Supplementary Material File 1

Appendix 1. Participant information sheet

**Title of Project (student study):** *Investigating and improving mental health outcomes for Black Asian and minority ethnic (BAME) women in IAPT*

You are invited to take part in a study which is exploring the experiences of therapists in treating women from BAME communities, who use the iCope service (Camden & Islington NHS Foundation Trust, IAPT service). The aim of the study is to find out more about therapists’ experiences providing both low and high intensity treatment, with a focus on finding out what they think could be improved to make sure people can get the best possible health and wellbeing outcomes. This study is a student study for Laura-Louise Arundell, who is registered at UCL and is working to complete a PhD in Clinical, Educational and Health Psychology. The Chief Investigator for this research is the academic supervisor for this student: Professor Steve Pilling.

**What is the purpose of this research?**

This research is intended to find out how iCope (and wider IAPT services) could be improved by speaking directly to the people who use the service and the professionals working in it. The results of the study will form part of a PhD thesis in Clinical, Educational and Health Psychology at UCL which is looking at improving outcomes of IAPT for BAME women. We know from other data and existing research that women from BAME communities do not always benefit from IAPT as much as other people and that treatment drop-out 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. This study is one part of a larger research project which involves other research methods, including interviewing service users and speaking to professionals. The ultimate aim of the research is to work towards making changes to IAPT that could improve it and ensure it can help people to achieve the best possible outcomes of treatment.

**What would taking part involve?**

If you agree to participate, you would be invited to take part in a brief interview with a female researcher at UCL – this would last approximately 40 minutes. The researcher will take you through a few questions, asking you to reflect on your experiences of providing IAPT treatment and to make suggestions about how it could be improved. The interview would take place via a video call. This call would be audio-recorded and eventually transcribed by the researcher, at which point it will be anonymised and audio files deleted. The transcripts will not be sent to participants for verification unless there is a specific query requiring clarification with a participant. Interviews are being conducted with both Psychological Wellbeing Practitioners (PWPs) and High Intensity Therapists/Practitioners. You will also be asked to fill out a brief tick-box form which will ask you about your age bracket, ethnicity, gender and other information. This data will be kept anonymous and does not require you to give any personal or sensitive data apart from your ethnicity and your gender. This form **will not** collect any identifiable information such as your name or date of birth.

**What are the possible benefits of taking part?**

* You will be compensated for taking part with a £15 online shopping voucher
* 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
* Your views, advice and suggestions would be heard and we hope these can be used to inform changes which could be made to improve services
* Taking part is easy, requiring only a small amount of your time – up to 40 minutes
* You would be supporting part of the researcher’s PhD thesis
* Confidentiality will be maintained at all times.

**What are the possible risks/disadvantages of taking part?**

* Taking part in this research would require you to reflect on your experiences and provide ideas and suggestions for service improvements – some people can find this anxiety-provoking or stressful
* Questions may elicit discussions about challenges associated with care provision and may give rise to negative emotions or feelings

A full debrief with one of the researchers, on a confidential, one-to-one basis will be offered to participants should they wish to do this.

**Confidentiality**

There will be strict measures in place, as required by the Research Ethics Committee and Data Protection Legislation to ensure that information collected in the study is kept anonymous. All research conducted in this way has gone through checks and has been approved by the Data Protection Office at UCL. Involvement in the study will in no way affect your role within the iCope service or any other NHS services. Anonymization will ensure that participants will not be able to be identified in any reports, publications or conference documentation.

**Notice:**

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at [data-protection@ucl.ac.uk](mailto:data-protection@ucl.ac.uk)

This ‘local’ privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our ‘general’ privacy notice:

For participants in health and care research studies, click [here](http://www.ucl.ac.uk/legal-services/privacy/participants-health-and-care-research-privacy-notice)

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the ‘local’ and ‘general’ privacy notices.

The lawful basis that will be used to process your personal data are: ‘Public task’ for personal data and’ Research purposes’ for special category data.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at [data-protection@ucl.ac.uk](mailto:data-protection@ucl.ac.uk).

**Further supporting information**

This study has been approved by <insert NHS REC Project ID number>. <add contact details>

*Researcher Contact Details*

Student researcher: <add contact details>

Student supervisor: <add contact details>

iCope Service Manager: <add contact details>

*What will happen if I don't want to carry on with the study?*

You can withdraw your involvement in the study at any time. You do not need to provide a reason for this and your withdrawal will have no bearing on your role within iCope or any other NHS service. Data given before withdrawal will still be used for the study.

*How will my information be kept confidential?*

The interview would be audio-recorded and eventually transcribed by the researcher, at which point it will be anonymised and audio files deleted. The anonymised transcripts of interviews would form the data. This data will not be linked to any other data or information. Data will be stored on secure UCL servers until the end of the researcher’s PhD (September 2023), after which time it will be anonymised and archived, kept for up to 20 years in accordance with UCL data retention policy guidelines and GDPR guidelines. Participants will be able to request access to their data or for us to delete their data, in accordance with GDPR guidelines. All of the Researchers have completed online GDPR training provided by UCL Legal Services. Data on gender, ethnicity, age bracket and years of service in the NHS and IAPT will be collected by way of a brief data collection form. The data collection form does not require any information by which participants can be identified but is intended to provide descriptive statistics about the participants as a group. Data collected from any forms will be immediately be transferred to a password protected Excel spreadsheet. Participants will not be not be able to be identified from the information provided on the form or in the Excel sheet.

*What are my choices about how my information is used?*

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have*.*

*What will happen to the results of this study?*

The results of the study will form part of a PhD thesis in Clinical, Educational and Health Psychology at UCL. It is intended for the results to be written up as an article for submission to a peer-reviewed journal. It is possible that results may be presented at relevant conferences and professional events (e.g., webinars, seminars). Anonymization will ensure that participants will not be able to be identified in any reports, publications or conference documentation. Results and ensuing reports are likely to be shared with NHS Trusts and stakeholder bodies to hopefully influence future policy and guidance for the provision of IAPT services to BAME communities.

*Who is organising and funding this study?*

The study is organised by the department of Clinical, Educational and Health Psychology at UCL with support from the Camden & Islington NHS Foundation Trust – iCope service. The study is funded as part of a PhD programme at UCL.

*How have patients and the public been involved in this study?*

The Camden and Islington NSH FT Patient Advisory Group supported the development of interview questions and provided input regarding which questions should be asked and how they should be phrased.

*What to expect during the consent process?*

If you agree to take part after reading this information sheet, you will be given a consent form to read and sign. You can either sign this consent form manually using a pen, and email your signed copy back to the researchers, or you can sign this electronically using the Microsoft Word Digital signature feature, which has been enabled on the consent form. In either case, you will need to email the consent form back to the researchers. If you are uncertain about the consent form or need to ask any questions, you may contact the study researchers using the contact information provided on this information sheet.

*What will happen if something goes wrong?*

In the unlikely event that something goes wrong and you need to make a complaint, in the first instance, research participant complaints will be reported to the Chief Investigator to investigate and to the Sponsor (in this case, UCL) via [research-incidents@ucl.ac.uk](mailto:research-incidents@ucl.ac.uk), following the *UCL Complaints from Research Subjects about UCL Sponsored Studies and Trials* policy. For participants who are NHS patients, complaints will be reported to the NHS Complaints Manager at the Camden & Islington NHS Foundation Trust. Complaints should go to [complaints@candi.nhs.uk](mailto:complaints@candi.nhs.uk). Complaints from NHS patients are handled under NHS complaints policies and procedures, with involvement from PALS and the Sponsor where necessary. Further details of the patient advice and complaints service at the Camden & Islington NHS Foundation Trust can be found on the [Trust website](https://www.candi.nhs.uk/service-users-and-carers/advice-and-complaints-service).

END OF INFORMATION SHEET

Appendix 2. Participant consent form

IRAS ID: ###

Centre Number: ###

Study Number: ###

Participant Identification Number for this study:

**CONSENT FORM (Therapist Participants)**

Title of Project: *Investigating and improving mental health outcomes for Black, Asian and minority ethnic women in Improving Access to Psychological (IAPT) Services: a qualitative study into experiences of treatment in a London-based IAPT service* (*student study).*

Name of Researcher: Laura-Louise Arundell

Please initial box

1. I confirm that I have read the information sheet dated.................... (version............) for the  
   above study. I have had the opportunity to consider the information, ask questions and have  
   had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time  
   without giving any reason, without my legal rights being affected.
3. I agree to have my personal data audio/video recorded.
4. I agree to take part in the above study.

