in the London office – people see [it] as wellness and not necessarily as psychological. That word [psychological] can be quite frightening to people, could exude potential of madness, insanity, what's wrong with you, kind of*

Theme	Quote
	thing. So I think "wellness", and just changing the psychology of the language.'

2.8.2. Focus groups with IAPT therapists

Theme	Quote
Outreach activities	• *'One of the things we did was to go into the community to attract them. Not relying on them coming forward, because that has been a problem, because within the community itself, there are barriers. [...] Their experience of mental health has actually been secondary care and they lack the insight into knowing about preventative mental health services, which is what IAPT is really, you know. So I think access is what we need to have. Maybe by looking at good practices and looking at how we can make it across the board, because access is a major thing. And then another one is even when they come into service, even when they've gained that access, what do we offer them, you know?'* • *'So I guess the problem, I think that issue comes with funding. Because the problem we have, and I'm just talking about our service in terms of funding, too, because we're using constantly our own pool of staff, a clinician to go and [...] promote their service, to go into communities. So we're not using other members of staff to go and do that. So, constantly, you're digging from the same pool of the clinicians you have. So if you're doing less therapy, doing more promotion at one point and then you're thinking you're waiting, this is growing, then you pull them back into doing more treatment... so it's this balance. But I guess if we did have more funding specifically to look into these issues, that would help [in] promoting the service, getting more people in. But then being able for clinicians to do their job by doing treatment rather than trying to promote the service and getting access.'*
***Language* and accessibility**	• *'Language is a big barrier when you expect people to do self-referral and they can't even speak or read English. How do they do that, and how do they express their mental health issues?'* • *'Some clients actually struggle to understand mental health described under the IAPT model and the interventions like CBT protocols.'* • *'I think there's a big [...] disconnect between us, both the language and our own awareness of what we offer as services, and what is known in the communities. Overcoming some of those cultural barriers [...] is something that's really key, because of all the attitudes, and different languages that are [...] used around mental illness. So we are quite lucky in our service, that we have got a fairly diverse workforce and where we've had the ideas that maybe the representation from our workforce can go*

Theme	Quote
	into those communities to promote, do a lot of service promotion and things like workshops.' • *'We're looking to – again, in different languages – have it [questionnaires] as an audio to send along with the questionnaires when we send them out, so that they can listen to the audio interpreted. So the questions are interpreted and then they can score their answers and either feed them back in the session, or we're gonna try and find a link to make it link up to our app.'*
Cultural barriers	• *'There's an element of culture as a barrier to all of this. So even before coming through the gates of IAPT treatment, stigma behind actually accessing it as an individual stops people from accessing it to begin with. Which is something we need to look at, to improve access in that way by [...] normalising the fact that it's OK to seek support. [...] some cultures [...] don't see mental health as a thing, it's something that doesn't happen to us. You just get on with life. Get on with things and it gets pushed to the side until it's a bit too late or until you're further down that patient journey and the mental health has deteriorated even more.'* • *'[For] young Black men in our localities, it's more difficult. [...] It's more difficult for them to access the service. We have found that they have the lowest referrals into the service. So I think that we need to do some work. Sometimes we get bogged down with languages and people from minoritised ethnic groups, but there are quite a lot of [...] English-speaking ethnic minorities who we then failed to access because we're concentrating on some of the things we need to be more inclusive.'* • *'People don't trust IAPT services. They don't see this service. representing them they feel that they have to explain their culture during sessions, and they kind of waste their time. Their job feels that they're educating the therapist.'*
Treatment offered	• *'There's a lot of emphasis on CBT courses about interventions, and sometimes people don't feel like they have the permission to focus on the really important validation side. If patients are talking about experiences of feeling alienated or of discrimination, sometimes practitioners don't feel like they've got permission to spend time talking about it and validating that. Whereas that's a really important part of the treatment, because the one thing that the evidence repeatedly says is, people want to be understood and listened to and have their experiences acknowledged'*
Service-level/structural adaptations	• *'I think it's about matching the service to people's availability, and particularly when you think about the socioeconomic roles of*

Theme	Quote
	some of the clients from minority backgrounds, that they're not always able to adjust their shifts in the same way.' • *'It's really about flexibility and reaching out, and to make it as accessible as possible. That's what we were saying: use all resources we have to help people engage.'*
Adaptations made by therapists	• *'As a White therapist, if I actually invite people and ask them explicitly about experiences of racism, they will almost inevitably tell me about their experiences and they're almost always intrinsically linked to the formulation, and we wouldn't have been able to proceed with therapy in an effective way. … That's not something that standard training has ever included.'*
Language and diversity	• *'I deliver therapy in a different language, and can do assessments in a different language. And my own experience is, people have a better experience in their own language.'* • *'We're not going to fundamentally change services until we fundamentally change the leadership.'* • *'Thinking about [the] treatment side, how sometimes we can easily slip into the expectation or, I don't know what the word is, that perhaps people staff from a BAME background can be more inclusive of such populations. For example, if you're an Indian staff member you might be more suitable to work with such populations because of similar backgrounds. But actually this may not be true. I've certainly [had] it assumed that because I'm from a certain background that I would speak the language and be more culturally aware. But actually I'm probably the worst person to ask to be mindful of such things that we have on our own staff for our colleagues.'* • *'Overcoming some of those cultural barriers is something that's really key because of all the attitudes. And different languages that are […] used around mental illness. So we are quite lucky in our service that we have got a fairly diverse workforce and where we've had the ideas that maybe the representation from our workforce can go into those communities to promote, do a lot of service promotion and things like workshops.'* • *'I think there was a few musicians recently that kind of done some work around sort of NHS and IAPT that I didn't even know about. Someone has shared it on LinkedIn recently, but I think having representation within that I think could really be a positive thing as well. So yeah, making sure that I suppose kind of you know we see lots of lots of diversity within the promotion materials and maybe kind of our own materials as well.'* • *'trying to make sure that services the staff represent the population that they serve. I mean looking at the IAPT census data, there's clearly a high degree of I think diversity for PWP and*

Theme	Quote
	HI, but when I used to go to, I have leads meetings and look at service leads clinical leads and senior therapists, that diversity was very, very different.'
	• *'But what specifically could [we] be doing in IAPT to make sure that the clinical leadership and operational leadership actually reflects the workforce on the actual population.'*
	• *'On an IAPT level, definitely senior management – there's a scarcity of staff from the BAME backgrounds. Shall we say it's really, really noticeable but I understand, you know I would say not just in the senior management. Maybe there needs to be, you know. you know positions in some of these in the high up services. If it is as important as we are saying, it is as people are. All saying it is we need to kind of, you know manifest that really a bit more in in what we do, not in just in what we say. So that might be you know. Maybe a position somebody who's really focused laser focused on this singular issue. Okay, Maybe it's something to do with as I said you know the makeup of the senior management team. But there needs to be more focus on it I think really someone who's able to think about the implications of it across a lot of different areas.'*
Interpreters	• *'Some languages are not available. We had a very particular language in Africa that we couldn't get an interpreter for, unfortunately. However, I know that many services do have an interpreting service that they are aligned [with]… The problem with COVID is that everything has gone remote. And, sometimes because nowadays, the interpreting service we're using have gone worldwide …. So you might then be cut off and then somebody else picks up the phone. So that's where the discontinuity of care happens.'*
	• *'We are more flexible. But I know it does impact on clinicians as well, because…that session might not necessarily count as two contacts. So I think this is a question that might need addressing more, finding out what also exists. We often support therapy if the session needs to take longer. But I guess that might have clinical implications elsewhere, around targets for those individuals.'*
	• *'We developed a policy that does give people double time for appointments where it involves working with interpreters.'*
Training and supervision	• *'It's a systemic issue, and without any open discussion of social inequalities and racialised inequalities in training, then that will remain outside the radar of a lot of practitioners. And so the onus can't be on individual practitioners if any of this isn't being addressed openly at systemic level within services and within training.'*

Theme	Quote
	• *'So, what, after George Floyd I just thought I can't tolerate this anymore? The fact that there's never been anything included in our training as practitioners about racialisation, about discrimination, about the therapy being based on models that were developed by and for the majority group about our treatments, interventions that's not always being inclusive and there was nothing available. So I just wrote something to deliver in our service, and it's by no means perfect, and it's a starting point, but it's about raising awareness and then about help supporting practitioners to have open conversations. It's more of a kind of a reflective discussion, space to try and develop cultural humility and support people in being open to talking about identities, about our racialised identities, about people's, experiences, about creating opportunities. For patients to discuss it openly, and about bringing that into supervision as well. That thinking how the interventions might need to be adapted. So yeah, that was what we did.'* • *'Not only in the IAPT workforce, but in the training as well, is that how reflective of the workforce are the people, not only delivering the training, but contributing to the development of the training, and how much of co-production is there going on and listening to lived experience as part of that.'* • *'One thing I certainly find uncomfortable is having like training aimed at BAME staff, being You know, to promote them or encourage them into leadership. Because I suppose one thing is, I don't want to be a target in terms of You know. Only thing seen as a potential for a leadership role, because I'm from a BAME background. For example, I want to get there on my own accord, not just because I'm from a BAME background.'* • *'I've certainly noticed over the years that I attend so many things like this. I know this is a focus group, I attend conferences, I attend national things, local things, and a lot of it is aimed at clinicians. So whether it's step 2 staff or step 3 staff and I guess, because I'm not management. I wonder how often these things happen at management level even just to understand what's going on. I wonder how much of it's happening at the CEO, management-level to understand this. And then that's not what [participant name] was asking, but it is interesting that a lot of these kind of things are attended by such staff, but not a lot by IAPT leads or national leads etc.'* • *'There's a lot of pressure from my seniors to push that agenda [the PPG], to do that almost annoyingly, feeling like it's a very tokenistic gesture.'*
Resources	• *'My experience is, yes – we are committed. But I am pretty certain that because of the extra level of complexity or difficulty involved*

Theme	Quote
	with some, particularly where interpreters are required, even from an administrative... that part of the process of talking to my admin team […] Sometimes if there's five people, I've got to call and one of them needs an interpreter, that's the one I'm not going to call, and because of that, that has an impact on waiting times. And I don't really want to do it, but that's just something there about time and resources.'
	• *'I suppose it's almost like that reliance on individual services or clinicians to raise awareness, or to create change. […] In our trust […] we have BAME Champions, and I'm one of them. But actually in a small team lacking in time, lacking in what we're resourced, it does feel like you're reinventing the wheel. And it's not standardised nationally, in terms of targets, training resources. I've been shouting about resources since [inaudible], and it's almost like in individually, but kind of translating resources, creating things, adaptations, etc. But, for example, the prime example is in our service we've had the BAME Champions group running for a few years now, and only recently did we realise it's actually a trust-level group going on as well that are also trying to do their own thing, and how disconnected we were, right? So it definitely feels like a tiny cog in a massive wheel, and how are we going to create change? So nationally, it's more of a systemic thing rather than an individual clinician thing... We do a lot to work and adapt and etc. But this is a massive, massive thing'*
Promotion and opportunities	• *'When people do get into leadership positions there needs to be some kind of support structure around that, because there's probably not been a day gone by where I've not thought about leaving, if I'm honest. And even though my – I have to say, I'm not just saying this because some of them are here – but my service, I think, I'm pretty lucky, but it's still been super challenging, so I think some of the need there would be for some kind of network of support for minoritised leadership people if we were to advance them.'*
	• *'We're doing a lot of work around the culturally adaptive, culturally sensitive CBT and workforce and recruitment, because access work is always in the background or in people's minds and they sort of dip in and out of it. I think there's a lot of work to be done around recruiting and making the recruitment processes fair for all, but also around making people feel confident.'*
	• *'It's not just direct discrimination. It's people not being given the opportunity to take on projects to stretch themselves. It's about not being given the chance to do secondments. It's about being more likely to be discriminate against, disciplinaries once you are in post. I guess there's a lot we can learn from outside IAPT that*

Theme	Quote
	probably applies equally in IAPT. This is something we've got to address before we can make that change.' • *'For people getting progression opportunities, make sure that it is based on a particular sort of criteria, and looking at who's assessing that criteria. So one of the things we're looking at the moment is our recruitment and progression, every single stage along the way, and making sure that that's de-biased as much as it possibly can be, but without service leaders being aware of bias, of microaggressions, how can we eliminate those from processes?'* • *'With things like microaggressions, etc, you know, sometimes people might not know that they're being held back because of their cultural background. They might know, not know the opportunities available to them, or that this is not the norm, because sometimes they're very focused on people being explicit with discrimination.'* • *'I really want to have allies in this process, because it benefits us all to be on the same page, and it's about people who are all currently struggling and the debate can be very hot, and at times people can feel very scared to even engage in the debate, never mind to make any changes. And I guess it's about being able to have those conversations and for people to be able to see the inequalities which do exist out there, and start thinking about what that might be like, and whether they want to be part of the change.'* • *'I'm involved with the [scheme name] mentorship [programme]. So it is a bit of funding that's around mentoring staff across various different platforms. It's not just IAPT, it's various psychology platforms and counselling, but I guess we've been talking about some of the staff experiences around race like racialisation, their experiences on the receiving end as well clients perceptions and what comes up for them. I guess one of the things that is taken away from that forum is, we're having these important discussions, but what then? And so that that's kind of something that I'm seeing. We are having these discussions, but how do we then take that forward to have a meaningful difference?'*
Diversity monitoring	• *'Using that "BAME" label encapsulates such a large population and diversity. So it almost puts it into either you're BAME or non-BAME, creating those two categories. We're not, actually – there's such diversity in that label.'*
Integrating feedback	• *'Patient satisfaction tends to be lower [in] racialised minority people. And so I was thinking something about... cultural safety and cultural humility are very much dependent upon more*

Theme	Quote
	information from the patient, more feedback from the patient about the quality of the care. And I just wonder if there's more to be done around understanding people's experiences more, and because often when these patient experience groups as well within – I don't know what it's like, you know – the trust, but in our trust it's certain voices. You tend not to get heard in those groups. So finding some ways of getting more feedback.' • *'Getting the service user voice to understand what is working, what's not working, how would they like to see … because they also own the service.'*

2.9. NVivo code maps of the focus groups analysis

Directed content analysis[17] was used to thematically analyse the data. Codes were derived using the focus group topic schedules.

shows the initial code map produced by researchers, which were then inputted into NVivo.

Codes were refined throughout the coding process, and researchers discussed the suitability of codes, any codes that were added and any discrepancies between coding.