Name of Participant: Date:

\_\_\_\_

Signature of participant:

**FOR RESEARCHER USE:**

Name of Person Date

taking consent:

\_\_\_\_\_\_

Signature of person taking consent:

Appendix 3. Participant data collection form

**FOR RESEARCHER USE**

**Participant number:**

**\_\_\_\_\_\_\_\_\_\_**

1. **Please tick the box that most accurately describes your current role at iCope:**

Psychological Wellbeing Practitioner (PWP)

High Intensity Therapist (HIT)

1. **Which of the following best describes your gender? Please choose one of the options below:**

Male

Female

Transgender male

Transgender female

Gender variant/ Non-conforming

Non-binary

Not listed above (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prefer not to disclose

1. **How would you describe your ethnicity? Please choose one of the options below:**
2. White

British (English/Welsh/Scottish/Northern Irish)

Irish

Gypsy or Irish Traveller

Other White background (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Mixed/ Multiple ethnic groups

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed / Multiple ethnic background (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Asian / Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Black / African / Caribbean / Black British

African

Caribbean

Any other Black / African / Caribbean background (please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Other ethnic group

Arab

Other (please specify): ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Please select your age bracket:**

18-24

25-34

35-44

45-54

55-64

65+

Prefer not to disclose

1. **Approximately how many years have you worked in the NHS?**

*This includes any NHS service before you started working in iCope and should be an estimate of the total time you have been employed by the NHS in a clinical capacity, inclusive of any career breaks (e.g. sickness or parental leave)*

Less than one year

Between 1-3 years

Between 3-6 years

Between 6-10 years

More than 10 years

1. **Approximately how long have you worked as a therapist in IAPT services?**

*This includes any IAPT services you have worked in before you started working in iCope and should be an estimate of the total time you have been employed by an NHS IAPT service, inclusive any career breaks (e.g. sickness or parental leave)*

Less than one year

Between 1-3 years

Between 3-6 years

Between 6-10 years

More than 10 years

Thank you for taking the time to complete this form.

Appendix 4. Interview schedule

**Introduction**

*The purpose of this interview is to discuss your experiences of working in the iCope service. Specifically, you will be asked about your experiences providing treatment to people from BAME communities and there will be a particular focus on treatment for BAME women. The aims of the discussion are to explore your suggestions for improving how care is provided, accessed, adhered to and received by women from BAME groups in the iCope catchment area.*

**Discussion items**

**EXPERIENCE**

1. iCope sees a diverse range of service users from a myriad of backgrounds, ethnicities and cultures. Can you talk generally about your experiences in providing therapy services to such a diverse client group?

*If accessibility of treatment available or knowledge/training/support is mentioned, jump to question 5 here and then come back to 2, 4 and 4.*

**STRATEGIES/METHODS**

1. Can you talk about some of the methods or strategies you employ in your practice, in order to ensure the treatment is acceptable and appropriate to the service user?

*If adaptations/tailoring not mentioned, follow up with:*

* 1. What changes, adaptations or augmentations might you make/have you made when working with people from different ethnic backgrounds?

1. What are some of the strategies you use in your practice in order to develop therapeutic rapport and build a trusting professional relationship with service users with whom you do not share the same culture?

4.1) What methods would you employ/have you employed in order to ensure treatment is acceptable and appropriate?

**CHANGES OR IMPROVEMENTS TO IAPT**

1. What do you think would help to improve how IAPT care…:
2. is accessed
3. is delivered
4. is received (or accepted)
5. is adhered to
6. leads to the best possible outcomes for people?

*Prompts*

* At the organisational/service-level?
* In terms of how you delivery treatment as a therapist?
* In terms of the treatment content (e.g. reference to cultural adaptations)?

1. Treatment engagement at a national level, seems to be more challenging for people from BAME groups. What strategies, methods or changes do you think could improve engagement and adherence for BAME groups, based on your own knowledge and experience?

*Prompts*

* At the organisational/service-level?
* In terms of how you delivery treatment as a therapist?
* In terms of the treatment content (e.g. reference to cultural adaptations)?

*If jumped to 5 from 1, go back to 2, 3 and 4.*

1. How should IAPT provide a better service to BAME women specifically?
2. What should change about what IAPT provides?
3. What should change about how IAPT is provided?

**Appendix 5: Stages of data coding**

### Stage 1: Developing the codebook

The codebook was designed to capture the perspectives of therapists providing treatment. Five broad categories formed the codebook

Table 1: High-level deductive codes developed for text analysis of therapist interview data

|  |  |
| --- | --- |
| **Code label** | **Description** |
| 1. Experiences providing therapy to ethnically and culturally diverse service user populations | Any information provided about therapists’ own experiences of providing therapy to ethnically and culturally diverse service user populations, including their perceptions, observations and challenges delivering treatment to diverse groups. |
| 1. Strategies and methods used by the therapist that were focussed on the delivery of treatment | Details about the strategies and methods therapists report that they use to ensure suitability and acceptability of treatment delivery, including to making cultural adaptations to delivery, developing the therapeutic relationship, building trust, rapport and setting goals. |
| 1. Strategies and methods used by the therapist that were focussed on suitability and acceptability of treatment content | Details about what strategies therapists report that they use to ensure suitability and acceptability of treatment, including making cultural adaptations to content, treatment approaches, materials and resources. |
| 1. Organisation or service level aspects of treatment | Therapist perceptions on how organisation or service level factors impacted their delivery of care in the service, including reflections on the format in which treatment was provided, how treatment sessions were scheduled and any other organisational-level factors that therapists feel can influence patient treatment and outcomes. |
| 1. Improvements that could be made to NHSTTad services to achieve better access, experiences and outcomes for minoritised ethnicity women | Therapists’ thoughts and suggestions on improving NHS Talking Therapies for women from minoritised ethnic communities, including access uptake, engagement, outcomes, adaptations and changes at the delivery, content and organisation levels |

### Stage 2: Testing the codebook

Two researchers (L-LA, PB) independently applied the codebook (Table 1) to 2 randomly selected interview transcripts, to test its use. Differences in conceptualisation of the data were identified and discussed. This process led to the development of sub-codes to better organise the data within the high-level codes.

### Stage 3: Identifying and encoding important information

Codes were applied to the data using the 5 deductive high-level codes (Table 1). In addition to the deductive codes, 3 high-level inductive codes arose from the data (Table 2).

Table 2: Deductive codes developed for text analysis of therapist interview data

|  |  |
| --- | --- |
| **Code label** | **Definition** |
| 1. General reflections on providing psychological treatment as a therapist | Therapists’ general thoughts and reflections on being a therapist and their role as a provider of psychological treatment |
| 1. Therapists’ perceptions about ethnicity and culture | Therapists’ own thoughts, views and opinions on ethnicity and culture, including any mention of views about specific ethnic or cultural groups |
| 1. Therapists’ own thoughts, feelings and emotions | Any expression of emotion or feelings from therapists, linked to their own internal thoughts and emotions |

### Stage 4: Applying the codebook and additional coding

Both deductive and inductive codes were applied to segments of text that represented them to identify meaningful units of text. Annotations were used to note any additional relevant information or interpretation.

### Stage 5: Connecting codes and identifying themes

Inductive and deductive codes were pulled together and used to derive themes -constructed patterns derived from the data to help meet the research objectives. Themes were discussed between L-LA, SP and PB and were validated using a portion of the data. In addition, 2 therapist participants provided input on the themes and interpretation of results, further validating the themes.

**Appendix 6: Detailed results: Theme 1 - *Incorporating ethnicity and culture in the delivery of psychological therapies***

Figure 1: ‘*Incorporating ethnicity and culture in the delivery of psychological treatment’* and second-order themes

#### The importance of cultural adaptation, cultural awareness and cultural sensitivity

Therapists discussed how being aware of someone’s ethnicity or culture, and the experiences they may have had because of these factors, is important to consider when identifying the best approach to treatment and whether any adaptations are needed:

“I think the identity factor comes in a lot of ways to the adaptations I make and-and sort of not just in terms of thinking about anxieties and negative thoughts and recognising, you know, is this related to an identity factor and is it helpful for me to dismiss that? But also thinking about am I thinking about things like low mood and depression? And I do think one of the things we underestimate is people's sense of identity and perhaps that can actually be even-a sort of even bigger and more important factor for individuals who struggle with their sense of identity because of experiences and due to-sort of-racism and discrimination.” [P.B11]

Use of culturally congruent terms and language, or re-framing talking points in a culturally sensitive manner was frequently discussed when supporting service users from diverse cultures:

“…language is really important. And I know that there's a lot of different ways of just referring to things and within different-within different cultures and countries and people coming from a different cultural background will have a preference for the way they refer to even things like their mental health and well-being and the terms they use” [P.B11]

The value of having easy access to culturally appropriate and translated materials and resources was something considered to be essential in ensuring acceptability and suitability of the treatment when English was not the service user’s first or most comfortable language:

“We translated materials into languages as well. So that can also be really helpful. And if we didn't kind of have that, I think it would make engaging in therapy for those people quite difficult as well.” [P.B8]

Therapists provided examples of when they’d made religious, spiritual or faith-based adaptations in response to service users’ needs:

“…so, I had a Muslim client who's presenting with anxiety, really bad anxiety, so she- obviously I'm Muslim, I'm - and obviously they can't see me. But yeah, like a Muslim, I'm of Muslim faith as well. So we- that was something we had kind of in common. So, I kind of asked her, you know, because she was like, ‘oh, you know, I pray’. And that was kind of the thing that she uses to kind of help with her when she's feeling like overwhelmed and anxious and stuff. So, I kind of asked, ‘would it be helpful to incorporate some of that into the session?’ She was like, ‘yeah, I actually like that’. So, we kind of spoke about how she could use her faith to kind of help her.” [P.B13]