Figure 17: Initial thematic analysis code map
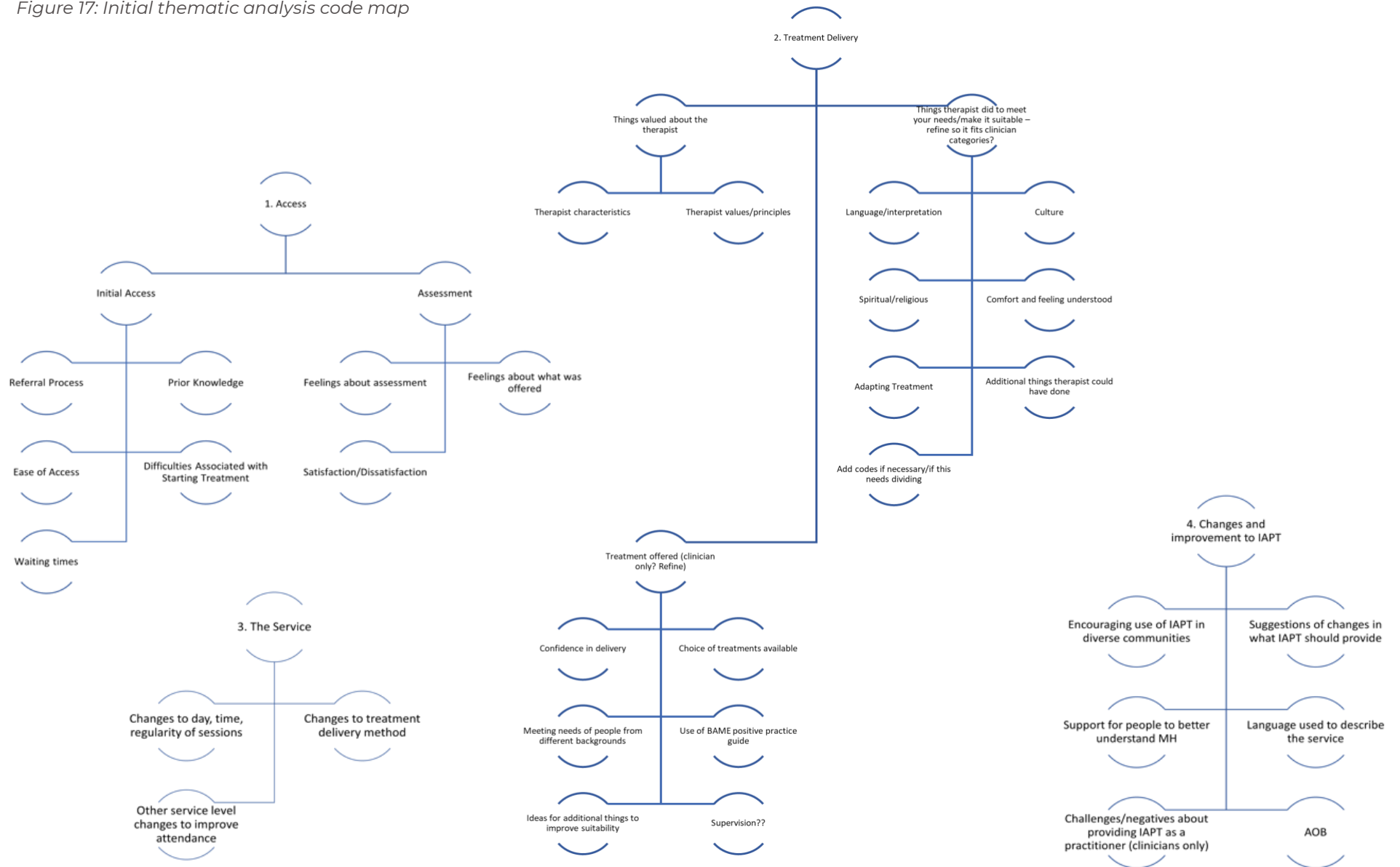
Appendix 3: Surveys for IAPT clinical leads and commissioners

3.1.   Survey development and recruitment

The clinical leads and commissioners surveys were co-produced with researchers in NCCMH and patient and carer representatives, and was reviewed by and Saiqa Naz (Chair of British Association for Behavioural & Cognitive Psychotherapies).

The surveys were open between 1 June and 5 July 2022, and were advertised:

- on the NCCMH website
- through a mailing to IAPT Café
- through a mailing to IAPT services
- through a mailing to IAPT commissioners.

The recruitment information and survey questions can be found in Appendix 3.2 and Appendix 3.3.

3.2.   Survey for IAPT clinical leads

Title of project: Policy Review of the Improving Access to Psychological Therapies Programme (IAPT) – commissioned by the NHS Race and Health Observatory

This survey forms part of a wider piece of work to review the existing policy of the IAPT programme and to explore inequalities experienced by people from minoritised ethnic groups.

We know from other data, existing research and from the development of the PPG that people from minoritised communities do not always benefit from IAPT as much as other people and that treatment dropout rates are higher. This indicates that the care provided by IAPT could be improved to better meet the needs of people from these communities and to ensure they get better treatment.

What are the possible benefits of taking part?
- **Taking part allows you to reflect on your own service's approach to tackling inequalities**
- **Taking part supports the effort to improve mental health services in the NHS**
- **You would be contributing to valuable research looking to ensure that mental health support is made accessible, appropriate and useful for all people**
- **Taking part is easy, requiring only a small amount of your time – this survey should take no longer than 10 minutes to complete**

Further supporting information

This project has been commissioned by the NHS Race and Health Observatory.

Details of the project are available on the Royal College of Psychiatrists' website: https://tinyurl.com/IAPTEI

Project Manager: Hazel.Webb@Rcpsych.ac.uk

General information

1. **Please enter the region in which you work**

   - *East of England*
   - *London*
   - *Midlands*
   - *North East and Yorkshire*
   - *North West*
   - *South West*
   - *South East*

Use of the IAPT Black, Asian and Minority Ethnic Service User Positive Practice Guide

The IAPT Black, Asian and Minority Ethnic Positive Practice Guide was published in 2019 and laid out a series of strategies to support IAPT services to provide high quality and appropriate care to people from diverse and minoritised communities. There are a series of strategies in the guide under four categories:

1. Improving access
2. Adapting therapy
3. Improving engagement with service users and communities
4. Workforce and staffing.

2. **How would you rate your knowledge of and familiarity with the IAPT Black, Asian and Minority Ethnic Positive Practice Guide?**

   1 star = I have little to no knowledge of the guide and am unfamiliar with its contents

   2 stars = I have some knowledge of the guide and am somewhat familiar with its contents

   3 stars = I have fair knowledge of the guide and I am quite familiar with its contents

   4 stars = I have very good level of knowledge of the guide and am familiar with its contents

   5 stars = I have an excellent level of knowledge of the guide and I am very familiar with its contents

3. **In your opinion, how well do you think the IAPT Black, Asian and Minority Ethnic Positive Practice Guide is implemented in your service?**

   1 = not well at all
   2
   3
   4
   5 = extremely well

4. **Is there anything you would like to add about the use of the IAPT Black, Asian and Minority Ethnic Positive Practice Guide in your service?**

   [Free text box]

Improving access for people from minoritised communities

The questions in this section ask about the methods in your service to improve access to IAPT for people from ethnic minority groups.

5. **Which best describes your knowledge about how your service uses data on ethnicity?**

   - *I have a very good understanding of how the service uses ethnicity data*
   - *I have fair understanding of how the service uses ethnicity data*
   - *I have some/minimal knowledge of how the service uses ethnicity data*
   - *I do not know much at all about how the service uses ethnicity data*

6. **In your opinion, how consistently does your Trust's IAPT service collect data on ethnicity?**

   1 = ethnicity data collection is extremely inconsistent
   2
   3
   4
   5 = ethnicity data collection is extremely consistent

7. **Which statement below best describes your opinion on the quality of data collected about ethnicity in your service?**

   - *The quality of data collected about ethnicity is poor*
   - *The quality of data collected about ethnicity is adequate*
   - *The quality of data collected about ethnicity is high*
   - *I don't have a view on the quality of data collected about ethnicity*

8. **You have selected that you think data quality is poor. Can you expand below as to your reasons for this opinion? (e.g., are patients not asked about their ethnicity? Are response options inadequate? Or some other reason?)**

   [Free text box]

9. **In your opinion, how well does your Trust's IAPT service make use of data to understand the needs of people from minoritised ethnic communities?**

   1 = data is not used well at all to understand need
   2
   3
   4
   5 = data is used extremely well to understand need

10. What strategies does the service have in place to support better access and mitigate access challenges for people from minoritised ethnic communities?

- *The service has mapped the ethnicity of the population served*
- *Information about the IAPT service (e.g., leaflets, signage) are available in a range of languages*
- *Information about IAPT services (e.g. leaflets, signage) have been co-produced with service user and community representatives*
- *Staff have access to materials and resources to support adapted therapy*
- *Other strategies (please detail below)*

11. What 'other strategies' does the service have in place to support better access for people from minoritised ethnic communities?

[Free text box]

Adapting therapy

The questions in this section ask about the methods in your service to adapt therapy to ensure it is suitable to meet the needs of people from different ethnic minority groups.

12. How would you rate your service in terms of <u>availability of 'culturally adapted' therapy</u> for those who may need it?

The following definition of culturally adapted therapy is from the IAPT Black, Asian and Minority Ethnic Positive Practice Guide (2019):

'Culturally adapted therapy takes an existing therapy as a starting point and then specifically adapts the language, values, metaphors and techniques of that approach for a particular community. The adaptation and provision of this therapy is typically carried out by therapists who are members of that community. This ensures that the work is done by staff who have an inside knowledge of the language, values and beliefs of that community.'

> *1 star = extremely poor (not available)*
> *2*
> *3*
> *4*
> *5 stars = extremely good (readily available)*

13. How would you rate your service in terms of <u>availability of 'culturally responsive' therapy</u> for those who may need it?

The following definition of **culturally responsive therapy** is lifted from the IAPT Black, Asian and Minority Ethnic Positive Practice Guide (2019):

'Culturally responsive therapies may be more helpful for teams which do not reflect the ethnic composition of the communities served... This approach means that therapists are able to recognize and value diversity and draw on the support of team members and supervisors to make adaptations to evidence-based therapies, so that they will fit with the particular culture and context of the service user.'

> *1 star = extremely poor (not available)*
> *2*
> *3*
> *4*
> *5 stars = extremely good (readily available)*

14. What <u>cultural adaptation strategies</u> are in place for people from minoritised ethnic communities in your service? Select all that apply

- *Therapists are trained to a high standard to work with cultural diversity*
- *The service regularly reviews whether there is a need to develop a provision in specific culturally adapted therapies*
- *Therapists ask about relevant information on service users' culture, religious and/or spiritual beliefs when starting work with them*
- *The service enables language translation where needed (including provision of translated resources and use of formal interpreters)*
- *Where interpreters are used, therapists are allowed additional time*
- *Other cultural adaptation strategies (please detail below)*

15. What <u>other cultural adaptation strategies</u> are in place?

> *[Free text box]*

16. **Which (if any) <u>organisation-level/service-level adaptations</u> are implemented in your service, where needed? Select all that apply**

Organisation-level/service-level cultural adaptations encompass service design and delivery, which are informed by cultural knowledge and its interface with existing service structures. Such adaptations can include changes to the time or length of the intervention, to the place it is provided, putting measures in place so that treatment can be accessed more easily (for example by out-reach work with minoritised ethnic communities to develop more effective pathways into care), or changing the form used to provide treatment (for example, providing interventions remotely or in a group setting) (Arundell et al., 2021)

- *The service enables service users to access therapy via several different routes/pathways (i.e., there is more than ONE access route such as self-referral or GP)*
- *The service is flexible in offering treatment sessions at different times of day if needed (e.g. outside of 'office hours')*
- *The service is flexible in offering treatment sessions of different lengths (e.g. 30 mins, or 1 hour or 90 mins etc.)*
- *The service offers service users the option of having face-to-face or remote therapy sessions*
- *The service offers the provision of treatment in different locations other than the clinic (e.g., at locations in the local community such as community halls, places of worship etc.)*
- *The service/organisation does specific and targeted outreach work with communities at risk of inequality*
- *Other organisational-level/service-level adaptations (please detail below)*

17. **What other <u>organisational-level/service-level adaptations</u> does the service have in place?**

   [Free text box]

Improving engagement with service users and communities

The questions in this section ask about the strategies used in your IAPT service to engage with people in the community and service users from different ethnic minority groups.

18. **How would you rate your service in terms of <u>how well it engages with communities</u>?**

   1 star = extremely poor (little to no engagement)
   2
   3
   4
   5 stars = extremely well (consistent and regular engagement)

19. **To your knowledge, does the IAPT service you work in have** <u>**regular co-production and/or community engagement strategies**</u> **in place?**

   - *No – there are no co-production/community engagement strategies in place*
   - *Yes – regular co-production/community engagement strategies are in place*
   - *Not sure – I am not sure what we have in place for co-production and community engagement*

   a) **You answered** <u>**'No – there are no co-production/community engagement strategies in place'**</u> **– please briefly outline the co-production/community engagement strategies you think would be helpful, in the space below**

   [Free text box]

   b) **You answered** <u>**'Yes – regular co-production/community engagement strategies in place'**</u> **– please briefly describe these strategies in the space below**

   [Free text box]

   c) **You answered** <u>**'Not sure – I am not sure what we have in place for co-production and community engagement'**</u> **– please briefly outline the co-production/community engagement strategies you think would be helpful, in the space below**

   [Free text box]

20. **Does the IAPT service have methods in place to capture** <u>**service users' experiences**</u> **of the care and treatment provided?**

   - *Yes*
   - *No*
   - *Not sure*

   a) **You answered 'Yes' to the question about capturing patients' experiences. Please provide detail about these methods in the space below**

   [Free text box]

   b) **You answered 'No or Not Sure' to the question about capturing patients' experiences. What methods do you think should be in place to capture patients' experiences of care and treatment?**

   [Free text box]

21. **Which of the following (if any) community engagement strategies are in place for people from minoritised ethnic communities in your service?**

    - *There are workshops on mental health and accessing support held with local BAME communities*
    - *There are participation groups that involve stakeholders who reflect the ethnic composition of the population served*
    - *There are Stakeholder groups which include organisations that reflect the ethnic composition of the population served*
    - *Other strategies (please detail below)*

22. **What 'other strategies' does the service have in place to engage with communities?**

    [Free text box]

Workforce and staffing

Questions in this section are about workforce and staffing strategies that can help to improve quality of care for people from minoritised ethnic communities

23. **Please tell us the number of High Intensity Therapists working in your service**

    If you are not certain, please provide your best estimate (e.g. ~27) or range (e.g. between 25-30)

    [Free text box]

24. **Please tell us the number of Psychological Wellbeing Practitioners (PWPs) there are working in your service. If you are not certain, please provide your best estimate (e.g. ~27) or range (e.g. between 25-30)**

    [Free text box]

25. **How much do you agree with this statement with regard to your IAPT service: 'The clinical staff group broadly reflects that of the population served'**

    1 = strongly disagree
    2 = disagree
    3 = neither agree nor disagree
    4 = agree
    5 = strongly agree

26. **How much do you agree with this statement with regard to your IAPT service: 'Staff from ethnic minority communities have the same access to CPD and career development as White-British staff'**

    1 = strongly disagree
    2 = disagree
    3 = neither agree nor disagree
    4 = agree
    5 = strongly agree

27. **How much do you agree with this statement with regard to your IAPT service: 'Development for staff from ethnic minority communities is guided by the Workforce Race Equality Standard (WRES)'**

    1 = strongly disagree
    2 = disagree
    3 = neither agree nor disagree
    4 = agree
    5 = strongly agree

28. **How much do you agree with this statement with regard to your IAPT service: 'The senior staff group includes a range of ethnic diversity that reflects the community served'**

    1 = strongly disagree
    2 = disagree
    3 = neither agree nor disagree
    4 = agree
    5 = strongly agree

Resource and funding to address inequalities

This section includes questions about the IAPT service you work in, with regard to the importance of resource and funding in addressing inequalities. Please answer all questions to the best of your ability. For some questions, you may need to estimate or approximate values but please try and be as accurate as possible. Other questions ask for your own personal opinion.

29. **Are you aware of any specific allocated resources or funding dedicated to addressing inequalities associated with ethnicity in your IAPT service?**

This question refers to any allocated funding or resources you are aware of. It included any resource, capacity or funding that is dedicated to research and identification of potential inequalities as well as strategies to address inequalities already identified, including workforce initiatives.

- *Yes – the service I work for has allocated specific resources or funding towards addressing ethnic inequalities*
- *No – to my knowledge, the service I work for has not allocated any resources or funding towards addressing ethnic inequalities*
- *I am not sure whether the service I work for has allocated any resources or funding towards addressing ethnic inequalities*

a. **You answered 'Yes – the service I work for has allocated specific resources or funding towards addressing ethnic inequalities' – use the space below to provide additional detail about this**

   What resource has been allocated? What funding has been provided? What steps are being taken to address ethnic inequalities?

   [Free text box]

b. **Your answer indicates that you are not aware of any allocated resources or funding provided by your service to address ethnic inequalities in the service. In your opinion, is additional resource or funding needed to address this?**

   Yes
   No
   Don't know

30. **Please expand on your opinion about the need for additional resource or funding to address ethnic inequalities, in the space below.**

   Why do you think additional resource is needed/not needed? What suggestions would you make for the provision of additional resources and capacity to address ethnic inequalities?

   [Free text box]

The value of community engagement – positive practice examples

We are looking to identify examples of positive practice from the Voluntary Community and Social Enterprise (VCSE) Sector to use as case studies. Please use the space below to provide one or more examples of VCSE organisations that you know of that work closely with IAPT services. We are interested in VCSE services that provide an exemplary service, particularly those that support people from minoritised ethnicity and underserved communities to access mental health care and support.