“Incorporating things like reading the Quran, praying, because BA [behavioural activation] is always about activities”. [P.B12]

Religious and faith-based adaptations also factored into organisational-level aspects of treatment, for example when the service user might need to attend their treatment session at an alternative time or day. Therapists discussed how they would work to accommodate these needs:

“So, for example, if I had a client who had to pray in the middle of the day and I offered a session in the middle of the day, I would want them to say, ‘OK, now I can't because that's when I pray’ and go ‘OK, we'll make the adaptation’, then we'll move it to a different time and stick to another time.” [P.B2]

“…making sure that you are flexible around like the holy days or festivals that they have.” [P.B4]

Although cultural adaptation was considered vital, service user choice and working together with the person to determine the level of adaptation needed, if any, was raised:

“So when we're talking about making adaptations, again that feels like that should be a collaborative-collaborative activity and you're not going to naturally assume someone needs adaptations because they’re of a specific ethnic background, even if they raise it as a factor impacting their mental health, they may not want the adaptation. They may not want it to be a focus. And so, I think opening the door and just allowing that question to be asked” [P.B11]

#### The significance of knowledge, awareness and stigma of mental health problems and treatment

Closely linked to cultural sensitivity and awareness, was the theme of knowledge, awareness and stigma that may be associated with mental health problems and treatment across different cultures. Therapists commonly recognised the impact of culture on service users’ perceptions of mental health and treatment, including where they perceived there to be stigma:

“… I know that a lot of, for example, African women, churches are very important area. So, I guess for example like engaging more with churches to just like normalise talking about mental health because I can't speak for all cultures, but I know generally mental health in general is a bit of a stigma.” [P.B6]

Ways that therapists could address the challenges associated with awareness and stigma were discussed:

“So, I think first of all explaining kind of very thoroughly what the sessions are gonna involve, because I think a lot of people have quite-especially they've not accessed therapy before and if they're from a kind of, minoritised group where mental health is quite stigmatised, then they might have a very stereotyped vision of what therapy involves.” [P.B8]

#### The importance of the therapeutic relationship, building trust and rapport

Therapists often spoke of demonstrating interest in a person’s ethnicity or culture and their experiences related to that, as part of developing therapeutic rapport:

“Unfortunately, we know that some, you know, people from minoritised backgrounds do encounter discrimination, racism. ‘Is this something that is important or has happened?’ And then you may wish to, yeah, check in with them. And I say they don't have to talk about it…before, I would not have asked that. But now I do tend to ask…if that's something that kind of feeds into the-I guess is another issue that goes alongside their general mental health.” [P.B6]

However, striking a balance between showing interest and expecting the service user to fill the gaps in the therapists’ cultural awareness, was also raised:

“…in terms of developing a rapport, for me, with a client whose background is-whose ethnic background is different from mine, I do find It's important that you're striking the right balance of UM being sort of openly curious while not putting the emphasis, sort of, on the client to, sort of, educate you. And actually, I think this is this can be a really fine line that I still and not always sure whether I'm striking or not, to be honest. And-and for me it's a learning process.” [P.B11]

Therapists commonly recognised that service users might feel more comfortable working with a therapist with whom they share the same or a similar identity characteristic, such as ethnicity, culture or gender. Reasons given for this included, perceived relatability and therefore, feelings of comfort discussing difficult topics, as well as helping to address stigma:

“…I do think often, especially with women especially women from BAME backgrounds. Uh, because of the shame, a lot of the times, especially in the Asian community and a lot of, you know, mental health is still not classified as mental health and you know, they like. There's this notion that there is no such thing as depression when they see an Asian woman as a practitioner allowing them- giving them a space to talk. It definitely does, I think, behave as the facilitator gives them that confidence to talk as well and share their feelings. [P.B11]

“So, I guess maybe they feel more comfortable sharing things with people that really understand their culture and what's going on.” [P.B4]

However, this was at times discussed as controversial alongside the issue that the lack of diversity in the NHSTTad workforce could pose a challenge in accommodating requests for ethnicity, culture or gender matching:

“… we've recently been having people asking for particular therapists with particular characteristics, and we can't guarantee that because we just, it would end up, you know that the few Black therapists that we have in the team have to see just Black patients and they may not want to, you know, they- it's not fair.” [P.B5]

Also discussed as essential to the therapeutic relationship and building rapport were quality interpreters for people for whom English is not their native language. Therapists discussed how having a competent interpreter had helped them to develop a good rapport with service users:

“They [interpreter] can be really helpful in that sense. Like there was a couple of questionnaires that hadn't been translated into Ukrainian. So, I got an interpreter to kind of write down the questions and then we had -and yeah, sometimes they'll help explain things about the kind of cultural norms and stuff like that.” [P.B1]

#### The value of supervision

Supervision was a theme that arose across interviews. This included therapists giving examples of occasions where they felt supervision had supported their professional growth or development and enabled them to provide better care to diverse groups (such as through discussion about potential adaptations with the supervisor):

“…And-and I remember my supervisor at the- so I had a sort of one-off supervision session with the clinical lead. And she was from a minority ethnic group. And she was sort of really interested in this bit of the critical incident [of the patient] where they'd been some kind of racism. And she was saying, like, ‘oh, tell me a bit more about, you know, the patient like, has she experienced racism at other times and how long has she been in the UK?’ and I didn't know the answers to any of these questions.” [P.B1]

However, therapists also gave examples of occasions where they felt supervision was lacking, particularly that there was not always enough opportunity for discussions about ethnicity and culture in supervision:

“…there would be a chance to like obviously discuss issues in supervision around like just generally the kind of like a protocol that you're using with the patient. But when it came to things around like a race and their culture, it was like a there wasn't really that much of it opportunity really to discuss those things.” [P.B6]

While allowance for discussions about culture and ethnicity in supervision was considered important in the delivery of care for minoritised and diverse groups, it was clear that therapists perceived there to be some inconsistencies in opportunities to discuss these topics with their supervisors.

#### The opportunity for learning and professional growth

Therapists often spoke warmly about their experiences treating people from diverse backgrounds, including that the experiences were enriching, and that they learned from working with people from different cultures:

“…I enjoy working with multicultural groups of people and I think it's-it's...Yes, it'- it's, it's enriching…it kind of keeps you on your toes. So yeah…I would describe it as quite an enriching experience and a, and a learning experience. [P.B9]

In particular, therapists referenced occasions where they had felt that working with diverse service user groups had helped them to improve their clinical skills and delivery of care going forward:

“I feel like there's, things that I've learned from clients that I found really helpful about their culture and it's like sort of social norms that they've explained to me and then when I've worked with subsequent patients from the same culture, I've-I've held that in mind and it's been really helpful… I've learned a lot from working with those people. Like I've learned about their cultures, and I've learned about things that happen, you know, like if they've maybe experienced trauma, I've learned about, you know, what's going on in other countries. So, I feel like it's positive.” [P.B1]

#### The role of the organisation to support therapists to deliver good care

While therapists reflected on their own individual responsibilities in the provision of good care for people from minoritised ethnic groups, they also discussed the vital role of the organisation in supporting them to do so. Therapists viewed themselves as part of a team and discussed the importance of being enabled to deliver the quality of care that service users need. A manageable workload was one factor that was raised as essential to delivering quality care to people from diverse cultures and backgrounds:

“I think that's always hard… because we're always- always doing back-to-back to back appointments, especially as a PWP, you don't even have time sometimes in between to think about even [sic] adaptations” [P.B12]

The organisation enabling therapists a degree of flexibility with regard to treatment formats, timing and intervention duration was also considered important:

“I have this other Turkish lady starting and I also work with clients that have LTC, so she she's got mobility difficulties and the adjustment with her is she wants to have sessions every other week and she-she can't come in every week because of the mobility difficulties, because she is dependent on others, but also there's issues with connecting online because she doesn't have a laptop and a device. [P.B4]

“Like uh CBT cases, it it's up to six sessions and it can be quite hard to-to do everything all at once and consolidate all of that information in such a brief intervention.” [P.B3]

#### The importance of a diverse workforce

The theme of workforce diversity was commonly raised by therapists who were generally of the view that ethnic diversity of workforce is essential. A multi-ethnic, multi-cultural workforce was seen as a benefit to service users who belong to minoritised ethnic groups. Reasons given for this view included that representation and visibility of different cultures and ethnicities in the workforce can provide a sense of belonging for service users from minoritised communities:

“I'm thinking about recruitment and actually having a, a diverse workforce that is more reflective of the community that we [are] working within.” [P.B10]

Appendix 7. Detailed results: Theme 2 - *Challenges associated with the delivery of therapeutic interventions to women from minoritised ethnic groups*

Figure 2: ‘Challenges associated with the delivery of therapeutic interventions to women from minoritised ethnic groups’ and second-order themes

#### Limited service resources and capacity

Issues of limited resources and capacity were challenges commonly discussed by therapists (as above regarding the importance of a manageable workload to provide good care). In addition to the challenges of a high caseload, therapists discussed having limited capacity to engage in outreach and community engagement work that they considered necessary to improve uptake of people from minoritised or underserved communities. A lack of presence in the community and limited time to do any outreach work was a common challenge raised:

“So, I don't think iCope has any presence in those [communities], so we've-we've been trying to kind of set up something with the Somali community, but we don't have time. That's the problem. We don't have time to kind of see it through” [P.B5]

Resource and capacity challenges associated with the impact of the Covid19 pandemic were common. This was often linked to the fact that existing outreach and engagement strategies had to be terminated as a result of lockdowns and changes to health service delivery during the height of the pandemic:

“That was our work. Literally every day we'll go to different community centres, offering workshops, making those connections, etcetera, whereas here my time was quite limited. Obviously, this pandemic happened, so a lot of the connections that I had didn't quite, you know, things didn't quite work out and stuff.” [P.13]

However, it should be noted that therapists also discussed the ways in which the Covid19 pandemic improved the iCope service’s ability to provide remote treatment, leading in some ways to better use of limited resources and improved service user engagement:

“I think it's been a really positive thing, to be honest. Like for a long time, it seemed like every so often there'd be a bit of an initiative to bring in, like, video sessions, and it would just never really work before COVID... but we found when COVID hit, and we started doing telephone and video sessions that people weren't cancelling…” [P.B1]

#### The stigma of mental health problems and treatment

Understanding the stigma associated with mental health problems and treatment across cultures was discussed in terms of it’s significance as part of incorporating ethnicity and culture in treatment, as noted above. Naturally, therapists who noted the significance of this issue also discussed the challenges that stigma can cause when working with diverse cultural and ethnic groups. One such challenge was associated with some service users’ tendencies to focus only on physical rather than mental health needs:

“I've had, yeah, a couple of assessments where they've sort of been like 'I don't have any mental difficulties, like my-my difficulty is purely physical’ and the GP picks up on perhaps there is a mental health side, but I don't know if there are a suggestion. Could be there's a-a lack of acceptance of the mental health impact maybe?” [P.B3]

#### Communication and language barriers

Communication challenges and language barriers were common issues raised. In particular, using interpreter services was seen as a common challenging experience for therapists. While therapists did acknowledge of the benefits that interpreters can bring (as above), they also discussed challenges such as the lack of continuity and variation in quality of the interpretation service provided, as well as practical issues linked to using interpreter services outsourced by the organisation:

“…there’d be a range of quality in the interpreting, and we'd find a really good interpreter and then try and book them for all of the sessions that I had with the patient because it's good for continuity, but also they were they were good at interpreting, but then there'd be loads of practical issues where the interpreting company we used would send-send someone different even though we'd requested the same person.’ [P.B1]

The need for face-to-face treatment and the challenges of remote therapy came up in discussions about working with people with limited English-speaking proficiency or where English was not their first language. An example was given regarding the potential for solving technical or IT issues that may occur during sessions; this was described as more challenging with non-native English speakers by the therapists and a reason as to why in-person treatment might be preferable when the patient is non-English speaking:

“…if I was working with someone that spoke English and they were saying, ‘oh, it's not letting me log in’ I'd say, ‘well, you just need to go to your settings and do this’. But…because she was trying to describe what she could see on her phone, but it wasn't in English like it was just-it was really difficult to get it to work on a practical level. [P.B1]

Therapists also spoke of the challenges of exploring personal difficulties with service users and displaying therapeutic empathy when English was not the first language or when an interpreter was present:

“There will be the ones that need interpreters, which makes it hard in the sessions to-to explore their main difficulties. But like trying to calm them down, regulate their emotions, and trying to engage them in an assessment quite difficult when there's an interpreter there…I guess if there's a translator and well then-or it's on the phone…it's more…I don't know how to explain this, but if it's like an interpreter in the session with-with the client and it's a face to face session, there's a lot of facial expressions that would express that you are being empathetic and you're listening” ” [P.B4]

#### Dropout and disengagement

One of the challenges commonly raised by therapists was to do with disengagement:

“…the dropout rates are higher for the BAME population.” [P.B4]

“I notice that with-and they kind of they kind of discharge or drop out earlier, yeah.” [P.B2]

Therapists also offered potential explanations for this observation:

“This is the thing like I think [people] from minoritized backgrounds, if we're not happy with something, we just we just don't engage rather than complain, we just wouldn't even engage. And I think that comes from the fact that… I mean this is a generalisation, but the-the thing that we were saying is that people who are White, if they're not happy with something, they will complain and they…it's like having that privilege of knowing that actually you can complain, and your voice will be listened to. Whereas if you feel like you come from a background where, OK, I'm looking at myself and thinking ‘I'm Black or I'm Asian and rather than complain, I'm just not gonna engage….and I just don't think I'll be listened to anyway. So, I'll just not- I'll just not even bother.’” [P.B6]

#### Inequalities that impact access and engagement

Closely linked to the topic of dropout and disengagement of minoritised ethnic groups were the challenges that were perceived to be associated with structural and societal inequalities. Therapists discussed these inequalities in reference to both access to and engagement in treatment. Regarding access, therapists talked generally about barriers getting into treatment:

“It is a minority and-and I don't think enough people are accessing-enough people from ethnic backgrounds are kind of accessing IAPT services for a few different reasons. But I'd say once-once you get over the more, kind of, ‘getting them in the door’ aspect of things, the barriers there…again kind of speaking anecdotally, I find that there has been kind of some barriers or some issues in terms of getting people actually into treatment” [P.B7]

They also discussed socioeconomic inequalities that might disproportionately limit certain minoritised groups from engaging in treatment, including financial and digital poverty:

“…people who are not on high incomes as well and a lot of the Turk- patients with Turkish backgrounds are either refugees or you're not on benefits and they cannot afford childcare. They cannot afford to make way and pay for bus travel or and train travel to come to appointments….” [P.B12]

“I guess like maybe it-the one thing where it doesn't work very well is if someone's Internet doesn't work very well. And I guess the more well off and affluent you are, the more likely you are to have good Internet, I guess. And-and I guess we know different groups are more likely to be living in poverty because of the discrimination experience, the opportunities that they offered.” [P.B1]

#### Managerial and leadership challenges

Closely linked to the role of the organisation in supporting therapists to deliver high quality care (as above), were challenges associated with people in positions management and leadership. Therapists made it clear that their ability to perform to the best of their ability in their roles and to provide adequate care to service users from diverse cultural and ethnic backgrounds, was dependent to some degree, on adequate support from those in positions of leadership. Commonly raised challenges included therapists feelings like managers and leaders were not likely to take the initiative to implement changes that could improve treatment for minoritised ethnic groups:

“…I think with our management team they-they won't-they won't necessarily generate these things, or they won't say ‘oh we've been thinking of-‘ or- I mean in Camden, I think the management team seems to be much more involved, unfortunately in Islington they seem to kind of-well wait for us to come and suggest things rather than initiating things… It does sometimes feel like it's all on our shoulders in, in terms of their equality and diversity team that I-I sometimes wonder if I didn't mention anything, would it ever be talked about.” [P.B5]

“…it [initiatives to increase uptake of minoritised ethnic groups] needs some buy in from senior members of the team management.” [P.B10]

Appendix 8: Detailed results: Theme 3 – Improvements

Figure 3: *Improvements for women from minoritised ethnic groups’* and second-order themes

Therapists were asked explicitly about improvements that could be made to NHSTTad services for women from minoritised ethnic communities. Questions seeking out improvements were intentionally asked towards the end of the interview, after participants had been asked to discuss their experiences of care provision. This allowed participants to reflect on their answers to previous questions in their suggestions for improvements. As a result, suggested improvements were closely linked to the previous two themes on incorporating ethnicity and culture into treatment and challenges associated with delivering care to women from minoritised ethnic communities. ‘Improvements to NHSTTad for women from minoritised ethnic groups’ as a theme was broken down into second- and third-order themes for deeper exploration. This was done in order to extract and focus on tangible actions that therapists suggested could improve NHSTTad treatment for women from minoritised ethnic groups.