31. **Please list any examples of exemplary VCSE services below, including the reason(s) for this choice**

    [Free text box]

32. **Is there anything else you would like to comment on or add? Please do so in the space below**

    [Free text box]

3.3.   Survey for commissioners of IAPT services

Title of Project: Policy Review of the Improving Access to Psychological Therapies (IAPT) Programme – commissioned by the NHS Race and Health Observatory

This survey forms part of a wider piece of work to review the existing policy of the IAPT programme and to explore inequalities experienced by people from minoritised ethnic groups.

We know from other data, existing research and from the development of the **IAPT Black, Asian and Minority Ethnic Positive Practice Guide** that people from minoritised communities do not always benefit from IAPT as much as other people and that treatment dropout rates are higher. This indicates that the care provided by IAPT could be improved to better meet the needs of people from these communities and to ensure they get better treatment.

What are the possible benefits of taking part?
- **Taking part allows you to reflect on your own commissioning body's approach to tackling inequalities**
- **Taking part supports the effort to improve mental health services in the NHS**
- **You would be contributing to valuable research looking to ensure that mental health support is made accessible, appropriate and useful for all people**
- **Taking part is easy, requiring only a small amount of your time – this survey should take no longer than 10 minutes to complete**

Further supporting information

This project has been commissioned by the NHS Race and Health Observatory.

Details of the project are available on the Royal College of Psychiatrists' website: https://tinyurl.com/IAPTEI

Project Manager: Hazel.Webb@Rcpsych.ac.uk

General information

1. Please enter the region in which you work

- *East of England*
- *London*
- *Midlands North East and Yorkshire*
- *North West*
- *South West*
- *South East*

Use of the IAPT Black, Asian and Minority Ethnic Positive Practice Guide

The IAPT Black, Asian and Minority Ethnic Positive Practice Guide was published in 2019 and laid out a series of strategies to support IAPT services to provide high quality and appropriate care to people from diverse and minoritised communities. There are a series of strategies in the guide under four categories:

1. Improving access
2. Adapting therapy
3. Improving engagement with service users and communities
4. Workforce and staffing.

2. How would you rate your knowledge of and familiarity with the IAPT Black, Asian and Minority Ethnic Positive Practice Guide?

1 star = I have little to no knowledge of the guide and am unfamiliar with its contents

2 stars = I have some knowledge of the guide and am somewhat familiar with its contents

3 stars = I have fair knowledge of the guide and I am quite familiar with its contents

4 stars = I have very good level of knowledge of the guide and am familiar with its contents

5 stars = I have an excellent level of knowledge of the guide and I am very familiar with its contents

3. In your opinion, how well do you think the IAPT Black, Asian and Minority Ethnic Positive Practice Guide is used to guide commissioning decisions?

1= not well at all

2

3

4

5 = extremely well

4. **Is there anything you would like to add about the use of the IAPT Black, Asian and Minority Ethnic Positive Practice Guide in making decisions about commissioning?**

    [Free text box]

Improving access for people from minoritised communities

The questions in this section ask about the methods used to improve access to IAPT for people from ethnic minority groups.

5. **Which best describes your knowledge about how IAPT services use ethnicity data?**

    - *I have a very good understanding of how services use ethnicity data*
    - *I have a fair understanding of how services use ethnicity data*
    - *I have some/minimal understanding of how services use ethnicity data*
    - *I do not know much at all about how the services use ethnicity data*

6. **In your opinion, how consistently is data on ethnicity collected?**

    1 = ethnicity data collection is extremely inconsistent
    2
    3
    4
    5 = ethnicity data collection is extremely consistent

7. **Which statement below best describes your opinion on the quality of data collected about ethnicity in IAPT services?**

    - *The quality of data collected about ethnicity is poor*
    - *The quality of data collected about ethnicity is adequate*
    - *The quality of data collected about ethnicity is high*
    - *I don't have a view on the quality of data collected about ethnicity*

    a. **You have selected that you think data quality is poor. Can you expand below as to your reasons for this opinion? (e.g., are patients not asked about their ethnicity? Are response options inadequate? Or some other reason?)**

    [Free text box]

8. **In your opinion, how well do IAPT services make use of data to understand the needs of people from minoritised ethnic communities?**

    1 = data is not used well at all to understand need
    2
    3
    4
    5 = data is used extremely well to understand need

9. **What strategies does the CCG have in place to ensure IAPT services can support better access and mitigate access challenges for people from minoritised ethnic communities?**

    - *IAPT services are mapped to the ethnicity of the population served*
    - *IAPT services are held to account by the CCG to ensure they meet the needs of ethnic minority groups*
    - *The CCG ensures there are resourced for outreach work with minoritised communities*
    - *Language translation (such as translated resources and access to interpreters) are provided and funded*
    - *Other strategies (please detail below)*

10. **What 'other strategies' does the CCG have in place to ensure services can support better access for people from minoritised ethnic communities?**

    [Free text box]

11. **Which (if any) organisation-level/service-level adaptations are implemented in IAPT service(s) you commission?**

Organisation-level/service-level cultural adaptations encompass service design and delivery, which are informed by cultural knowledge and its interface with existing service structures. Such adaptations can include changes to the time or length of the intervention, to the place it is provided, putting measures in place so that treatment can be accessed more easily (for example by outreach work with BME [Black and minority ethnic] communities to develop more effective pathways into care), or changing the form used to provide treatment (for example, providing interventions remotely or in a group setting) (Arundell et al., 2021)

Select all that apply

- The service enables service users to access therapy via several different routes/pathways (i.e. there is more than ONE access route such as self-referral or GP)
- The service is flexible in offering treatment sessions at different times of day if needed (e.g. outside of 'office hours')
- The service is flexible in offering treatment sessions of different lengths (e.g. 30 mins, or 1 hour or 90 mins etc.)
- The service offers service users the option of having face-to-face or remote therapy sessions
- The service offers the provision of treatment in different locations other than the clinic (e.g. at locations in the local community such as community halls, places of worship etc.)
- The service/organisation does specific and targeted outreach work with communities at risk of inequality
- Other organisational-level/service-level adaptations (please detail below)

12. **What 'other organisational-level/service-level adaptations' does the service have in place to support better access for people from minoritised ethnic communities?**

    [Free text box]

Engagement and outreach with service users and communities

The questions in this section ask about the strategies used to engage with people in the community and service users from different ethnic minority groups.

13. **Does the CCG you work in have regular co-production and/or community engagement strategies in place?**

    - *No – there are no co-production/community engagement strategies in place*
    - *Yes – regular co-production/community engagement strategies are in place*
    - *Not sure – I am not sure what we have in place for co-production and community engagement*

    a.   **You answered 'No – there are no co-production/community engagement strategies in place' – please briefly outline the co-production/community engagement strategies you think would be helpful, in the space below**

    [Free text box]

    b.   **You answered 'Yes – regular co-production/community engagement strategies in place' – please briefly describe these strategies in the space below**

    [Free text box]

    c.   **You answered 'Not sure – I am not sure what we have in place for co-production and community engagement' – please briefly outline the co-production/community engagement strategies you think would be helpful, in the space below**

    [Free text box]

14. **Does the CCG you work for have methods in place to capture service users' experiences of the care and treatment provided?**

    - *Yes*
    - *No*
    - *Not Sure*

a. You answered 'Yes' to the question about capturing patients' experiences. Please provide detail about these methods in the space below

[Free text box]

b. You answered 'No or Not Sure' to the question about capturing patients' experiences. What methods do you think should be in place to capture patients' experiences of care and treatment?

[Free text box]

15. Which of the following (if any) community engagement strategies are in place for people from minoritised ethnic communities who use the IAPT services you commission?

- *There are workshops on mental health and accessing support held with local BAME communities*
- *There are participation groups that involve stakeholders who reflect the ethnic composition of the population served*
- *There are Stakeholder groups which include organisations that reflect the ethnic composition of the population served*
- *Other strategies (please detail below)*

16. What 'other strategies' are in place to engage with communities?

[Free text box]

Workforce and staffing

Questions in this section are about workforce and staffing strategies that can help to improve quality of care for people from minoritised ethnic communities.

17. How much do you agree with this statement with regard to your IAPT services you commission: 'The clinical staff group broadly reflects that of the population served'

1 = strongly disagree
2 = disagree
3 = neither agree nor disagree
4 = agree
5 = strongly agree

18. **How much do you agree with this statement with regard to IAPT services you commission: 'Staff from ethnic minority communities have the same access to CPD and career development as White-British staff'**

    1 = strongly disagree
    2 = disagree
    3 = neither agree nor disagree
    4 = agree
    5 = strongly agree

19. **How much do you agree with this statement with regard to IAPT services you commission: 'Development for staff from ethnic minority communities is guided by the Workforce Race Equality Standard (WRES)'**

    1 = strongly disagree
    2 = disagree
    3 = neither agree nor disagree
    4 = agree
    5 = strongly agree

20. **How much do you agree with this statement with regard to IAPT services you commission: 'The senior staff group includes a range of ethnic diversity that reflects the community served'**

    1 = strongly disagree
    2 = disagree
    3 = neither agree nor disagree
    4 = agree
    5 = strongly agree

Resource and funding to address inequalities

This section includes questions about your CCG's IAPT Services, with regard to the importance of resource and funding in addressing inequalities. Please answer all questions to the best of your ability.

21. Has your CCG put in place any specific allocated resources or funding dedicated to addressing inequalities associated with ethnicity in your IAPT service?

This question refers to any allocated funding or resources you are aware of. It included any resource, capacity or funding that is dedicated to research and identification of potential inequalities as well as strategies to address inequalities already identified, including workforce initiatives.

- *Yes – the service I work for has allocated specific resources or funding towards addressing ethnic inequalities*
- *No – to my knowledge, the service I work for has not allocated any resources or funding towards addressing ethnic inequalities*
- *I am not sure whether the service I work for has allocated any resources or funding towards addressing ethnic inequalities*

a. You answered 'Yes – the service I work for has allocated specific resources or funding towards addressing ethnic inequalities' – use the space below to provide additional detail about this

What resource has been allocated? What funding has been provided? What steps are being taken to address ethnic inequalities?

[Free text box]

b. Your answer indicates that you are not aware of any allocated resources or funding provided the CCG to the service(s) to address ethnic inequalities. In your opinion, is additional resource or funding needed to address this?

- *Yes*
- *No*
- *Don't know*

22. Please expand on your opinion about the need for additional resource or funding to address ethnic inequalities, in the space below.

Why do you think additional resource is needed/not needed? What suggestions would you make for the provision of additional resources and capacity to address ethnic inequalities?

[Free Text Box]

Challenges and barriers associated with changes to IAPT service provision to reduce inequalities

23. What are the challenges/barriers associated with making changes to IAPT service provision to reduce ethnic inequalities?

Select all that apply

- *Funding and budget constraints*
- *Poor quality data on ethnicity*
- *Poor quality data/information on specific inequalities and those affected by them*
- *Staff/workforce shortages*
- *Staff morale*
- *Other – please detail below*

24. Are there any other challenges/barriers associated with making changes to IAPT service provision to reduce inequalities?

[Free text box]

The value of community engagement – positive practice examples

We are looking to identify examples of positive practice from the Voluntary Community and Social Enterprise (VCSE) Sector to use as case studies. Please use the space below to provide one or more examples of VCSE organisations that you know of that work closely with IAPT services. We are interested in VCSE services that provide an exemplary service, particularly those that support people from minoritised ethnicity and underserved communities to access mental health care and support.

25. Please list any examples of exemplary VCSE services below, including the reason(s) for this choice

[Free text box]

26. Is there anything else you would like to comment on or add? Please do so in the space below

[Free text box]

3.4.   Findings from the surveys

Figure 18 and Figure 19 show the clinical leads and commissioners by region.

Figure 18: Surveyed IAPT clinical leads' location in regions of England, by percentage

Figure 19: Surveyed commissioners of IAPT services' location in regions of England, by percentage

3.4.1. Survey responses about the IAPT Black, Asian and Minority Ethnic Positive Practice Guide

Table 46: How would you rate your knowledge of and familiarity with the IAPT PPG?

	Clinical leads (%) N = 38	Commissioners (%) N = 10
I have little to no knowledge of the guide and am unfamiliar with its contents	3	40
I have some knowledge of the guide and am somewhat familiar with its contents	11	40
I have fair knowledge of the guide and I am quite familiar with its contents	32	20
I have very good level of knowledge of the guide and am familiar with its contents	42	0
I have an excellent level of knowledge of the guide and I am very familiar with its contents	13	0

Table 47: In your opinion, how well do you think the IAPT PPG is implemented in your service (clinical leads) / to guide commissioning decisions (commissioners)?

	Clinical leads (%)	Commissioners (%)
Not well at all	0	0
Slightly well	15	55
Moderately well	56	36
Very well	24	9
Extremely well	5	0

3.4.2. Survey responses about use of ethnicity data and data quality

Table 48: Which best describes your knowledge about how your service uses data on ethnicity?

	Clinical leads (%)	Commissioners (%)
I have a very good understanding of how the service uses ethnicity data	49	9
I have fair understanding of how the service uses ethnicity data	34	73
I have some/minimal knowledge of how the service uses ethnicity data	12	9
I do not know much at all about how the service uses ethnicity data	5	9

Table 49: In your opinion, how consistently does your Trust's IAPT service collect data on ethnicity?

	Clinical leads (%) N = 39	Commissioners (%) N = 10
Extremely inconsistently	0	0
Inconsistent/quite consistently	0	20
Neither inconsistently nor consistently	0	40
Consistently/quite consistently	44	20
Extremely consistently	56	20

Table 50: Which statement below best describes your opinion on the quality of data collected about ethnicity in your service?

Data quality	Clinical leads (%)	Commissioners (%)
The quality of data collected about ethnicity is high	54	45
The quality of data collected about ethnicity is adequate	34	36
The quality of data collected about ethnicity is poor	2	9
I don't have a view on the quality of data collected about ethnicity	5	0

3.4.3. Survey responses about strategies to support access

Table 51: Percentage of clinical leads who felt their service could support access and mitigate access challenges for people from minoritised ethnic groups

	Clinical leads (%)
The service has mapped the ethnicity of the population served	71
Information about the IAPT service* is available in a range of languages	56
Information about IAPT services* has been co-produced with service user and community representatives	27
Staff have access to materials and resources to support adapted therapy	95
* For example, leaflets and signage.	

Table 52: Percentage of commissioners who felt their service could support access and mitigate access challenges for people from minoritised ethnic groups

	Commissioners (%)
The service has mapped the ethnicity of the population served	55
IAPT services are held to account by the clinical commissioning group (CCG) to ensure they meet the needs of ethnic minority groups	64
The CCG ensures there are resourced for outreach work with minoritised communities	36
Language translation (such as translated resources and access to interpreters) are provided and funded	73

3.4.4. Survey responses about availability of culturally adaptive/responsive therapy

Figure 20 and Figure 21 show clinical lead ratings of the availability of culturally adapted and culturally responsive therapy in their services.

*Figure 20: Clinical leads' indication of the availability of culturally **adapted** therapy in their service, by percentage*
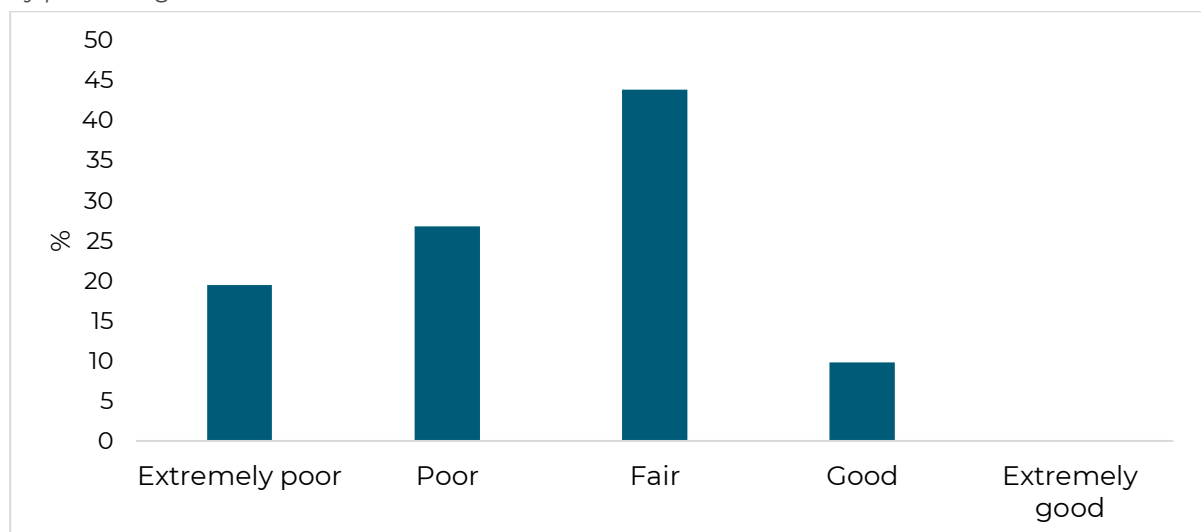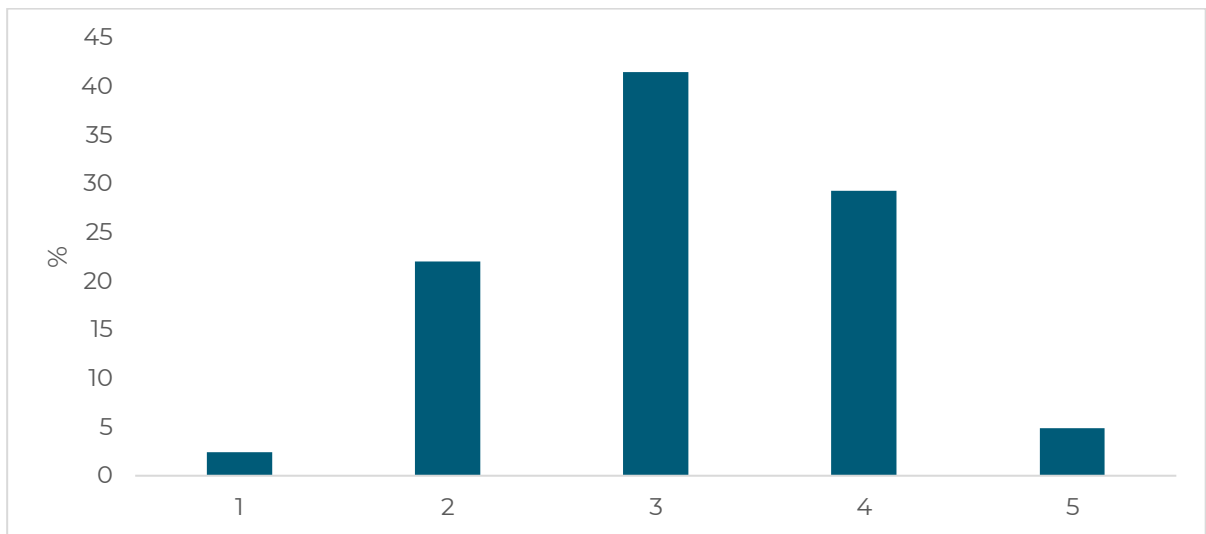
*Figure 21: Clinical leads' indication of the availability of culturally **responsive** therapy in their service, by percentage (1 = extremely poor, 3 = fair, 5 = extremely good)*


Clinical leads indicated that they had certain cultural adaptation strategies (defined in the surveys) in place (see Table 53 and Figure 22).

Table 53: Percentage of clinical leads with cultural adaptation strategies in place

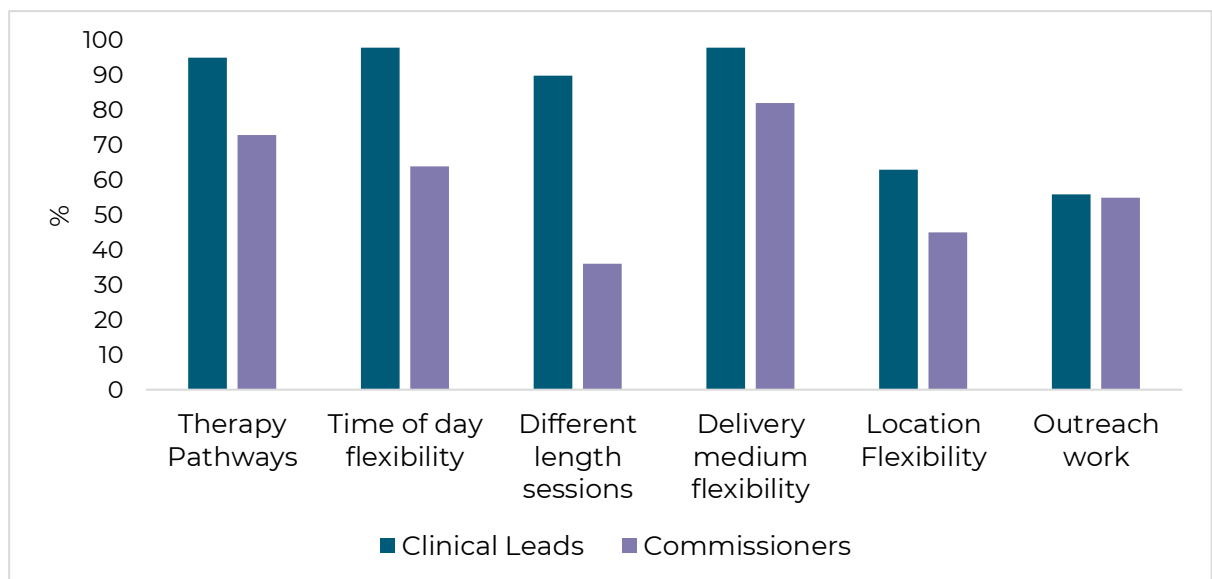|	Clinical leads (%)
Therapists are trained to a high standard to work with cultural diversity	39
The service regularly reviews whether there is a need to develop a provision in specific culturally adapted therapies[b]	41
Therapists ask about relevant information on service users' culture, religious and/or spiritual beliefs when starting work with them	83
The service enables language translation where needed (including provision of translated resources and use of formal interpreters)	90
Where interpreters are used, therapists are allowed additional time	93

[b] From the PPG (2019): 'Culturally adapted therapy takes an existing therapy as a starting point and then specifically adapts the language, values, metaphors and techniques of that approach for a particular community. The adaptation and provision of this therapy is typically carried out by therapists who are members of that community. This ensures that the work is done by staff who have an inside knowledge of the language, values and beliefs of that community.'

Figure 22: How well clinical leads thought their services engaged with communities, by percentage.
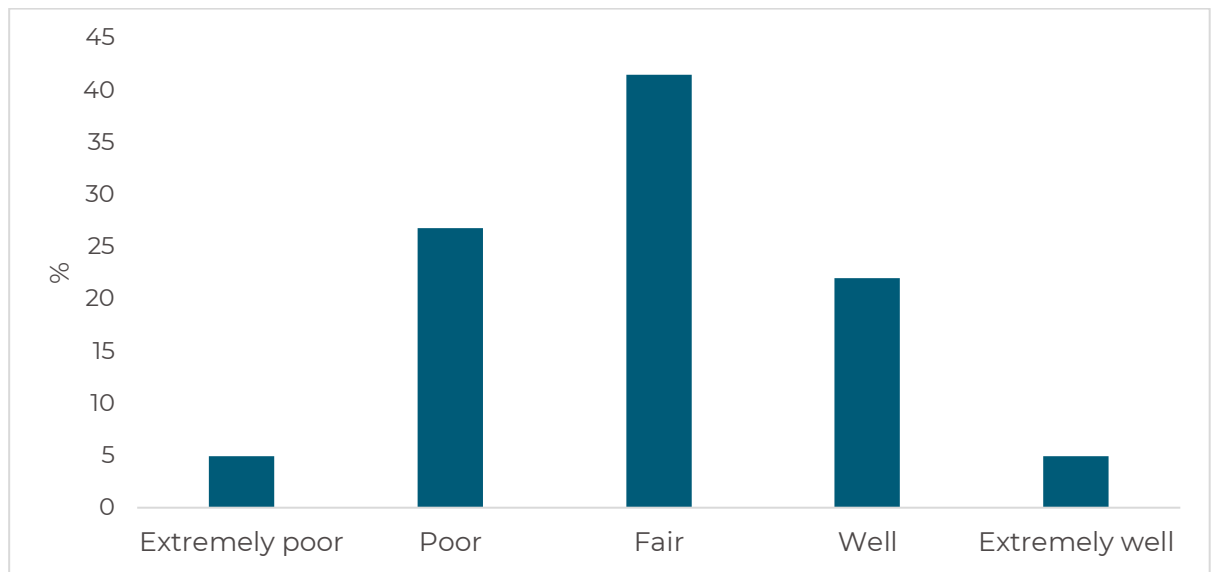
3.4.5. Survey responses about organisational-level adaptations

Figure 23: Percentage of clinical leads and commissioners agreeing with statements about organisational adaptations in their services

3.4.6. Survey responses about how well services engage with communities

The graph in Figure 24 shows the indication of clinical leads as to how well they thought their service engaged with communities.

Figure 24: Clinical leads' indication of how well they thought their services engaged with communities, by percentage (1 = extremely poor [little to no engagement], 5 = extremely well [consistent and regular engagement])
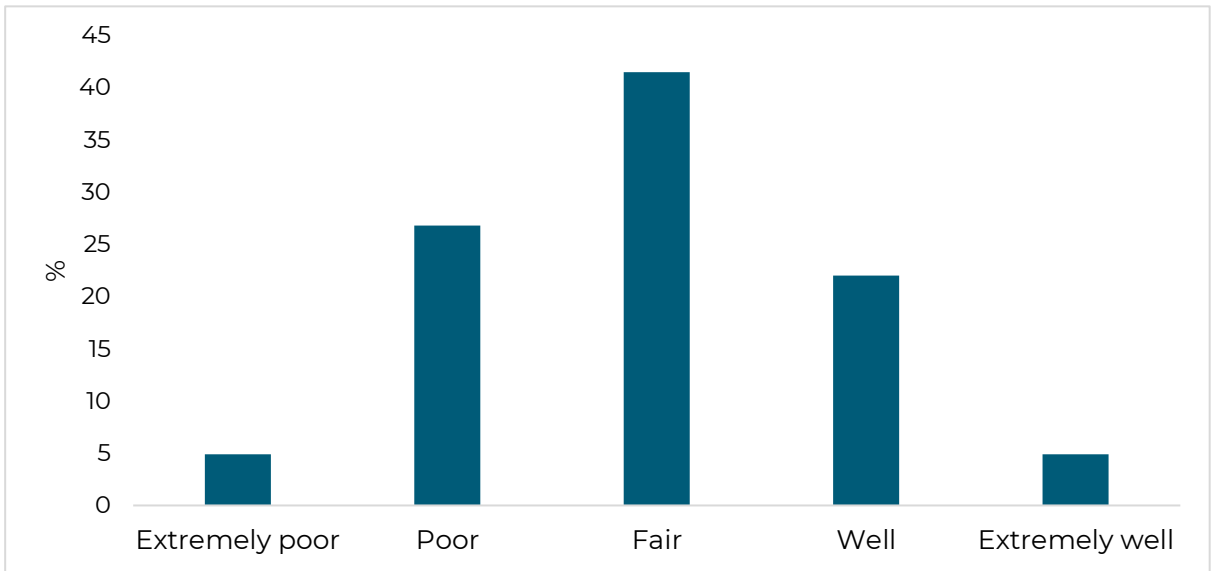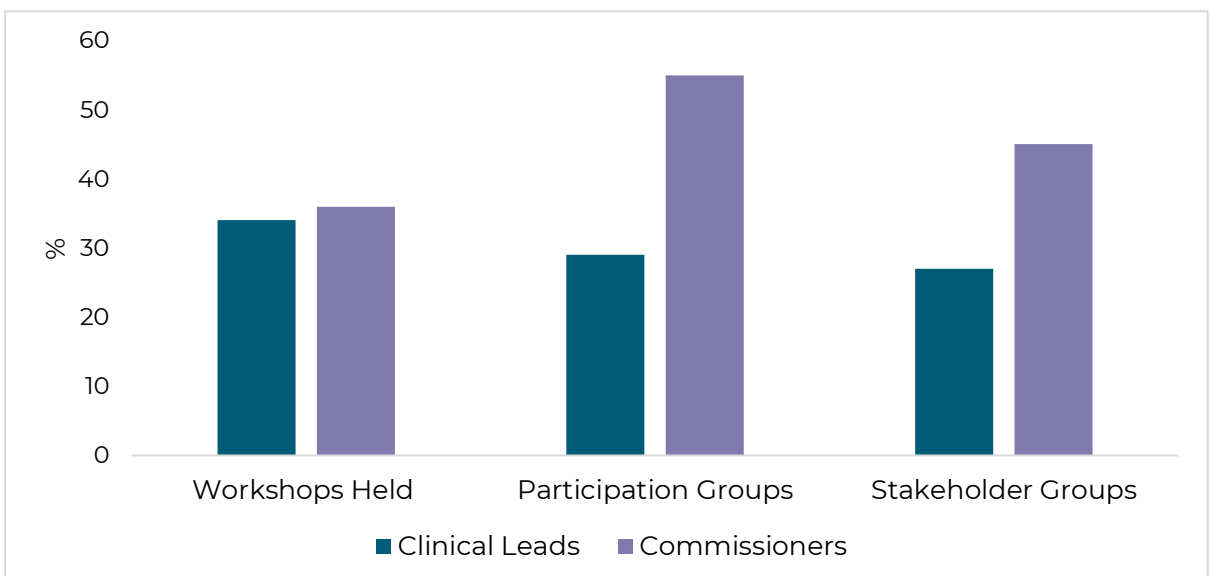

Figure 25: Percentage of clinical leads and commissioners agreeing with or having in place (respectively) certain community engagement strategies for people from minoritised ethnic groups

3.4.7.   Survey responses about workforce and staffing

Table 54: How much do you agree with this statement with regard to your IAPT service: 'The clinical staff group broadly reflects that of the population serve'

	Clinical leads (%)	Commissioners (%)
Strongly disagree	2	0
Disagree	32	36
Neither agree nor disagree	20	27
Agree	29	36
Strongly agree	17	0

Table 55: How much do you agree with this statement with regard to your IAPT service: 'Staff from ethnic minority communities have the same access to CPD [continuing professional development] and career development as White British staff'

	Clinical leads (%)	Commissioners (%)
Strongly disagree	0	0
Disagree	0	0
Neither agree nor disagree	7	50
Agree	20	20
Strongly agree	73	30

Table 56: How much do you agree with this statement with regard to your IAPT service: 'Development for staff from ethnic minority communities is guided by the Workforce Race Equality Standard (WRES)'

	Clinical leads (%)	Commissioners (%)
Strongly disagree	0	0
Disagree	2	0
Neither agree nor disagree	34	70
Agree	37	20
Strongly agree	27	10

3.4.8. Survey responses about resources and funding to address inequality

Table 57: Are you aware of any specific allocated resources or funding dedicated to addressing inequalities associated with ethnicity in your IAPT service?

	Clinical leads (%)	Commissioners (%)
Yes – the service I work for has allocated specific resources or funding towards addressing ethnic inequalities	34	27
I am not sure whether the service I work for has allocated any resources or funding towards addressing ethnic inequalities	32	27
No – to my knowledge, the service I work for has not allocated any resources or funding towards addressing ethnic inequalities	34	45

Table 58: Your answer indicates that you are not aware of any allocated resources or funding provided by your service to address ethnic inequalities in the service. In your opinion, is additional resource or funding needed to address this?