***Cultural adaptation and cultural sensitivity***

Commonly suggested improvements on the issues of cultural adaptation and cultural sensitivity were to do with how ethnicity and culture are explored early on in the assessment and treatment processes:

“So, UM I try kind of in the first session to get a sense of that from people like kind of where they grew up-up in terms of kind of their adherence let's say, to beliefs or how important kind of religious beliefs are for them. Sometimes it's kind of also important t- to ask about, yeah, significant events.” [P.B5]

“Diversity is Something that UM specifically should be taken into account when it comes to their mental health and I would always be interested in asking within assessments about how clients feel their diversity characteristics may impact their mental health and their well-being, and whether historically or currently” [P.B11]

Improvements to cultural sensitivity and awareness training for staff and managers were considered necessary:

“I think they need to be more training or how managers can be more culturally competent as managers as well and-and as I said, I do think these things trickle down to then the care that we provide” [P.B10]

“I think going back to that idea of education, training for the provider is really important because I think a big thing that contributes to outcomes is feeling that your therapist doesn't understand you and there's not that sort of connection for them to appreciate, sort of where you're coming from with the difficulties you're having.” [P.B11]

In addition to suggesting improvements to cultural sensitivity and awareness training, therapists often recognised that more could be done to make use of existing guidance and resources on cultural sensitivity and adaptation. While some therapists were vague in their suggestions about using available resources, several therapists (*n*=5, 38.5%) made explicit reference to the BAME Positive Practice Guide (Beck et al., 2019)and how they could use this more proactively in their work:

“Well, I know of like, you know, positive practice guides and stuff like that. And I do-do refer to them probably not as much as I should, but-but occasionally” [P.B7]

“I know the positive practice guide and I've read through that-that.  
Yeah, that's quite helpful actually to get like generic guidelines on how to adapt the sessions, including the length of the sessions.” [P.B4]

A final suggestion on the theme of cultural adaptation and cultural sensitivity was the availability of inclusive, diverse and relatable therapeutic materials suitable for diverse groups. This included things like ensuring that materials, text and pictures provided to service users or used in treatment sessions were representative:

“So, in every booklet that we have, there's always like a pseudo patient, a patient who is currently experiencing that problem. So, let's say in a stress booklet, it'll be someone with stress. Anxiety will be someone with anxiety. And actually, now thinking about it, all them patients, they’re names like Amanda or Josh and yeah, maybe like a change in that as well, because I'm just thinking someone from BAME background, how would they feel about that? How-how relatable? Because the whole point of having that pseudo-patient there is for it to be relatable. So, when you read it, you relate to it and how relatable would that be?” [P.B12]

***Service availability and delivery***

Therapists made a number of suggestions for improvements to the availability and delivery of NHSTTad that they felt could benefit women from minoritised ethnic communities. Unsurprisingly, given the challenges raised regarding language barriers, making changes and improvements to interpreter and translation processes and services were common suggestions:

“…it's really good if the interpreter is consistent every week. So somehow like making sure we are booking in the same person for the next 10 weeks.” [P.B4]

“…maybe a bit more of a policy in terms of how we manage interpreting with different languages … so that we all know, I guess like a structure in a way.” [P.B8]

More flexibility in how services are able to be delivered to service users to improve their experience, engagement and potential outcomes comprised several suggestions. These included therapists being able to offer longer sessions depending on need, and this was often related to the challenges of working with interpreters:

“For me I had to do this one specific assessment using telephone interpreting. So yeah, it was quite interesting. I-I was able to contain him, but it also meant that in the 50 minutes I wasn't able to do the questionnaires, which is a requirement for IAPT…if we could get like maybe 1 and a 1/2 hours instead of 50 minutes for a session with that interpreter, having that flexibility” [P.B4]

Therapists also suggested that flexibility in the number of sessions they are able to provide, could be beneficial to some service users, especially where the person might benefit from additional time to familiarise themselves with therapy:

“But I think just if it was a standard to basically even have a bit more, I guess, I don't know if that's possible, just like even just having 7-8 sessions in terms of like, because 6 sessions is very brief. I know it works. I've seen amazing things it’s done, you know, in terms of helping clients. But I think when you need firstly to kind of socialise the client to CBT.” [PB.13]

Another common improvement around flexibility was to do with scheduling treatment. Often, therapists reported having a decent amount of freedom when it came to scheduling sessions with service users who might need to cancel, change or re-schedule appointments for different reasons. The recognised this as an important factor when working with women from minoritised communities and diverse cultures to sustain engagement, as well as something that could be improved in practice:

“…because they-they haven't wanted to have sessions during that time, they felt like they wouldn't be in the right frame of mind, or we tried to change the time of the session so that it-it-they can get more from more from it. So, we just-I guess I've just it's not a huge adaptation. It's just kind of thinking together with the client about how can we apply what we were doing and kind of keep that going now that your day is looking really different and there's different kind of challenges for you throughout the day. [P.B1]

There were also suggestions made regarding flexibility in the structure of treatment, depending on need:

“…let's say we have three to six half an hour sessions but instead of three to six half an hour sessions we might do like [a] 15 minute session every week? So, it's not too overwhelming for them.” [P.B12]

In particular, a suggestion was made around flexibility in the process of discharge on the basis of lack of engagement, especially for people experiencing language and communication challenges:

“…being a bit more flexible with people and if they can't attend appointments like for example, I'm seeing it a lot where kind of we have a policy where they don't attend twice, it's a discharge and like that's absolutely fine. But like a condition of the discharge is they have to make contact within certain amount of time and if they can't kind of speak the language, it's difficult for them to.” [P.B8]

Flexibility was also referenced with regard to the format in which treatment is offered to service users. As above, therapists spoke of the benefits of providing treatment remotely, using telephone or video formats and many spoke of how NHSTTad services are generally able to provide service users with a choice as to how they receive their care. However, it was clear that therapists felt this could be improved. Sometimes, this was also linked to language and communication:

“…we're having face to face sessions because she said she would prefer that because of the language barrier and she's fine face to face and I can understand her.” [P.B4]

Some therapists specific expressed ideas they’d had about providing therapy in group formats for specific groups of women from minoritised ethnic communities:

“I think offering groups and for um people from different minoritised groups and yeah, especially for women. Yeah, it's a group sessions. It could be based on ethnic background and-and more specific problems for women from particular backgrounds and-and umm, I think they can be incredibly healing, and they really can, I think be co-created.” [P.B10]

Linked to the idea of alternative treatment formats, were several suggestions about alternative routes or pathways to care for underserved groups of minoritised ethnic women:

“So, I think again, it's very related to access in that sense… I mean, aside from the general routes of GP, self-referral like there aren't really any routes that I'm aware of- this specifically helping my minoritised, kind of, women access our service. Like aside from like the general advertising, it would be good to see maybe specific pathways that kind of inform minoritised women about our services and the services that we offer because we have like perinatal services, we have long term conditions services…So I guess more work and more of a pathway to be set up at service level in terms of that.” [P.B8]

In addition to discussing alternative treatment formats and pathways to care, therapists also made suggestions around increasing the availability of alternative services and treatment options to meet patient need. There was a recognition that treatments more typically offered, such as CBT, might not always be the right choice for service users and that NHSTTad services could do more to provide more flexibility of treatment options:

“So, I think their counselling provision for sure is something that they need to sort out…I think when it comes to women from minoritised backgrounds is that there's that there's a lot of certain age demographics is that there's a-a sense of that, the stigma and being silenced in a way or like not having our mental health difficulty heard and so initially counselling is so helpful because it gives you that space to process some of that stuff and explore it. Yeah, I think the counselling provision would be really good to push.” [P.B3]

Therapists also suggested that service availability and delivery could be improved by the collection of more useful data to inform service delivery:

“And it it's interesting because national identity is not every-. It's kind of in that section of the records that we can fill in, but it's not a required one. So, we often have someone's ethnicity, but we don't have the national identity. And I just always us because I just think it's really helpful to know.” [P.B1]

Similarly, therapists referenced the need for better incorporation of research findings into practice to improve treatment for minoritised ethnic groups:

“I think quite a lot of research and-is-is already been done around what-what can help, its lacking implementation, it’s very slow. It doesn't happen at all. So, I think so much more needs to be done. And in terms of how we carry forward the-the recommendations and suggestions from whether it's the- And like the clinical psychology students who do a service related project name during their placement. It's so, so much has already been done there. And it links in and from-from what I have observed and looked into, doesn't seem like much [is] taken forward. So, I think there's been a range of recommendations.” [P.B10]

***Outreach, uptake and engagement***

Given that several of the challenges reported by therapists were to do with limited time to engage in necessary outreach work, it is not surprising that improvements to outreach and update work were common suggestions.

The most frequently discussed suggestions were around service promotion, community linkage and increasing awareness of mental health support available via NHSTTad in underserved minoritised ethnic communities:

“Yeah, maybe like going into the community and spreading the word a bit more like handing out flyers. And maybe if they like translated in their language then- yeah, they can read and know that our service is there for them… let's spread some translated materials as well around.” [P.B4]

“Sometimes within IAPT is that it can feel a bit removed from the community and in my experience umm, of working with sort of some of the minority ethnic background women that I have worked with, The sort of link between iCope and them has perhaps come from somewhere within the community and-and it feels like a perhaps we're not always taking advantage of community spaces where we could reach out to people rather than wait for them to reach out to us…And then maybe it's a case of us needing to be the ones reaching out and making sort of more connections within the community.” [P.B11]

Along these same lines, therapists also suggested how NHSTTad services could better target specific communities of women at risk of being underserved by mental health services:

“… you know when you're doing your advertising and stuff like that, like, do you have, like, Black women that, you know, when-when you do advertising on, like, ‘come to iCope’ like is-is a Black person, particularly a Black woman, maybe a black woman of a particular age, and are they, kind of represented? Are you kind of, in the community spaces? Again, start typically, maybe like…if you can do projects in Black Barber shops, can you also do them in like Black salons?” [P.B7]

“But when I worked in [name of other London service] and some therapists that spoke Punjabi would go to this like Desi radio station and like and promote the service and that was really helpful because people that listen to that wouldn't necessarily-like it might not be that common to kind of talk about mental health and think about it. So, I think those targeted things…so there's like a Tamil centre where we would try and sort of establish links. So, I think that doing tailored things with the local community like thinking about what kind of groups of people are in our borough…” [P.B1]