	Clinical leads (%)	Commissioners (%)
Blank/not applicable	32	22
Yes	37	11
No	12	22
Don't know	20	67

3.4.9. Survey responses about challenges and barriers

Table 59: Percentage of commissioners agreeing with challenges and barriers to making changes that reduce inequalities in IAPT services

	Commissioners (%)
Funding and budget constraints	27
Poor quality data on ethnicity	18
Poor quality data/information on specific inequalities and those affected by them	55
Staff/workforce shortages	82
Staff morale	18

Figure 26: Commissioners' reported challenges and barriers to making changes that reduce inequalities in IAPT services
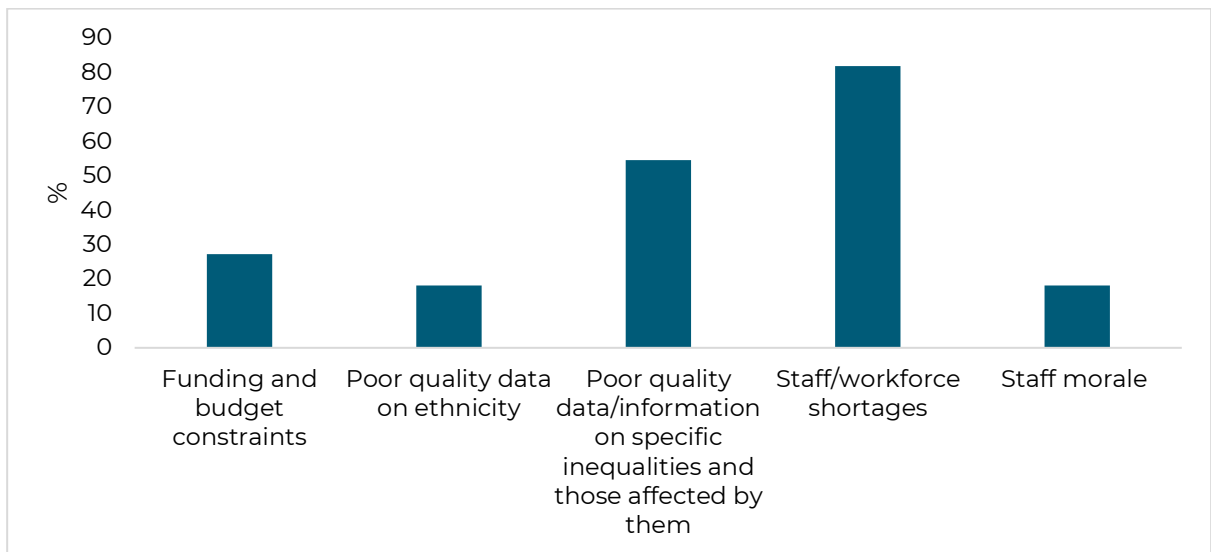
Appendix 4: Rapid literature review

4.1. Review protocol

4.1.1. IAPT Ethnic Inequalities: Rapid Review Protocol

Review question(s)

1. How do access and outcomes vary by ethnicity in IAPT?
2. What factors are associated with ethnic inequalities in IAPT access and outcomes?

Searches

The electronic databases public MEDLINE (PubMed), Excerpta Medica Database (Embase) and PsycINFO (via Ovid) and Cumulative Index to Nursing and Allied Health Literature (CINAHL) will be systematically searched for published literature. Limited grey literature searches will also be conducted via Google, Google scholar and the National Institute of Health and Clinical Excellence.

All studies published in English.

Search terms (electronic database and grey literature):

terms for: "ethnicity" OR "ethnic group" AND *terms for:* "IAPT" OR "improving access to psychological therapies" AND *terms for:* "access" OR *terms for:* "outcomes"

Date of publication: Dec 2008–present

Country: England

Types of study to be included

Include:

Peer-reviewed (published) literature: all study designs, qualitative and quantitative studies, systematic reviews, meta-analyses and literature reviews

Grey literature: guidance documents, reports, presentations, conference abstracts or proceedings, theses/dissertations, presentations.

Exclude: Editorials and opinion pieces; news articles; blogs.

Condition or domain being studied

Mental health conditions or symptoms treated by way of Improving Access to Psychological Therapies (IAPT) services.

Participants/population

Include: individuals accessing IAPT services in England.

Intervention(s), exposure(s)

Treatment provided by IAPT services (including CBT, group therapy, counselling, iCBT [internet-based CBT] etc.)

Comparator(s) / control

N/A

Context

Improving Access to Psychological Therapies (IAPT) services in England.

Main outcome(s)

To answer the questions of this review, studies should include outcomes relating to access and clinical and individual outcomes:

- Access includes:
  - Availability (appointments, assessments, facilities, workforce/staffing)
  - Accessibility (location, quantity of services in a given locality, transport considerations, waiting times to assessment, waiting times for treatment)
  - Awareness (health promotion-related variables, for example knowledge and understanding of IAPT services)
- Outcomes include:
  - Treatment outcomes: recovery, improvement, deterioration (PHQ-9, GAD-7, WSAS), dropout
  - Individual outcomes: employment status
  - Clinical outcomes: medication status

Data extraction (selection and coding)

Titles and abstracts will be screened for inclusion and exclusion criteria independently by two reviewers using Rayyan. At least 20% will be dual screened by both reviewers. One reviewer will then complete the full screening. The second reviewer will screen to confirm that the appropriate abstracts have been excluded and any discrepancies will be resolved through discussion. Full text articles will be retrieved and screened for inclusion and exclusion criteria using Microsoft Excel. The following data will be extracted using Microsoft Excel by one reviewer. The second reviewer will verify that the data has been extracted correctly and completely.

Descriptive data

- Study reference
- Study design
- Country
- Selection/eligibility criteria
- Sample size
- Age: mean sample age
- Gender: % of sample of who are female
- Ethnicity: % of each ethnicity recorded
- Diagnosis

Outcome data for synthesis

Access

- Availability (appointments, assessments, facilities, workforce/staffing)
- Accessibility (location, quantity of services in a given locality, transport considerations, waiting times to assessment, waiting times for treatment)
- Awareness (health promotion-related variables, for example knowledge and understanding of IAPT services)

Treatment outcomes

- Recovery, improvement/deterioration (PHQ-9, GAD-7, WSAS)
- Dropout
- Individual outcomes: employment status
- Clinical outcomes: medication status
- Data collection points and follow-up
- Reference to missing data or loss to follow-up

General data

- Funding

Risk of bias (quality assessment)

An appropriate risk of bias tool will be used where possible; for example, the Newcastle-Ottawa tool for cohort studies and the Cochrane Risk of Bias Tool for randomised controlled studies. Risk of bias assessments will be conducted by one reviewer, with the second reviewer verify that the correct judgements have been made. Disagreements will be resolved through discussion between the reviewers.

Strategy for data synthesis

The results of this rapid review will be synthesised narratively. Results will be disseminated according to ethnic background, highlighting potential differences, or similarities, in a) access to IAPT services, b) factors mediating access, c) outcomes of treatment.

Analysis of subgroups or subsets

If appropriate, subgroups may be included based on factors such as age, location or diagnosis.

Type and method of review

Rapid review

Anticipated or actual start date

January 2022

Anticipated completion date

May 2022

Funding sources/sponsors

NHS Race & Health Observatory

Conflict of interests

None to declare

Language

English

Country

United Kingdom

4.2.   Search strategies

Review question: How do access and outcome vary by ethnicity in IAPT?

- What factors are associated with ethnic inequalities in IAPT access and outcomes?

4.2.1.   CINAHL

Table 60: CINAHL search strategy

Terms for "ethnic minorities" + "inequalities OR disparities" + "IAPT OR improving access to psychological therapies" + "access" + "outcomes"			
Search ID#	**Search terms**	**Search options**	**Results**
S1	MH (minority groups or minority group*) OR MH (ethnic groups or ethnic group*) OR MH (ethnic N1 minorit* or racial minorit*) OR TI (marginali* group*" or "marginali* people" or "marginali* communit*" or "minoritised ethnic*" or "minoritized ethnic*" or "BAME" or "BME" or "black asian and minority ethnic" or "black asian minorit*" or "black and minority ethnic" or "minorit*" or "minority group*" or "ethnic group*" or "people of col*" or "person* of col*" or "black people" or "black*" or "black and mixed race" or "mixed rac*" or "caribbean" or "African" or "African British" or "African Caribbean*" or "Asian" or "Asian British" or "South Asian" or "East Asian" or "Indian" or "Pakistani" or "immigrant*" or "migrant*" or "refugee*" or "asylum seeker*" or "white" or "white british" or "white-british" or "caucasian" or "irish" or "nonwhite" or "non white" or "non-white" or "non white-british" or "non-white-british" or "gyps*" or "traveller*" or "travell* communit*" or "eastern european*" or "european*") OR TI ("race" or "racial" or "ethnic*") OR AB (marginali* group*" or "marginali* people" or "marginali* communit*" or "minoritised ethnic*" or "minoritized ethnic*" or "BAME" or "BME" or "black asian and minority ethnic" or "black asian minorit*" or "black and minority ethnic" or "minorit*" or "minority group*" or "ethnic group*" or "people of col*" or "person* of col*" or "black people" or "black*" or "black and mixed race" or "mixed rac*" or "caribbean" or "African" or "African British" or "African Caribbean*" or "Asian" or "Asian British" or "South Asian" or "East Asian" or "Indian" or "Pakistani" or "immigrant*" or "migrant*" or "refugee*" or "asylum seeker*" or "white" or "white british" or "white-british" or "caucasian" or "irish" or "nonwhite" or "non white" or "non-white" or "non white-british" or "non-white-british" or	**Expanders** – Apply equivalent subjects **Search modes** – Boolean/Phrase	223,484

	"gyps*" or "traveller*" or "travell* communit*" or "eastern european*" or "european*") OR AB ("race" or "racial" or "ethnic*")		
S2	TI ("iapt" or "improving access to psychological therapies" or "stepped care") OR AB ("iapt" or "improving access to psychological therapies" or "stepped care")	**Expanders** – Apply equivalent subjects	1,151
S3	(MH "Health Services Accessibility") OR TI ("treatment access" or "service access" or "care access" or "access to treatment*" or "access to service*" or "access to care" or "access to health care" or "access to healthcare" or "healthcare access" or "health care access" or "uptake" or "treatment uptake" or "service uptake" or "referral" or "care pathway*" or "treatment pathway*" or "pathway*" or "pathway* to care" or "pathway* to treatment") OR AB ("treatment access" or "service access" or "care access" or "access to treatment*" or "access to service*" or "access to care" or "access to health care" or "access to healthcare" or "healthcare access" or "health care access" or "uptake" or "treatment uptake" or "service uptake" or "referral" or "care pathway*" or "treatment pathway*" or "pathway*" or "pathway* to care" or "pathway* to treatment")	**Search modes** – Boolean/Phrase	292,910
S4	(MH "Outcomes (Health Care)+") OR TI ("outcome*" or "therapy outcomes" or "treatment outcomes" or "care outcomes" or "health care outcomes" or "healthcare outcomes" or "clinical outcomes" or "recovery" or "symptom* improv*" or "symptom" reduction*" or "deteriorat*" or "attrition" or "dropout" or "drop out" or "drop-out*) AB (("outcome*" or "therapy outcomes" or "treatment outcomes" or "care outcomes" or "health care outcomes" or "healthcare outcomes" or "clinical outcomes" or "recovery" or "symptom* improv*" or "symptom" reduction*" or "deteriorat*" or "attrition" or "dropout" or "drop out" or "drop-out*)	**Expanders** – Apply equivalent subjects **Search modes** – Boolean/Phrase	542,968
S5	S3 OR S4	**Expanders** – Apply	815,245

		equivalent subjects **Search modes** – Boolean/Phrase	
S6	S1 AND S2 AND S5	**Limiters** – Publication Year: 2008–2021 **Expanders** – Apply equivalent subjects **Search modes** – Boolean/Phrase	17
S7	S1 AND S2 AND S5	**Limiters** – Publication Year: 2008–2021 **Expanders** – Apply equivalent subjects **Narrow by Subject** Geographic: – UK & Ireland **Search modes** – Boolean/Phrase	12

4.2.2.   Medline (via Ovid)

Ovid MEDLINE(R) ALL <1946 to February 02, 2022>

1   exp Minority Groups/   16021

2   exp Ethnic Groups/   167208

3   ("marginali* group*" or "marginali* people" or "marginali* communit*" or "minoritised ethnic*" or "minoritized ethnic*" or "BAME" or "BME" or "black asian and minority ethnic*" or "black and minority ethnic*" or "black asian minorit* ethnic*" or "black minorit* ethnic*" or "minorit*" or "minority group*" or "ethnic group*" or "raci*" or "race*" or "ethnic*" or "people of colo?r" or "black people" or "black$1" or "black and mixed race" or "mixed rac*" or "mixed ethnic*" or "mixed ethnic group*" or "caribbean*" or "caribbean british" or "african*" or "african british" or "afr* caribbean*" or "afro-caribbean*" or "afrocaribbean*" or "asian*" or "asian british" or "south asian*" or "east asian*" or "south east asian*" or "southeast

asian*" or "south-east asian*" or "indian*" or "indian british*" or "pakistani*" or "pakistani british" or "middle east*" or "arab*" or "irish" or "immigrant*" or "migrant*" or "refugee*" or "asylum seeker*" or "nonwhite" or "non white" or "non-white" or "non white-british" or "non-white-british" or "gyps*" or "traveller*" or "travell* communit*" or "white" or "white british" or "white-british" or "caucasian" or "eastern european*" or "european*").tw.   1471290

4   ("iapt" or "improving access to psychological therapies" or "stepped care").tw.   1677

5   Health Services Accessibility/   82354

6   ("treatment access" or "service access" or "care access" or "access to treatment*" or "access to service*" or "access to care" or "access to healthcare" or "access to health care" or "healthcare access*" or "health care access*" or "uptake" or "treatment uptake" or "service uptake" or "referral" or "care pathway*" or "treatment pathway*" or "pathway*" or "pathway* to care" or "pathway* to treatment").tw.   1767380

7   treatment outcome/   1083400

8   ("outcome*" or "therapy outcome*" or "treatment outcome*" or "care outcome*" or "healthcare outcome*" or "health care outcome*" or "clinical outcome*" or "recovery" or "reliable recovery" or "improvement" or "reliable improvement" or "symptom* improve*" or "symptom reduction*" or "deterirorat*" or "drop-out" or "dropout" or "drop out" or "attrition").tw.   2983765

9   1 or 2 or 3   1533221

10   5 or 6   1832603

11   7 or 8   3585533

12   10 or 11   5219521

13   4 and 9 and 12   96

14   limit 13 to humans   80

4.2.3.   PsycINFO (via Ovid)

APA PsycInfo <1806 to January Week 5 2022>

1   exp Minority Groups/   18474

2   exp Ethnic Groups/   141721

3   ("marginali* group*" or "marginali* people" or "marginali* communit*" or "minoritised ethnic*" or "minoritized ethnic*" or "BAME" or "BME" or "black asian

and minority ethnic*" or "black and minority ethnic*" or "black asian minorit* ethnic*" or "black minorit* ethnic*" or "minorit*" or "minority group*" or "ethnic group*" or "raci*" or "race*" or "ethnic*" or "people of colo?r" or "black people" or "black$1" or "black and mixed race" or "mixed rac*" or "mixed ethnic*" or "mixed ethnic group*" or "caribbean*" or "caribbean british" or "african*" or "african british" or "afr* caribbean*" or "afro-caribbean*" or "afrocaribbean*" or "asian*" or "asian british" or "south asian*" or "east asian*" or "south east asian*" or "southeast asian*" or "south-east asian*" or "indian*" or "indian british*" or "pakistani*" or "pakistani british" or "middle east*" or "arab*" or "irish" or "immigrant*" or "migrant*" or "refugee*" or "asylum seeker*" or "nonwhite" or "non white" or "non-white" or "non white-british" or "non-white-british" or "gyps*" or "traveller*" or "travell* communit*" or "white" or "white british" or "white-british" or "caucasian" or "eastern european*" or "european*").tw.   468876

4   ("iapt" or "improving access to psychological therapies" or "stepped care").tw.   1352

5   Health Services Accessibility/   0

6   ("treatment access" or "service access" or "care access" or "access to treatment*" or "access to service*" or "access to care" or "access to healthcare" or "access to health care" or "healthcare access*" or "health care access*" or "uptake" or "treatment uptake" or "service uptake" or "referral" or "care pathway*" or "treatment pathway*" or "pathway*" or "pathway* to care" or "pathway* to treatment").tw.   147174

7   treatment outcome/   37297

8   ("outcome*" or "therapy outcome*" or "treatment outcome*" or "care outcome*" or "healthcare outcome*" or "health care outcome*" or "clinical outcome*" or "recovery" or "reliable recovery" or "improvement" or "reliable improvement" or "symptom* improve*" or "symptom reduction*" or "deterirorat*" or "drop-out" or "dropout" or "drop out" or "attrition").tw.   617302

9   1 or 2 or 3   504784

10   5 or 6   147174

11   7 or 8   623091

12   10 or 11   745190

13   4 and 9 and 12   71

14   limit 13 to humans   71

4.2.4. Embase (via Ovid)

Embase Classic+Embase <1947 to 2022 February 02>

1 exp Minority Groups/ 16888

2 exp Ethnic Groups/ 171589

3 ("marginali* group*" or "marginali* people" or "marginali* communit*" or "minoritised ethnic*" or "minoritized ethnic*" or "BAME" or "BME" or "black asian and minority ethnic*" or "black and minority ethnic*" or "black asian minorit* ethnic*" or "black minorit* ethnic*" or "minorit*" or "minority group*" or "ethnic group*" or "raci*" or "race*" or "ethnic*" or "people of colo?r" or "black people" or "black$1" or "black and mixed race" or "mixed rac*" or "mixed ethnic*" or "mixed ethnic group*" or "caribbean*" or "caribbean british" or "african*" or "african british" or "afr* caribbean*" or "afro-caribbean*" or "afrocaribbean*" or "asian*" or "asian british" or "south asian*" or "east asian*" or "south east asian*" or "southeast asian*" or "south-east asian*" or "indian*" or "indian british*" or "pakistani*" or "pakistani british" or "middle east*" or "arab*" or "irish" or "immigrant*" or "migrant*" or "refugee*" or "asylum seeker*" or "nonwhite" or "non white" or "non-white" or "non white-british" or "non-white-british" or "gyps*" or "traveller*" or "travell* communit*" or "white" or "white british" or "white-british" or "caucasian" or "eastern european*" or "european*").tw. 2093453

4 ("iapt" or "improving access to psychological therapies" or "stepped care").tw. 2158

5 Health Services Accessibility/ 60036

6 ("treatment access" or "service access" or "care access" or "access to treatment*" or "access to service*" or "access to care" or "access to healthcare" or "access to health care" or "healthcare access*" or "health care access*" or "uptake" or "treatment uptake" or "service uptake" or "referral" or "care pathway*" or "treatment pathway*" or "pathway*" or "pathway* to care" or "pathway* to treatment").tw. 2302391

7 treatment outcome/ 909003

8 ("outcome*" or "therapy outcome*" or "treatment outcome*" or "care outcome*" or "healthcare outcome*" or "health care outcome*" or "clinical outcome*" or "recovery" or "reliable recovery" or "improvement" or "reliable improvement" or "symptom* improve*" or "symptom reduction*" or "deterirorat*" or "drop-out" or "dropout" or "drop out" or "attrition").tw. 4394381

9 1 or 2 or 3 2192149

10 5 or 6 2349159

11	7 or 8	4895866
12	10 or 11	6957434
13	4 and 9 and 12	121
14	limit 13 to humans	115

4.3. Search results

Searches of electronic databases resulted in retrieval of 263 studies (after removing duplicates), while 94 (of which seven were already identified through the systematic database search) documents were retrieved through searches of Google, Google Scholar and National Institute of Health and Clinical Excellence databases.

Published articles were screened independently by two reviewers against the inclusion and exclusion criteria, at title and abstract. The Rayyan tool[25] was used to screen the published literature and Microsoft Excel was used to screen the unpublished (grey) literature. At least 20% of all documents retrieved were dual screened by both reviewers. One reviewer then completed the full screening. The second reviewer screened the results to confirm that the appropriate abstracts were excluded, and any discrepancies were resolved through team discussion.

4.4. Published literature summary table

Full bibliographic references for the study IDs in <u>Table 61</u> can be found in the report.

Table 61: Published literature summary table

Study ID	IAPT service	Findings
Outcome: AVAILABILITY		
Bhavsar2021 Cohort study	The South London and Maudsley NHS Foundation Trust (SLaM)	**Rate of psychological treatment use:** Overall use: 14.4 cases per 1000 person-years (cases/1000 pyrs; 95% CI 12.4, 16.7). **Migration status and treatment use:** Residing in the UK for 10–20 years: 21.1 cases/1000 pyrs. Residing in the UK for >10 years: 7.1 cases/1000 pyrs (rate ratio 0.4, 95% CI 0.2, 0.7, p-value for overall association 0.01). People who had migrated more recently were less likely to use IAPT services compared with people who had lived in the UK for <20 years (unadjusted comparison RR 0.3, 95% CI 0.2, 0.7, adjusted 0.4, 95% CI 0.2, 1.2). **Ethnic groups and rate of psychological use:** Lowest rate: Black African participants (12.2 cases/1000 pyrs). Highest rate: (21.7 cases/1000 pyrs). Rate ratio comparison did not yield a strong statistical association (p=0.390). **Residing in the UK for less than 10 years:** 0.41 lower rate of use compared with people born in the UK. The overall association between migration and treatment use was significant (p=0.01), though ethnicity results point to no significant correlation (p=0.12). **Self-referral versus GP referral:** Lower rates of GP referral (RR 0.3, 95% CI 0.1, 0.8) showed a stronger association compared with self-referral (RR 0.4, 95% CI 0.2, 1.0).

Study ID	IAPT service	Findings
Outcome: AVAILABILITY		
Buckman2021 Retrospective cohort study	All IAPT services belonging to the North Central and East London IAPT Service Improvement and Research Network	Young adults who are not in education, employment or training (NEET) association with treatment outcomes moderated by ethnicity: People from minority ethnic groups were more likely to attend booked appointments: Engagement, Beta (95% CI), p-value] 0.00 (-0.02 to 0.01), p< 0.001 **Appointments, ethnicity and young adults who are NEET:** Booked appointments: Proportions were highest in people from a minority ethnic group (p<0.001).
Harwood2021 Clinical data analysis	SLaM: Croydon, Lambeth, Lewisham and Southwark	**Referral route** **Self-referral versus GP**: Compared with White British groups, the following were less likely to be self-referred than GP referred: Black African (OR 0.67, CI 0.63–0.71), Asian (OR 0.65, CI 0.61–0.69) and Mixed Ethnic groups (OR 0.80, CI 0.76–0.84). Black Other (OR 0.68, CI 0.62–0.76), White Other (OR 0.81, CI 0.75–0.87) and Other (OR 0.83, CI 0.74–0.94) ethnic groups were less likely to be self-referred than GP referred in comparison with White British ethnic group (complete case data only). **Secondary care versus GP:** Compared with people from White British groups, the following were more likely to be referred to IAPT from secondary care than GP referred: Asian (OR 1.24, CI 1.08–1.41) and Black Caribbean (OR 1.16, CI 1.01–1.33) groups (after adjustments). **Community versus GP:** Compared with White British service users (after adjustments), the following groups were more likely to be referred by community service than GP: Black Caribbean (OR 1.92, CI 1.65–2.24), Black Other (OR 2.62, CI 2.03–3.38) and White Other (OR 1.85, CI 1.52–2.24). Black African (OR 1.77, CI 1.43–2.19) and Asian groups (OR 1.64, CI 1.38–1.94). People from these groups were less likely to be referred by community services: Mixed ethnic group (OR 0.77, CI 0.63–0.95) (complete case data only). **Variation in assessments:** Compared with the White British ethnic group, the following were less likely to be assessed after referral:

Study ID	IAPT service	Findings
Outcome: AVAILABILITY		
		Black Caribbean 0.78 (0.73–0.82), Black African 0.24 (0.22–0.25), Black Other 0.26 (0.23–0.28), Asian 0.34 (0.32–0.26), Mixed 0.56 (0.53–0.59) and White Other 0.5 (0.47–0.53) ethnic groups.
		Weighted multiple imputation dataset versus complete case dataset:
		In the weighted multiple imputation dataset, people from Other ethnic group were significantly less likely to be assessed after referral (OR 0.55, CI 0.49–0.61); however, in the complete case dataset a positive non-significant association was found (OR 1.10, CI 0.97–1.25).
		Assessment acceptance:
		Highest percentage of declining assessments: Black African service users (26.5%).
		Highest percentage of referrals elsewhere Black Other service users (19%).
		Treatment variation:
		For those assessed, the following ethnic groups were less likely to receive treatment than White British groups (1 [1–1]): Black Caribbean 0.72 (0.68–0.77), Black African 0.77 (0.71–0.84), Black Other 0.73 (0.64–0.83), Asian 0.83 (0.77–0.89), Mixed 0.93 (0.88–0.99), White Other 0.82 (0.75–0.89), Other 0.79 (0.7–0.9) (except Mixed ethnic group).
Yasmin-Qureshi2021 **Qualitative study using semi-structured interviews**	West Midlands IAPT, North London, West London, South London and East London IAPT	**Qualitative data for South Asian women**
		Referral pathway:
		Participants perceiving reluctance from GPs *'I went to the doctor and he told me but I feel he was very reluctant even when he did tell me [about IAPT]'*.
		Experience:
		Personal experience: Some participants felt that appointments should be offered to people who *'really needed it'*: *'I mean, I thought they were always booked out so give it to someone who needs it more'.*
Delgadillo2018 **Cross-sectional survey**	205 IAPT services identified from a	**Mental healthcare access gap:**
		Minority ethnic groups were not significantly associated with the access gap (B=.03, p=.65).

Study ID	IAPT service	Findings
Outcome: AVAILABILITY		
	national register	
Jackson-Blott2015 **Qualitative study using semi-structured interviews**	Least Intervention First Time (LIFT) Psychology in Swindon part of IAPT	**Qualitative data from asylum seekers** **Promoting engagement:** 6 participants mentioned 'Familiarity with the community venue enabled a sense of safety and comfort, thereby promoting attendance: *'Yes, I feel very, very good when I come to [local charity]. This place makes me very relaxed (P4)'. 'And this is a place [local charity] where I feel secure (P7)"* **Location preference:** 1 participant had concerns around trusting unfamiliar people: *'He like to do it here, cause you know and he know all the people around him, but when he go to there [GP surgery] and he don't know about everyone, and he can, even he cannot tell you the truth, and ah, what is, what is going on for him'*
Brown2014 **Cross-sectional analysis**	Southwark IAPT	Ethnic group proportions in IAPT ethnic groups: Significant differences between ethnicity: χ^2 (8) = 28.14, p = 0.0028 White ethnic group: Greater in the Southwark IAPT (73.7%, 95% CI:72.1–75.2) group than the SELCoH 12 (South East London Community Health) group (62.1%, 95% CI: 54.0–70.3). Black African participants: Greater in the SELCoH 12 group (13.0%, 95% CI:7.2–18.7) than among people using Southwark IAPT services (6.0%, 95% CI: 5.1–6.9). **GP-referral pathway:** Ethnicity: Significant differences: SELCoH 12 versus Southwark IAPT GP referral: χ^2 (8) = 35.99, p\0.001 A higher proportion of people using Southwark IAPT services identified themselves as White (75.4%,95% CI:73.7–77.1), with fewer identifying as Black African (5.4%, 95% CI:4.5–6.4). **Self-referral:** Ethnicity: No significant differences in people using Southwark IAPT services compared with people in SELCoH 12. SELCoH 12 versus Southwark IAPT self-referral: χ^2 (8) = 4.75, p = 0.827.
Evans2014b	The Ealing Mental	**Referrals and link workers** **Practices without link workers (17):** Showed variation in referral rate.

Study ID	IAPT service	Findings
Outcome: AVAILABILITY		
Observational study (natural experiment)	Health and Wellbeing Service (MHWBS)	No change in referrals of people from Black and minority ethnic groups, over the study (April 2010 – September 2011), compared with the base referral rate (January – March 2010). Mean referral rate of people from Black and minority ethnic groups from the 17 practices: 0.35 per week, per 10,000 patients (stayed at this rate for the study duration). **Practices with link workers (6):** For people from Black and minority ethnic groups: higher base referral rate of 0.65 per week per 10,000 patients. From July 2010 there was an increase in referral rates (which lasted to the end of the study): 18 months after the first pilot link worker, 13 weeks after the second, 5 weeks before the third and <1 year before the last 3 were in place. (Increase from 0.65 to 1.37 BME referrals per week per 10,000).
Clark2009 **Observational prospective cohort study**	Doncaster and Newham IAPT services	**Ethnicity and referrals:** Newham: Black communities: More likely to self-refer (n=203; 22.2% were Black); GP-referral (n=688, 15.9% were Black, χ^2=4.17, p=0.41).

Study	IAPT service	Findings
Outcome: ACCESSIBILITY		
Bhavsar2021 **Cohort study**	SLaM	**Location and receiving treatment:** Compared with people living in Southwark, survey respondents living in Lambeth were less likely to use psychological treatment (RR 0.7, 95% CI 0.5, 0.9). **Migration:** Taking into account migration for asylum/political reasons, or English as first language, there was a limited impact for the association between 'years of residence with rate of referral to psychological treatment'.
Evans2014a	MHWBS	**Referral rate variation by location (link workers):** 6 link workers were established in GPs in Southall; however, none was established in Ealing.

Study	IAPT service	Findings
Outcome: ACCESSIBILITY		
Observational study (natural experiment)		In Ealing, rates of referral were similar during the analysis (December 2010 – July 2012). Though rates of referral started low in Southall, there was a gradual increase; specifically, BME rate of referral per 10,000 increased in Southall but remained unchanged in Ealing (December 2009 – July 2011).
Harwood2021 **Clinical data analysis**	SLaM: Croydon, Lambeth, Lewisham and Southwark	**Association of borough on IAPT service** **Assessment:** '*Borough of service was found to significantly moderate the effect of ethnicity on receiving an assessment (p<0.01, χ^2 = 71, [degrees of freedom] = 21)'*. **Treatment:** '*Borough was not found to significantly moderate the effect of ethnicity on receiving treatment (p>0.05, χ^2 = 32, [degrees of freedom] = 21).*'
Jackson-Blott2015 **Qualitative study using semi-structured interviews**	LIFT	**Engagement with asylum seekers:** Convenient location: 5 participants mentioned the importance of the location of the IAPT Healthy Minds course. Being within walking distance made it easier for participants to attend: *'it [was] walking distance. Yeah, that's what made it easy for me to attend (P1)'*.
Loewenthal2012 **Qualitative study using focus groups**	Not stated	**Qualitative** **Approaching services – cultural variation:** Male Urdu-speaking participants: 'it *can be a cultural factor to want to cope alone due to the patriarchal nature of the community'. 'Culturally, some men are still bound to not display their emotions because of a need to appear to remain strong for others*'. 7 of the Somali women: '*expressed a sense of helplessness in the face of mental illness', 'because of their place within the Somali community*'. **Interpreter and GP services:** Elderly Tamil-speaking female participant from India: '*felt that the GP did not understand her problems properly, resulting in an interpretation that was not correct*'.