Therapists recognised that combating stigma was essential to increasing uptake and engagement with NHSTTad services and suggested this could also be tackled with outreach into communities:

“…workshops and stuff in the community to kind of reduce some of that kind of fear of having to kind of access a service.” [P.B2]

“So, when you're there in the trenches where they are you, you know, you can help them and-and just become, yeah, I guess more familiar with your community. They become more aware of you. It takes a bit-maybe a bit of a stigma of the mental health off, that everybody's experiencing challenges.” [P.B9]

Therapists also discussed the need for improved psychoeducation as part of the early treatment process to tackle stigma, and emphasised that educating communities on mental health and working to normalise help-seeking was an essential part of the process to improve engagement:

“…start the intervention by doing some psychoeducation and then we move on to- and what the intervention actually is, and I think we almost need to stay in that kind of psychoeducation phase for a little bit more just to kind of understand, reduce the stigma” [P.B3]

A tighter focus on early intervention was also suggested as a way to increase uptake for underserved groups of women:

“…but maybe just focusing on like early intervention because we've seen women that are from an older age demographic who have been having to endure uh, you know, chronic mental health difficulties and not really accessing the support. And by that point we might assess them and they're too complex for IAPT and so they don't start here and they have to move, move further up and that process also takes longer as well.” [P.B3]

***Workforce***

One of the most common improvement suggestions was around workforce diversity. It was a commonly held belief amongst therapists that demonstrating and showcasing diversity in the workforce would facilitate uptake and engagement for minoritised ethnic women. Although NHSTTad services were often viewed by therapists as more ethnically diverse than other areas of mental health care, they still expressed feeling that more needed to be done:

“…although I say yes, we've got a-we've got colleagues and practitioners you know that that are from BAME background but there-there is still not that- how do I put into words? And there isn't enough still, I don't think. I think it's been increasing over the past few years. Like, we've been, you know, there's been more recruitment into trying to make sure that the place is diverse and that we have a diverse workplace, but some are obviously better than others, some do it great…But it's harder sometimes in some services there might not be a lot of people from BAME backgrounds.” [P.B12]

Showcasing an ethnically diverse workforce was suggested as a way services could communicate to underserved ethnic groups that the service is available and suitable for them:

“And we're trying to change our website as well to just make it feel more culturally acceptable across kind of all backgrounds. So, we're trying to create a mission statement and so that people can kind of read it even just thinking about, like the way our reception looks and like things like that and having pictures of staff and like showing that we are a diverse team because I think that's just as important in terms of getting engagement from patients and trying to make it look like that. We are like a diverse team who are able to a diverse range of patients as well.” [P.B2]

Service user preference to be seen by a therapist with certain characteristics was a common theme:

“…every year new trainees come they get trained on how to do BA [behavioural activation], worry management et cetera et cetera, they get put forward they just see the patients but they're missing that skill on when the patient just come through who was from a BME background. How do they actually support them? Should they have a think about do they need in a different therapist? Do they want to have a therapist that relates more to-? That question is never asked. So that question is actually not asked during, you know, a lot of assessment templates like would you prefer to have a therapist from a similar cultural background to you?” [P.B12]

Despite some varying opinions on ethnic, culture or gender-matching, there was a general consensus among therapists that there might be some benefit to asking service users about who they may prefer to work with:

“Sometimes it's more about who they might not want to work with, and I guess I tried to make it feel as safe as possible, that they can stay if things you know in lay terms, just-just say it as it is. What-what would help you feel safe?” [P.B10]

“…I think, and this is a bit controversial, but I do think that if like a White therapist is working with somebody from a BAME background, it's a difficult question and I don't know, maybe there's not really a right or wrong, but I do think that there should be something about any concerns that they have about whether-whether they feel like-yeah, there is a power dynamic there.” [P.B6]

However, it was acknowledged that some service users might prefer not to be seen by therapist with whom they share a cultural or ethnic background, further supporting the idea that what matters most is providing the service user with some degree of choice based on their individual needs:

“And sort of, I suppose, going back to basics, then I would always explore whether it would be helpful as well for a client to have somebody that would she either associated or not associated with. And that-that sort of ethnic background, if specifically, if that's a factor in their mental health and it sort of goes both ways. Sometimes I think there's an assumption that somebody will benefit from having somebody who is linked with their ethnic background and provide the support they're looking for. But actually, it can certainly -and I've seen it go the other way where actually, like, can make people more uncomfortable if mental health is viewed in a specific way.” [P.B11]

Given that language translation, communication barriers and use of interpretation services were raised commonly by therapists as importance treatment factors whilst also posing a series of challenges, it is unsurprising that a common workforce improvement centred around efforts to recruit bi-lingual therapists to the service:

“So, I think it would be good if we could maybe encourage like people who speak different languages to offer services in their native language if they were to feel comfortable doing so, because I think as well as one thing going for therapy and kind of- the important so yeah, I think that would be good to kind of encourage or maybe provide more support for staff to offer those kinds of things.” [P.B8]

***Team and staff support***

Improvements that could be made to team and staff support included opportunities for closer working with colleagues, to share resources, experiences and learning:

“And just even like speaking to colleagues…-and share resources with them like… what would you recommend for this particular client et cetera, what would you recommend for this client? And then just kind of yeah, share resources amongst us as well would be quite helpful…have like shared BAME resources.” [P.B13]

This included suggestions around creating or better utilising supervision, staff supportive groups and reflective spaces. It was clear how much therapists felt that having access to supportive reflective spaces was a benefit to them and in turn, the service they were able to provide to service users:

“I think also having a safe space where colleagues can go and talk to someone if they are- If they are struggling or they want to make adaptations. I know we have supervisors, but maybe a general service space.” [P.B12]

“…we've had a lot of training recently around kind of like being comfortable talking about race and we have, we-we have regular reflective sessions where we discuss various topics around like race and culture. And like we recently had a reflective session around race and class and things like that… it's really helpful. It’s a whole team meeting so people can, you know, bring stuff and talk about it.” [P.B6]

Finally, therapists also made suggestions as to how they felt they could be better supported and empowered by those in managerial and leadership positions to provide better care:

“I think there needs to be more training on how managers can be more culturally competent as managers as well and-and as I said, I do think these things trickle down to the-the care that we provide.” [P.B10]

“Some sort of, you know managers being trained or-or uh on board or I think that is really, really helpful. It just makes it easier because I just have a feeling right now of like holding it all or holding a lot of it. I've got some colleagues who work with me on equality and diversity, but I think something about managers making space for it, and again, you know, they have so much stuff to do, but it sort of feels like it needs to be embedded, thinking about differences needs to be embedded in the whole system. It shouldn't just be a kind of thing that we think of ‘oh, what about differences?’ It's in every-in every new service development or whatever there needs to be this question kind of ‘how can we make this more accessible to more people?’” [P.B5]

Appendix 8a. Additional supporting quotes from Theme 3- *Improvements for women from minoritised ethnic groups*

**Cultural adaptation and sensitivity**

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| **Second-order theme** | **Third-order themes – suggested improvements** | **Example supporting quotes** |
| Cultural adaptation and sensitivity | Adapt how culture and ethnicity is explored early on the assessment and treatment processes | *“…at the moment we have this question that we ask people in their initial assessment….that's like basically, what the question’s trying to do is capture if there's any aspects of someone's identity such as culture, but also gender identity, where they feel that- different or that they're from a minority group... So I think because that question's there PWP's feel like, ‘oh, well, I've done my bit with thinking about the person's...um... kind of identity so I don't need to sort of be on the lookout for any little avenues we might need to go down’. And so I think maybe making some adaptations about how we ask about culture and ethnicity would be important.” [P.B1]*  *“…the only thing that I'm doing more recently now is just again just trying to ask a bit more about their kind of culture and-and I guess even if they're born here…” [P.B6]*  *“…it depends on whether in assessment the person is asked the-the question of or ‘do you feel that like you're there's like an element of diversity or like if you there's anything about yourself, your identity that you feel is important?’. So I always think it's important especially the beginning of treatment to check back on that and think there's anything that didn't come up in the assessment, maybe that is relevant now or anything that you didn't mention or it maybe wasn't prompted for you to answer in that way that could inform us as well, so kind of- I feel like that kind of is an adaptation in a way to kind of check back on that and especially if it has come up in your conversation after the assessment as well, I think that's important and trying to think of what else we can do” [P.B8]*  *“So when we're talking about making adaptations, again that feels like that should be a collaborative. A collaborative activity and you're not going to naturally assume someone needs adaptations because of a specific ethnic background, even if they raise it as a factor impacting their mental health, they may not want the adaptation. They may not want it to be a focus. And so I think opening the door and just allowing that question to be asked” [P.B11]*  *“I think if we as therapists were-were more confident in asking people about their cultures that would improve people's experience, so if we- is there some kind of training or if it was just like in our kind of ethos in supervision and things that we would-that it's OK to ask…it's often beneficial as long as it's done in a sensitive and respectful way.” [P.B1]*  *“So, UM I try kind of in the first session to get a sense of that from people like kind of where they grew up-up in terms of kind of their adherence let's say, to beliefs or how important kind of religious beliefs are for them. Sometimes it's kind of also important t- to ask about, yeah, significant events.” [P.B5]*  *“Diversity is Something that UM specifically should be taken into account when it comes to their mental health and I would always be interested in asking within assessments about how clients feel their diversity characteristics may impact their mental health and their well-being, and whether historically or currently” [P.B11]* |
| Increase cultural sensitivity and awareness training for staff | *“I think if we as therapists were-were more confident in asking people about their cultures that would improve people’s experience, so if we- is there some kind of training or if it was just like in our kind of ethos in supervision and things that we would-that it’s OK to ask to just it’s OK and it’s often a beneficial as long as it’s done in a sensitive and respectful way.” [P.B1]*  *“I find that I learned through kind of engaging in sort of less in the reading but more in conversation. So I think going to those trainings is quite helpful.” [P.B5]*  *“…as a white British therapist, you sort of say stuff and sometimes it lands a bit of a different way to what you're expecting, and you don't really know why and you just sort of forget about it and do the exact same thing next time. And I-I think that if we can improve therapy, if we're a bit more aware and mindful of like slightly different ways that things are sort of perceived between different cultures, if that makes sense.” [P.B1]*  *“…just because someone is from a particular background, of course it doesn't mean that they are culturally competent. So I think it also goes back to the training we get.” [P.B10]*  *“I think they need to be more training or how managers can be more culturally competent as managers as well and-and as I said, I do think these things trickle down to then the care that we provide” [P.B10]*  *“I think going back to that idea of education, training for the provider is really important because I think a big thing that contributes to outcomes is feeling that your therapist doesn't understand you and there's not that sort of connection for them to appreciate, sort of where you're coming from with the difficulties you're having.” [P.B11]* |
| Use existing cultural adaptation and cultural sensitivity guidance and resources | *“There's like a positive practice guide that we should be using” [P.B1]*  *“So there's the-the kind of manual, there is a manual that helps with cultural competencies and sort of like CBT and at Step 2, so that's a useful resource” [P.B3]*  *“…maybe looking at translated materials online so. I can send them as resources to them.” [P.B4]*  *“there's the positive practice guidelines that I'm kind of aware of. I I wouldn't be able to quote them to you, but I think they've influenced my thinking.” [P.B5]*  *“It's just been like the norm for people to read things like the positive practice guide for BAME and positive practice guide for perinatal and all these other things that we should be doing because that helps us, especially when it's an area where we don't really know that even when we do know, we just, I just want to know a bit more about how more I could do, I don't know much about this culture or this community, what could we do more etcetera and just taking ideas from that like I appreciate you as a quite a long document, but it actually makes you better as a clinician.” [P.B13]*  *“Well, I know of like, you know, positive practice guides and stuff like that. And I do-do refer to them probably not as much as I should, but-but occasionally” [P.B7]*  *“I know the positive practice guide and I've read through that-that. Yeah, that's quite helpful actually to get like generic guidelines on how to adapt the sessions, including the length of the sessions.” [P.B4]* |
| Make materials that are inclusive, diverse and relatable for different minoritised ethnic groups readily available | *“So, in every booklet that we have, there's always like a pseudo patient, a patient who is currently experiencing that problem. So, let's say in a stress booklet, it'll be someone with stress. Anxiety will be someone with anxiety. And actually, now thinking about it, all them patients, they’re names like Amanda or Josh and yeah, maybe like a change in that as well, because I'm just thinking someone from BAME background, how would they feel about that? How-how relatable? Because the whole point of having that pseudo-patient there is for it to be relatable. So, when you read it, you relate to it and how relatable would that be?” [P.B12]* |

**Outreach, uptake and engagement**

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| **Second-order theme** | **Third-order themes – suggested improvements** | Example supporting quotes |
| Outreach, uptake and engagement | Work with communities to combat stigma | *“But I also think we could also for example…a Black women demographic, we know that …for African women, churches are very important area. So, I guess for example like engaging more with churches to just like normalize talking about mental health because I can't speak for all cultures. But I know generally mental health in general is a bit of a stigma” [P.B6]*  *I think that's what more services need more services need; outreach projects they need to be going to the communities they need to be offering services in the communities. We need to be doing things in the Community because again, there's still a lot to be about people coming to the hospitals still, you know, all of that stuff. So we need to be not only offering well-being workshops and you know, kind of introductory kind of just normalizing workshops around general Mental health and things like that [P.B13]*  *“…workshops and stuff in the community to kind of reduce some of that kind of fear of having to kind of access a service.” [P.B2]*  *“So, when you're there in the trenches where they are you, you know, you can help them and-and just become, yeah, I guess more familiar with your community. They become more aware of you. It takes a bit-maybe a bit of a stigma of the mental health off, that everybody's experiencing challenges.” [P.B9]* |
| Support early intervention | *“…but maybe just focusing on like early intervention because we've seen women that are from an older age demographic who have been having to endure uh, you know, chronic mental health difficulties and not really accessing the support. And by that point we might assess them and they're too complex for IAPT and so they don't start here and they have to move, move further up and that process also takes longer as well.” [P.B3]*  *We need to be doing things in the Community because again, there's still a lot to be [done] before people [are]coming to the hospitals still, you know, all of that stuff. [P.B13]* |
| Focus more on psychoeducation as a part of the early treatment process | *“…also because I guess in lots of cultures like we thought mental health is thought about differently to how it is in like Western kind of Britain. And so I think giving people information is really helpful” [P.B1]*  *“…but perhaps that could be clarified early on and to kind of make that link there between like physical and mental health or even just running like those psychoeducation groups could be run via the GP like a GP can directly refer to it psychoeducation group and it can be held at the practice and just things like that that make it a little bit easier rather than going to a different hospital or somewhere else.” [P.B3]*  *“So I think first of all explaining kind of very thoroughly what the sessions are gonna involve, because I think a lot of people have quite especially they've got access therapy before. And and if they're from a kind of my minoritized group where mental health is quite stigmatized, then they might have a very stereotyped vision of what therapy involves….maybe explaining the difference between different kinds of therapy. So, for example, guided self-help versus counselling or guided self-help versus psychotherapy because they might be going into it with different expectations and it might not be what they wanted to do, and that could be a reason for dropout as well.” [P.B8]*  *“… I think it's being about really, really transparent with people about what CBT can and can't help with and being kind of realistic about you know, working people with people over a short time frames, being realistic about what we might be able to achieve together and making sure that the person has a really good understanding of what- What's CBT is how how it works and like having a very clear kind of set of expectations about how the how the sessions might work.” [P.B7]*  *“…start the intervention by doing some psychoeducation and then we move on to- and what the intervention actually is, and I think we almost need to stay in that kind of psychoeducation phase for a little bit more just to kind of understand, reduce the stigma” [P.B3]* |
| Actively engage in service promotion, community linkage and increasing awareness | *“Getting engagement? Yeah, I-I definitely think more community work needs to be done in terms of like linking and I feel like a lot of our referrals from- for people from ethnic minority backgrounds tends to be through GP rather than self-referral.”*  *“…there are certain kind of pathways for people to access the service like through the GP and-and that sort of thing. But sometimes the GP might not mention it and I think we don't have much of a presence in community spaces, like I'm thinking churches or cafes or gyms or, you know, places where people kind of from a variety of groups might go and trust sort of like, say their pastor or or someone kind of religious figure or something.” [P.B5]*  *“having a specific outreach role I think would be really, really helpful. So like having somebody whose job-maybe they could be a therapist too, but they had a part of their job that was about kind of going out to communities and and speaking to people and just making them aware of kind of the service exists and having a chance for people to ask questions. Because even the whole idea of psychology might be very like sort of weird for for some people.”*  *“…start going into GP practices and do a bit more outreach work.” [P.B4]*  *“I think it like I'm not sure kind of where it's advertised that we do have interpreters. It probably is on the website somewhere, but I think it probably needs to be a bit clearer and especially at the GP surgery kind of again we get a lot of GP referrals and then it actually turns out that they do need an interpreter and they've just kind of struggled through the GP appointment and it's not been picked up on. They might have very, very like good levels of English, but like, it's probably easier for them to tell people how they feel with sensitive issues uhm in their native language and it's always an option that we want people to be aware of. So maybe kind of making GP's more aware that they have, that we have interpreting the services available, putting it on the website and a lot of the community outreach when we kind of go into the community and kind of like let people know about our service, maybe making it quite clear there as well in community centres and things where our services kind of advertised as well.” [P.B8]*  *“… you know when you're doing your advertising and stuff like that, like, do you have, like, black women that, you know, when when you do advertising on, like, ‘come to iCope’ like is is a black person, particularly a black woman, maybe a black woman of a particular age? And are they kind of represented? Are you kind of in the the the Community spaces? Again start typically, maybe like touch if if you if you can do projects in Black Barber shops, can you also do them in like black salons?” [P.B7]*  *“…making them aware that we exist and making them aware of the adaptations we can provide for them in terms of do they need an interpreter, do they need longer sessions, do they need a specific kind of therapy and what we are able to offer me very kind of clear about that because I think the vagueness can confuse and deter people a little bit sometimes. And yeah, in terms of what we do offer in that awareness” [P.B8]*  *“…the makeup of the borough being- the diversity as it is there, being sort of a higher expectation for us to have um a better understanding that's gonna help us link in with communities, be a bit more- Just be a bit more open, seaming and and friendly in terms of the accessibility of iCope to communities when we at the moment perhaps have very limited knowledge of particular diversities, particular ethnic backgrounds and cultures. It can make it seem silly, actually, that we'd expect those people to reach out if we don't have the knowledge and understanding to always benefit them.” [P.B11]*  *“I think the other thing that comes up is, for me is sort of marketing and advertising almost. And and I don't think this is just I don't think this is all IAPT services per se. Umm so I I know there are some services that actually seem to market and advertise the service really well in terms of gearing it towards and making sure it's inclusive of different ethnic minorities, different diversities. But I certainly don't think all IAPT services do. I don't think they're marketing is always particularly inclusive.” [P.B11]*  *“I think that's what more services need more services need; outreach projects they need to be going to the communities they need to be offering services in the communities…So we need to be not only offering well-being workshops and you know, kind of introductory kind of just normalizing workshops around general Mental health and things like that, but then also even doing groups and things in those communities.” [P.B13]*  *“Yeah, maybe like going into the community and spreading the word a bit more like handing out flyers. And maybe if they like translated in their language then- yeah, they can read and know that our service is there for them… let's spread some translated materials as well around.” [P.B4]*  *“…there are certain kind of pathways for people to access the service like through the GP and-and that sort of thing. But sometimes the GP might not mention it and I think we don't have much of a presence in community spaces, like I'm thinking churches or cafes or gyms or, you know, places where people kind of from a variety of groups might go and trust sort of like, say their pastor or-or someone kind of, religious figure or something…having a specific outreach role I think would be really, really helpful. So, like having somebody whose job-maybe they could be a therapist too, but they had a part of their job that was about kind of going out to communities and-and speaking to people and just making them aware of kind of the service exists and having a chance for people to ask questions. Because even the whole idea of psychology might be very like sort of weird for-for some people.” [P.B5]*  *“Sometimes within IAPT is that it can feel a bit removed from the community and in my experience umm, of working with sort of some of the minority ethnic background women that I have worked with, The sort of link between iCope and them has perhaps come from somewhere within the community and-and it feels like a perhaps we're not always taking advantage of community spaces where we could reach out to people rather than wait for them to reach out to us…And then maybe it's a case of us needing to be the ones reaching out and making sort of more connections within the community.” [P.B11]* |
| Target specific demographic groups and communities | “*And I feel like more Community work needs to be done. I know in a in a in a different IAPT service they went to say for example, they went to an Eid festival to increase engagement within that local community for their IAPT service. And that was something that actually brought back to our team to think about what we could be doing to improve that, because I think it's about normalizing kind of, mental health and having those kind of difficult conversations with people.” [P.B2]*  *“if there's, like therapists or they, they have, like, health topics, health in the church. So for example, that's an opportunity for therapists to You know, talk about mental health and raise awareness about services that are available.” [P.B6]*  *“… you know when you're doing your advertising and stuff like that, like, do you have, like, Black women that, you know, when-when you do advertising on, like, ‘come to iCope’ like is-is a Black person, particularly a Black woman, maybe a black woman of a particular age, and are they, kind of represented? Are you kind of, in the community spaces? Again, start typically, maybe like…if you can do projects in Black Barber shops, can you also do them in like Black salons?” [P.B7]*  *“I think first would be like more outreach work and it's something we're definitely looking at this year. I mean, I'm going to be delivering some outreach work on what we do in the service to some Bangladeshi woman in a few weeks. So, things like that.” [P.B12]*  *“But when I worked in [NAME OF OTHER LONDON SERVICE] and some therapists that spoke Punjabi would go to this like Desi radio station and like and promote the service and that was really helpful because people that listen to that wouldn't necessarily-like it might not be that common to kind of talk about mental health and think about it. So, I think those targeted things…so there's like a Tamil centre where we would try and sort of establish links. So, I think that doing tailored things with the local community like thinking about what kind of groups of people are in our borough…” [P.B1]* |