Study	IAPT service	Findings
		Outcome: ACCESSIBILITY
		The Bengali-speaking participants indicated caution with interpreters, '*even if, as one female participant felt, they "are perhaps now being trained better"'*.
Yasmin-Qureshi2021 **Qualitative study using semi-structured interviews**	West Midlands IAPT, North London, West London, South London and East London IAPT	**Qualitative** **Location:** Having IAPT services in community buildings/GP practices increased accessibility to therapy sessions: '*'To be fair I think the location was quite good, I thought it was quite good that they had options of being seen in different locations […]'.* **Waiting:** For 8 of the 10 participants, there was a long gap between assessment and first session: '*[…] having CBT was even worse, I had to wait a little more than 6 months'.* Waiting for therapy often led to the development of unhealthy coping mechanisms. '*So the fact that I was waiting for however many weeks I was waiting, it was […] in that [at] times, like, I kind of developed my own coping mechanisms, which weren't exactly helpful for myself'.* Limited inclusion of culture in the therapeutic process*: 'I suppose it would have been nice to have my culture recognised. I mean, it's a part of who I am. But I just didn't think the two could go together. I couldn't see how my culture could be brought into therapy to help me with my depression so I just never spoke of it'.*

Study	IAPT service	Findings
		Outcome: AWARENESS
Yasmin-Qureshi2021 **Qualitative study using semi-structured interviews**	West Midlands IAPT, North London, West London,	**Qualitative** **Patient choice and treatment:** Treatment being based on symptom severity meant people's expectations were not always met, and they had little control over treatment received: '*I got the impression, well […] erm the lady said that I was almost too low risk to be having face-to-face first so it meant I had to have a workshop first. I wasn't happy but I needed the help, so I did'.*

Study	IAPT service	Findings
	South London and East London IAPT	
Jackson-Blott2015 Qualitative study using semi-structured interviews	LIFT	**Qualitative** **Increasing engagement:** **Signposting:** Information-sharing through posters, letters, and directly informing people: *'I was given the information in the [local charity] and ah, a poster and a letter was put up for everybody that wants to attend (P3)'. 'They look for the courses and say "look" [...] (P5)'* **Future support:** *Members of the asylum-seeking community: '[...] if you can increase these courses of all these kind of things, it will help a lot of people, because people are in problem (P5)'.'*
Loewenthal2012 Qualitative study using focus groups	Not stated	**Qualitative** **Understanding of 'mental health issues' and services:** Tamil participants had less awareness of mental health diagnosis: *'Lots of people who come to us [GP surgery] do not have a clue of what they are going through and that they suffer and live with it. I am so surprised that there's still lack of knowledge and awareness among this community'.*

Study	IAPT service	Findings
Outcome: TREATMENT		
Buckman2021	All IAPT services part	**Outcomes moderated by ethnicity:**

Study	IAPT service	Findings
Outcome: TREATMENT		
Retrospective cohort study	of the North Central and East London IAPT Service Improvement and Research Network	*'Those that were NEET who identified as being of an ethnic minority group were more likely to reliably recover 1.18 (1.02–1.37) (p = 0.028), more likely to reliably improve 1.22 (1.06–1.41) (p=0.007)'.* *'Analyses conducted on observed data compared with primary analyses with imputed data': 'less strong evidence of an interaction between ethnicity and treatment outcomes: OR (95% CI) for reliable recovery among BAME participants who were NEET = 1.16 (0.97–1.38).'*
Yasmin-Qureshi2021 Qualitative study using semi-structured interviews	West Midlands IAPT, North London, West London, South London and East London IAPT	**Qualitative data** **Benefits of CBT:** Provides participants with the framework to link thoughts and behaviours: *'I am enjoying CBT, I am learning a lot more about my own issues…I knew the principles of CBT but I didn't connect the dots together, like, connecting my thoughts to these behaviours'.* **Limitations of the CBT model:** Potential Eurocentric bias: *'I don't think those steps were made for people of colour. These are modelled upon White people, come on! Those are not models of people for colour, those are standard procedures that were not tried and tested or based on the context of what brown people face…like, immigration, detention centres, non-papers […] those are our mental health issues […] I don't think those models were based on brown people's mental health concerns'.* **CBT structure:** Exploration of culture in the therapeutic process may be limited: *'For the cultural stuff I think I might just have to look online to see if any groups or if anyone in particular I can talk to elsewhere.'* **Cultural competence:** Potential lack of understanding of cultural differences from therapists: *'We have a good relationship but she just cannot understand the context from which I am speaking, so that makes the therapy not effective'. 'I couldn't really remember my parents hugging me, giving me a kiss or expressing their love by saying I love you […] so if you were to go to counselling and tell your therapist that, for them that's probably something they wouldn't understand and maybe assume that's why she is like that now. She is like this because her parents never hugged her or told her they loved her.'*

Study	IAPT service	Findings
Outcome: TREATMENT		
		Religion:
		Lack of inclusion could hinder the continuation of the therapeutic process.
Firth2020 **Individual patient analysis**	Services affiliated to the Northern IAPT Practice Research Network	**Primary outcome: Adequate versus inadequate attendance** Ethnicity was non-significant whether ethnicity was divided into a '*six-category variable (White, Mixed, Asian, Black, Chinese, Other), or as a two-category variable (White, Minority Ethnic Group)*'. **Investigating potential contextual effects:** Group interventions: If people had similar demographics, treatment completion was more likely when the groups were larger compared with smaller groups.
Rimes2019 **Prospective clinical cohort study**	IAPT services in England	**'Failure to improve':** '*significantly more likely for racial minority heterosexual patients (aOR [adjusted odds ratio] 1.30 (95% CI 1.25, 1.36), p<0.001) and White gay or lesbian patients (aOR 1.17 (95% CI 1.08, 1.27), p<0.001), compared with White heterosexual patients*' '*Racial minority heterosexual patients were more likely to fail to improve than White gay or lesbian patients (aOR 1.11 (95% CI 1.01, 1.21), p=0.023).*' No significant difference '*between racial minority gay or lesbian patients compared with White or racial minority heterosexual patients or White gay or lesbian patients (p-values >0.05).*' **Logistic regression, reliable recovery (depression/anxiety), reliable improvement, recovery in functioning: no significant interactions between race and sexual orientation.** **Treatment anxiety scores:** '*Racial minority heterosexual patients had significantly higher scores than White heterosexual patients (aMD [adjusted mean differences] .91 (95% CI .80, 1.02); p<0.01) and White lesbian or gay patients (aMD .50 (95% CI .26, .74); p<001); none of the other differences were significant.*' **Post-treatment functional impairment:** '*Racial minority heterosexual patients had significantly higher scores than White heterosexual patients (aMD 1.19 (95% CI 1.03, 1.35); p<0.01).*' **Full adjusted model:** '*none of the race by lesbian/gay or bisexual interactions were significant*'

Study	IAPT service	Findings
Outcome: TREATMENT		
Green2015 **Observational retrospective discriminant analysis**	2 IAPT services in London (anonymised)	Among many variables, ethnicity had an effect on treatment outcomes.
Jackson-Blott2015 **Qualitative study using semi-structured interviews**	LIFT	**Qualitative data** **Acquiring coping skills:** Benefits of course participation, participants gained techniques to cope with varying difficulties: '*[…] before, I got very angry, very quickly […] but now more I can control myself, which is very important for me […] (P6)'.* *'[…] In fact, you know, when I go to sleep […] I had, like, you know, very bad dream. And, after the course […] I am doing all the things, you know, you said, like, just sit and be relaxed […] and, ah, after, straight away, you know, I go to sleep (P2)'.'* Course participation increased resilience, confidence and social contact: Resilience*: 'Yes, it was very, very helpful. Because, ahhh, I learned, I learned that I have full potentials within myself that I can, like, that I can put into use and get myself out of, ahhh, whatever situation or challenge that I find myself in (P1).'* *'[…] it made me, like, stronger and it makes me, like, 'Oh, it's what I've been going through', and somehow I changed, become stronger (P8)'.* *'Even though I feel bad […] it's not going to bring me down to the pits. So it's really, really helped me because I find strength in what I've been taught. I find that, it's only when I appreciate myself, it's given me more strength to really look forward and be positive (P3).'* Confidence: *'But after this course, I a little bit change. I would like to change myself, to meet the friends or go for something to do (P6)'.* Social contact: *'Just for this reason, that I will sit and talk to the people around and to come out of isolation, and that course was really a good, good opportunity for me to join it and talk about such things (P7).'*

Study	IAPT service	Findings
Outcome: TREATMENT		
Clark2009 **Observational prospective cohort study**	Doncaster and Newham IAPT services	**Treatment outcomes** **In Newham:** Looking at changes in GAD-7 and PHQ-9 scores (pre/post-treatment, and recovery rates): Ethnicity did not have a significant effect on outcomes.

Study	IAPT service	Findings
Outcome: INDIVIDUAL		
Buckman2021 Retrospective cohort study	All IAPT services part of the North Central and East London IAPT Service Improvement and Research Network	**NEET:** More likely to identify as Mixed, Asian or Other than as Black, White or Chinese.
Yasmin-Qureshi2021 Qualitative study using semi-structured interviews	West Midlands IAPT, North London, West London, South London and	**Qualitative** Stigma: *'Even though I worry about that and there is shame and stigma, I know I have to go and do this and do this for myself so that I can get better. Otherwise, I suffer.''*

Study	IAPT service	Findings
Outcome: INDIVIDUAL		
	East London IAPT	

4.5. Grey literature summary table

Table 62: Grey literature summary table

Study ID	IAPT service	Findings
Outcome: TREATMENT		
NHSDigital2020 (updated 2021)	Varying IAPT services in England	**Improvement after treatment for anxiety or depression:** In every ethnic group (60%) **2018–19:** Highest percentage: White British ethnic group at 68.1%. The lowest percentage: Bangladeshi ethnic group at 60.8%. **Between 2015–16 and 2018–19:** Improvements increased in every ethnic group. The biggest increase was seen in the Pakistani ethnic group. **Improvement, deterioration or no change after therapy for anxiety or depression:** **Most likely to have improved:** White British (68.1%) and White Other (66.9%) groups. **Least likely to show improvements:** Pakistani (63.0%), Asian Other (62.0%) and Bangladeshi (60.8%) ethnic groups. **Highest deterioration:** Bangladeshi group (8.8%) **Lowest deterioration:** White Other (6.0%) and Chinese (6.0%), White British (5.5%) ethnic groups.

Study ID	IAPT service	Findings
Outcome: TREATMENT		
		Least likely to show no change: Mixed White and Asian groups (29.2%), were Black African (25.3%) and White British (25.4%) groups.
		Improvement, deterioration or no change after therapy over time
		Increases in every ethnic group.
		2015/16:
		Biggest increase in improvements: Pakistani ethnic group (from 54.9% to 63.0%).
		Smallest increase: White Irish ethnic group (from 63.8% to 65.5%).
		2018/19:
		Biggest increase in improving: Asian ethnic group (from 56.7% to 63.9%).
		Smallest increase: White patients ethnic group (from 63.5% to 68.0%).
		The gap in improvements between White and Asian groups decreased from 6.8% to 4.1%, and in White and Other ethnic groups 7.1% to 4.0%.
		Improvement, deterioration or no change (psychological therapy, by ethnicity and gender)
		Most ethnic groups: women were more likely to improve than men (exceptions: Indian, Mixed White and Asian and Chinese ethnic groups).
		Women:
		More likely to improve: White British ethnic groups (68.5%).
		Least likely to improve: Bangladeshi (8.0%) and Asian Other (7.8%) ethnic groups.
		Men:
		More likely to improve: Chinese (71.5%) ethnic group.
		More likely to deteriorate: Bangladeshi (10.1%) and Asian Other (8.5%) ethnic groups.
Baker202	Varying IAPT services in England	41% people of White ethnicity were more likely to complete treatment after referral versus those of other ethnicities (34–46%).
		People of White ethnicity were more likely to move to recovery and see an improvement in their conditions than those of other ethnicities. 53% of people of White ethnicity moved to recovery, compared with 47% identifying as Asian or Asian British.

Study ID	IAPT service	Findings
Outcome: TREATMENT		
		68% of people of White ethnicity reliably improved, compared with 64–65% in the other ethnic groups.
Bignall2019	General IAPT services	**Recovery rates:** Highest for White Irish women (50.5%) and the lowest for Asian or Asian British-Pakistani men (33.5%). **Faith:** Jain, Christian and Jewish people had the highest recovery rates, with Pagan and Muslim people among the lowest recovery rates (NHS Digital, 2016).
NHSEngland AnalyticalServices2017	Varying IAPT services in England	Recovery rate increased in all ethnic groups apart from 2: stayed Static for Chinese groups and White-Caribbean ethnic groups declined slightly.
Little2015	IAPT services in Derbyshire	No significant difference in the equity of outcome scores between different ethnic groups. However, the size of the sample of non-White people moving from treatment to recovery was small (with large CIs), so may not be sufficient to identify a significant difference between groups.

Study	IAPT service	Findings
Outcome: AVAILABILITY		
Baker2021	Varying IAPT services in England	**Referrals with a known ethnicity:** 2020/21 people from White ethnic groups 83.6% 2019/2020 85.5% (May show that referrals fell more among White ethnic groups than Other ethnic groups during 2020/21, or is an artefact of better data coverage). **Gender breakdown:**

Study	IAPT service	Findings
		Outcome: AVAILABILITY
		In Black, Mixed and Chinese, and non-British/Irish White ethnic groups, over 70% of referrals were of women.
Rathod2020	England: London, Leeds, Birmingham and Solihull, and Manchester	**2019 and 2020 data show:** An increase in referrals for some people from a minority ethnic background. **2014–20 (as extracted from NHS Digital, 2020; for England, London, Leeds, Birmingham and Solihull, and Manchester, in the document appendix) shows:** Nationally, Black Caribbean and Other ethnic groups had a consistently higher referral rate compared with people from White British/Irish groups.
HCSC2017	IAPT services in Islington: iCOPE	**Referrals** 30% were from adults who identified as White British, 19% from non-White backgrounds. These are both below the Islington census: 48% are White British, 32% from non-White backgrounds. However, 40% of adults choose not to report their ethnicity or their ethnicity was not recorded. In 2016/17, ethnicity data recording improved with 95% of ethnicity information being recorded.
Little2015	IAPT services in Derbyshire	People from Asian and Black ethnic minority groups experienced lower equity of access, while people from Mixed and multiple ethnic groups experienced higher equity of access in comparison with people from White ethnic groups. White British people were overrepresented, and people from Minority White, Asian, Black and Other ethnic groups were underrepresented. **Methods to increasing access to services:** Promoting mental health awareness and knowledge of IAPT through community engagement. Mental health link workers in primary care. Venues that give confidentiality to service users in communities with more stigma around mental health. Self-referral into services. Building links with local religious groups.

Study	IAPT service	Findings
Outcome: AVAILABILITY		
HSCIC2014	Varying IAPT services in England	**2012/13**

Under HSCIC2014 findings:

Ethnicities accessing IAPT services

White ethnic groups: 89% (excluding unknown/unstated, which accounts for 30% of people referred).

Asian or Asian British ethnic groups: 4%

Other ethnic group, or Mixed Ethnic groups: 2% (8,196 and 11,057 people).

Gender

Black or Black: 68% female versus 31% being male (11,703 people versus 5,365 people).

Over 18 years old

Other Mixed ethnicities: 2,951 (number of people referred to IAPT per 100,000 population).

Other Black ethnicities: 1,818 (people referred per 100,000 population).

White and Black Caribbean ethnicity: 1,774 (people referred per 100,000 population).

Chinese ethnic group: 380 (people referred per 100,000 population).

Study	IAPT service	Findings
Outcome: ACCESSIBILITY		
Rathod2020	England: London, Leeds, Birmingham and Solihull, and Manchester	**Regional differences**
Little2015	IAPT services in Derbyshire	**Derbyshire County**

Under Rathod2020 findings:

Regional differences

London and Leeds: Higher referral rates for people from Black Caribbean ethnic groups, which reflects the national pattern.

Manchester and Birmingham: in comparison with Other groups, there was a higher referral rate for people from White British/Irish groups. Though in Birmingham and Solihull (2019–2022), there was an increased in observed referrals from 'Other ethnic' groups (NHS Digital, 2020).

Under Little2015 findings:

Derbyshire County

Census 2011

Study	IAPT service	Findings
Outcome: ACCESSIBILITY		
		24.7% of the population of Derby City and 4.2% of the population of Derbyshire County are from Black and minority ethnic groups.
		'Ethnicity was recorded for 94.4% of IAPT service users resident in Derby City (n=4,371) and for 80.2% of service users resident in Derbyshire County (n=10,982).'
		Of those recorded
		Derby City: 586 people who accessed IAPT services were from ethnic group Other than White (13.4%).
		Derbyshire County: 197 people were from an ethnic group Other than White (1.8%).
		Equity of access
		'Across both the city and county, compared with people from White ethnic groups, equity of access scores were significantly lower for Asian and Black ethnic groups, and significantly higher for people from Mixed and Multiple ethnic groups'

Appendix 5: Information from voluntary, community and social enterprise organisations about their services

- Table 63 (Sefton Diverse Ethnic Backgrounds [DEBs] Community Development, Merseyside)
- Table 64 (Bromley Well, Greater London)
- Table 65 (Living Well UK, Birmingham)
- Table 66 (Nishkam Civic Association Mental and Emotional Wellbeing Service, Birmingham)
- Table 67 (Zest Community Enterprise, Sheffield).

Table 63: Information about Sefton DEBs Community Development Service (Sefton, Merseyside)

OVERVIEW	**The DEBs Community Development Service is part of Sefton Council for Voluntary Service. The service works with local partners, including local NHS services, to tackle inequalities in the way health and social care are delivered to people in Merseyside.** **Service objectives** - To work with health and social care partners and members of the DEBs community to combat inequalities. - To tackle mental health stigma, raise awareness of mental health problems in the DEBs community. - To support access mental health services, including IAPT. - To address the low uptake, reduced engagement and high dropout rates for people from minoritised ethnic groups using IAPT Services in Sefton that has been evident since the service began operating. - To offer support for other needs including hate crime, employment issues, benefits claims and appeals. **How the service works with IAPT** - Signposts people to IAPT services. - Provides training to local NHS and CCG Trust staff around cultural competence and how best to work with minoritised ethnic communities. - One manager and one part time inclusion officer work directly with IAPT services. - The service actively promotes talking treatments and refers people as part of any new client initial assessment, if appropriate.

APPROACHES USED

Engaging local faith groups

The DEBs Community Development Service has been involved in providing training to local NHS and CCG staff around how best to engage local faith groups, to support people who may be more likely to seek initial support from religious community groups or faith leaders. Training includes focus on reducing mental health stigma to encourage engagement.

Improving the cultural competence and sensitivity of IAPT services

Recommendations made by the DEBs Community Development Service sought to improve the cultural competence of IAPT staff through the recruitment of culturally sensitive practitioners and provision of cultural competence training to practitioners.

Offering self-referral

The DEBs Community Development Service campaigned for the inclusion of self-referral as a method of access based on information received about some groups of people showing hesitance to go to their GP service for a referral.

Establishing networks among community groups

The service has set up a network between community groups for people from minoritised ethnicities called 'Equal Voice' to actively promote talking treatments in communities.

Bilingual support workers

2 cohorts of bilingual workers have been trained by the DEBs Community Engagement Service to support access to mental health services for people for whom English is not their first language. Bilingual workers and translation services include those for people who speak Ukrainian and Arabic. Mental health support for people seeking asylum in the UK includes signposting to IAPT and support for people to self-refer, which is where language translation services are particularly valuable.

Contact and support

While people are waiting for IAPT assessment or treatment, the DEBs Community Engagement Service keeps in contact with them and provides safeguarding, and staff will go to relevant multidisciplinary team meetings or assessments, to support people and provide advocacy.

CHALLENGES

Mental health stigma and scepticism of the service

An initial barrier was the stigma associated with mental health and scepticism about the service. To tackle this, the DEBs Community Development Service worked over a number of years to establish and build relationships in the local community and build community networks to promote mental health recovery. This included having information in different languages. This work increased community confidence in the service, evidenced by the community response.

LESSONS LEARNED

- Working with communities in the development and delivery of culturally appropriate mental health services is vital.

- Ability to facilitate a better understanding of mental health in communities where there is stigma should be included in cultural competence training offered to CCG and NHS staff.

Table 64: Information about Bromley Well (Bromley, Greater London)

OVERVIEW

Bromley Well is a primary and secondary intervention service delivered by a partnership of local charities in the London Borough of Bromley. Commissioned by Bromley Council and the local NHS, Bromley Third Sector Enterprise manages and oversees Bromley Well, working in close partnership with 4 large, local charities to deliver health and social support services: Age UK Bromley & Greenwich; Bromley Mencap; Bromley, Lewisham and Greenwich Mind and Citizens Advice Bromley. The service is free to residents in the borough.

Service objectives

- To support people with mental health difficulties.
- To work closely with other VCSE agencies and networks who provide targeted support for communities at risk of inequalities including (but not limited to) people from minoritised ethnic groups.

How the service works with IAPT

- Signposting people into IAPT services.
- Direct referrals can be made into the IAPT service from Bromley Well.
- A triage officer screens all people entering the service and can also directly refer people to IAPT.
- Bromley Well receives referrals from IAPT and other local NHS services.
- Provision of low-level mental health support in the community.

Contact and support

As well as signposting to IAPT and giving support with referrals, Bromley Well provides:

- Contact and support while people are waiting for IAPT treatment.
- Courses and programmes to support local community members with their mental health.
- Referrals to grief counselling services provided by St Christopher's Hospice
- Low-level mental health interventions.
- Debt support together with Citizens Advice.
- Support for carers.
- Referrals to high-level support when needed.

Promotion of IAPT services for minoritised groups

Bromley Well provides a range of types of support for people with mental health difficulties but it is worth noting that the service does not only focus its aims on supporting people from minoritised ethnic communities and it is not a specific service aimed at improving care for people belonging to these groups. That said, Bromley Well works closely with several other VCSE agencies and networks who give targeted support to communities at risk of ethnic inequalities, including the local Somali, African Caribbean, Asian and Traveller communities. Bromley well provides signposting to IAPT as well a referral support for people wanting to access IAPT services. Bromley Well works closely with Mind and can refer directly into this service and other services in the local NHS trust.

Engaging with communities

A community engagement officer is employed by Bromley Well to build and sustain trusted relationships with the community as a whole and with specific community groups. This is done through community meetings, regular online introductions to the service, community events and promotions during the year. Examples include engagement with a large, active, retired African Caribbean community in the borough, work with local mosques and with people in the local Asian community. A network of over 60 local charities working to support health and wellbeing in the borough enables sharing of resources, knowledge and understanding of needs in the community and provides Bromley Well with access to additional funding for innovative pilot projects. One example is work being carried out to support the wellbeing of the local Somali community through a network of community health champions.

Mind engages with the local community by:

- including local drop-ins at GP surgeries and community mental health teams
- having leaflets at different locations
- online forums
- information sessions in schools and universities through the MindsUp programme.

APPROACHES

Mind has started a diversity and inclusion working group, to improve access to mental health support services for all communities in the borough.

CHALLENGES

Difficulties engaging some community groups and lack of service visibility

Certain parts of the borough are underserved and the service experiences challenges in engaging with some communities. Funding constraints have meant that Bromley Well services are often placed in high-visibility support areas such as GP surgeries.

Gaps in service provision

People able to access treatment through Bromley Well is likely restricted to those who are already likely to seek support from these places. The service has identified a gap in its service provision here and a need to engage in more creative methods to reach communities who are underserved in the borough (such as Traveller communities).

Building trust with community groups

Building trusted relationships with communities is key and this takes time and resource to sustain. Part of the role of the Community Engagement Officer is to try and overcome this issue and provide ways to engage with underserved groups.

Table 65: Information about Living Well UK, Birmingham

OVERVIEW

[Living Well](#) **UK is a consortium of over 30 organisations, including charities, third sector organisations and social enterprises. It works with these organisations to meet mental health needs of the diverse community that it serves in Birmingham, in a sustainable way, with an emphasis on social values.**

Service objectives

To provide mental health services and activities to people in Birmingham.

To reach out to and support groups in the community that have low engagement with services, including IAPT.

How the service works with IAPT

- Some members of the consortium are providers of IAPT services.
- Project link worker acts as a link between Living Well UK and GPs.
- Community engagement officers promote the service.

APPROACHES

Service promotion

Living Well UK's strategies include:

- Mailshots: including to local barbers, low access areas and people with long-term health conditions.
- Free workshops in retirement villages and community centres, and Islamic-centred workshops to target Asian women.
- Putting on simultaneous events for adults and children in areas of deprivation.
- Sponsorship of and work with Solihull Moors Football Club (for example provision of psychoeducation).

Offering therapeutic and non-therapeutic activities

Living Well UK found that it was more acceptable to people if they attended sessions coupled with non-therapeutic activities. They therefore offer these activities to people in the community:

- Personal training sessions followed by a therapeutic group, delivered by someone who is a qualitied personal trainer and PWP.
- Couch to 5K, completed alongside an 8-week guided self-help course supported by a PWP.
- Walking therapies.
- Healing Circles, provided by trained support workers and volunteers.
- Some members of the consortium are also providers of IAPT treatment themselves.
- All of the providers of IAPT treatment have bilingual therapists, and sessions are offered in 17 different languages. If there is no bilingual therapist for a language, there is a translation service.

	• Art therapy, in partnership with Birmingham Centre for Art Therapy. They work with people, many of whom are refugees, who are unhoused and living in hotels in Birmingham. Because these people speak a wide range of languages, art is a good way of communicating. • Islamic-centred therapy, offered by Women's Consortium. • African-centred therapy, offered by Our Roots and Pattigift. After engaging with activities, attendees can engage in further therapy if required.
CHALLENGES	• Service promotion through GPs has been more difficult since COVID-19, and thus is no longer a reliable strategy. • Bilingual therapists do not cover some common languages (for example, Polish). • Walking therapies are less attended during winter, due to the cold weather. To get around this, sessions will be run in a tea room in the park, and the group course will be followed by a weather-dependent walk.
LESSONS LEARNED	• Offering therapeutic activities alongside non-therapeutic activities allows some people to engage better. • Underrepresented communities can be reached with targeted communication/service promotion.

Table 66: Information about The Nishkam Civic Association Mental and Emotional Wellbeing Service (Birmingham)

OVERVIEW	**The Mental and Emotional Wellbeing Service at the <u>Nishkam Civic Association in Birmingham</u> provides mental health access and emotional support for people in the local community. The service offers mental and emotional support to those who need it and who may experience challenges getting help from statutory services such as IAPT. The service is run through the Nishkam Healthcare Trust, which infuses faith-inspired, values-led care into clinical practice. The Trust is part of the Nishkam Group of Organisations, which are multi-faceted faith-based organisations practicing the Sikh faith. Nishkam Healthcare Trust is open to anyone who requires support, regardless of their faith.**
	Service objectives • To provide emotional wellbeing and mental health support to local communities including the large population of minoritised ethnic communities, including the large South Asian population in the area, who have emotional and mental wellbeing needs. • To fill the gaps if IAPT services are not seen as accessible by people in the community. • To provide a care connection service between Nishkam and other areas or support services in the area (for example, the job centre).
	How the service works with IAPT • Nishkam's mental and emotional wellbeing service, run by volunteers, can signpost into IAPT and vice versa. • Nishkam can support people who are waiting for IAPT assessments or treatment. • People can return to the service after IAPT treatment if they need support that IAPT services have not been able to give them. • Nishkam's mental and emotional support service can be used as an alternative to IAPT services, for people who need it.

APPROACHES USED	**Service promotion** Nishkam's strategies include signposting (for example through the Living Well consortium) through community engagement at the job centre, local job fairs, healthcare events, engagement with other faith centres, and pathways between the NHS and Nishkam.
	The Listening Ear service Nishkam provides low-level psychosocial support and interventions for people in the local community delivered by Listening Ear volunteers.
	Adult counselling service (4 days per week) Nishkam's qualified counsellor is accessed by self-referral, NHS referral, social prescribing, other Nishkam services or a job centre.
CHALLENGES	• The nearest IAPT service is not easily accessible to the local community because it is not within walking distance for many. • Nishkam staff have reflected on how difficult it can be to build and maintain community partnerships with IAPT services; there is heavy reliance on volunteers. • Not enough transparency around IAPT waiting times and whether waiting times are for assessment or treatment. This makes it hard for VCSEs to understand where their input best adds value.
LESSONS LEARNED	• Nishkam is relied on to fill some of the gaps where people in the community are underserved by NHS services. • It is likely that there would be a benefit in closer partnership working between local IAPT and community-based organisations, to make sure that the services are accessible to those who need them. • Innovative delivery models may be of benefit, in which IAPT is better integrated into local community services with efficient pathways between different kinds of care.

Table 67: Information about Zest Community Enterprise in partnership with Sheffield NHS IAPT (Sheffield)

OVERVIEW

Zest is a community enterprise delivering high-quality and responsive services to people in the local area, working to tackle inequalities and improve community wellbeing. Zest has established a new partnership with **Sheffield IAPT** which is still in its infancy. The Zest Centre, a community building includes gyms, meeting rooms, advice services and health improvement services. The team at Zest focus on tackling health and wellbeing inequalities, supporting people with employment and skills development, and helping people to engage in leisure activities.

Service objectives

- To enable everyone in the community to lead successful, health lives
- To provide a healthy living centre delivering responsive services to tackle local inequalities, including:
  - health and wellbeing
  - employment and skills
  - sport, leisure and recreation.
- To foster communities in which everyone feels welcomed, valued and can fully participate in the life of the community.
- To play an active role in supporting other disadvantaged communities in Sheffield.

How the service works with IAPT

Members of the equality and outreach team at Sheffield IAPT have begun to link with a number of community services, including Zest, to raise awareness of the Sheffield IAPT service. In particular Zest and the Sheffield IAPT services have been working together to improve access to the Sheffield IAPT service.

APPROACHES

Joint working with NHS staff

A PWP and Senior PWP have attended Zest on multiple occasions to link in with staff at Zest and discuss how to increase awareness of IAPT. One of the outcomes of these discussions has been the development of a training session for Zest staff provided by the equality and outreach team at the IAPT service. The aim of this is to help Zest staff to learn more about IAPT, including how they can support people to refer into IAPT.

Setting up 'Improving Wellbeing' sessions in different languages

Zest and the Sheffield IAPT services are setting up Improving Wellbeing Sessions (for women only) face-to-face rather than online to address access barriers that have been raised by some community members (for example, not enough privacy at home, poor Internet connectivity, lack of computer skills). These will be provided in Arabic and Urdu to support people for whom English is not their first language.

Promotion of IAPT services

- Zest provides a range of group activities and have a number of groups which specifically target women from minoritised backgrounds (yoga, Zumba, cycling, swimming, women's group). Zest aims to use these groups to increase awareness of IAPT services.
- Promotion of IAPT through Zest's English as a second language (ESOL/conversation) classes.
- Use of direct advice and signposting through Zest's Health and Wellbeing Coaching Service with clients in the community, who often have mental health needs.
- Signposting through Zest's social prescribing service and link worker.

In future (advertising to begin in January 2023) promotion of IAPT through a range of publicity routes: social media, posters around the centre/in the local community, on their website.

Roles in place to support people

Zest have these roles in place to support communities:

- health services co-ordinators
- health and wellbeing coaches
- social prescribing link worker
- weight management practitioners
- leisure staff
- community workers.

CHALLENGES

- Attempts to improve access by providing support groups online instead of face-to-face actually made access more challenging for some groups, leading to the decision to hold in-person groups.
- The partnership between Zest and Sheffield IAPT is still in development and will rely on close and consistent communication between the services, which can be challenging in terms of capacity and resource.

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Abbreviations

aMD	adjusted mean differences
aOR	adjusted odds ratio
BAME	Black, Asian and minority ethnic
BME	Black and minority ethnic
CBT	cognitive behavioural therapy
CCG	clinical commissioning group
CI	confidence interval
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CPD	continuing professional development
DEB	Diverse Ethnic Backgrounds
Embase	Excerpta Medica Database
IAPT	Improving Access to Psychological Therapies
IMD	Indices of multiple deprivation
KPI	Key performance indicators
LIFT	Least Intervention First Time
LSOA	Layer Super Output Area
MDS	Minimum dataset
N/A	not applicable
NCCMH	National Collaborating Centre for Mental Health
NEET	Not in education, employment or training
ONS	Office for National Statistics
OR	odds ratio
p	probability value
PPG	Positive Practice Guide
PsycINFO	American Psychological Association database
PubMed	public MEDLINE
PWP	Psychological Wellbeing Practitioner
pyrs	person years
Ref	reference category
SELCoH	South East London Community Health Study
SLaM	The South London and Maudsley NHS Foundation Trust
VCSE	voluntary, community and social enterprise
W&SAS	Work and Social Adjustment Scale
χ^2	Chi square