**Service availability and delivery**

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| **Second-order theme** | **Third-order themes – suggested improvements** | **Example supporting quotes** |
| Service availability and delivery | Make changes to interpreter and translation processes and services | *“And CPD is something that we're looking into cause we want to increase the use of interpreter work within our assessments and treatment. So encourage kind of, engagement.” [P.B2]*  *“…it's really good if the interpreter is consistent every week. So somehow like making sure we are booking in the same person for the next 10 weeks.” [P.B4]*  *“I think it like I'm not sure kind of where it's advertised that we do have interpreters. It probably is on the website somewhere, but I think it probably needs to be a bit clearer and especially at the GP surgery kind of again we get a lot of GP referrals and then it actually turns out that they do need an interpreter and they've just kind of struggled through the GP appointment and it's not been picked up on. They might have very, very like good levels of English, but like, it's probably easier for them to tell people how they feel with sensitive issues uhm in their native language and it's always an option that we want people to be aware of. So maybe kind of making GP's more aware that they have, that we have interpreting the services available, putting it on the website and a lot of the community outreach when we kind of go into the community and kind of like let people know about our service, maybe making it quite clear there as well in community centres and things where our services kind of advertised as well.” [P.B8]*  *“…it's really good if the interpreter is consistent every week. So somehow like making sure we are booking in the same person for the next 10 weeks.” [P.B4]*  *“…maybe a bit more of a policy in terms of how we manage interpreting with different languages … so that we all know, I guess like a structure in a way.” [P.B8]* |
| Allow more flexibility in how services are delivered (e.g. being able to offer longer sessions, patient preferred format of online or face to face, or extend the number of sessions) | *“I-thinking about when I work like interpreter cases and things like that as well, even just like long longer sessions as well. So kind of adapting that in just so that we can, obviously you have an interpreter, it's gonna take time for them to interpret the information. So having longer sessions.” [P.B13]*  *“I can think of a woman from, not necessarily similar background to me, but a woman I have worked with and where especially if we're using a an interpreter the only thing I would do differently is that I may I-I would have just allowed slightly longer sessions.” [P.B6]*  *“For me I had to do this one specific assessment using telephone interpreting. So yeah, it was quite interesting. I-I was able to contain him, but it also meant that in the 50 minutes I wasn't able to do the questionnaires, which is a requirement for IAPT…if we could get like maybe 1 and a 1/2 hours instead of 50 minutes for a session with that interpreter, having that flexibility” [P.B4]*  *“…thinking about when I work like interpreter cases and things like that as well, even just like long-longer sessions as well. So, kind of adapting that in-just so that we can, obviously you have an interpreter, it's gonna take time for them to interpret the information. So having longer sessions.” [P.B13]*  *“But I think just if it was a standard to basically even have a bit more, I guess, I don't know if that's possible, just like even just having 7-8 sessions in terms of like, because 6 sessions is very brief. I know it works. I've seen amazing things it’s done, you know, in terms of helping clients. But I think when you need firstly to kind of socialise the client to CBT.” [PB.13]*  *“…because they-they haven't wanted to have sessions during that time, they felt like they wouldn't be in the right frame of mind, or we tried to change the time of the session so that it-it-they can get more from more from it. So, we just-I guess I've just it's not a huge adaptation. It's just kind of thinking together with the client about how can we apply what we were doing and kind of keep that going now that your day is looking really different and there's different kind of challenges for you throughout the day. [P.B1]*  *“…let's say we have three to six half an hour sessions but instead of three to six half an hour sessions we might do like [a] 15 minute session every week? So, it's not too overwhelming for them.” [P.B12]*  *“…knowing what other people have done and that's being done across kind of like making adaptations and being flexible, and I think it is done at a service level in terms of making accommodations for, kind of, people…depending on what they need [P.B2]*  *In particular, a suggestion was made around flexibility in the process of discharge on the basis of lack of engagement, especially for people experiencing language and communication challenges:*  *“…being a bit more flexible with people and if they can't attend appointments like for example, I'm seeing it a lot where kind of we have a policy where they don't attend twice, it's a discharge and like that's absolutely fine. But like a condition of the discharge is they have to make contact within certain amount of time and if they can't kind of speak the language, it's difficult for them to.” [P.B8]*  *“…we're having face to face sessions because she said she would prefer that because of the language barrier and she's fine face to face and I can understand her.” [P.B4]*  *“So, another one would be seeing patients face to face actually that's-that's another adaptation and change...So, that's an adaptation as well, and you know, making sure that we will meet the need and also of course, when we see patients with like disabilities or hearing problems or any hearing issues or anything like that. Then again, we kind of adapt and make sure we give them a space and see them face to face. [P.B12]*  *Some therapists specific expressed ideas they’d had about providing therapy in group formats for specific groups of women from minoritised ethnic communities:*  *“I thought I was thinking that maybe doing groups with women from minoritized backgrounds and to kind of share their experience”. [P.B3]*  *“And women's only groups in the local communities or kind of like mother and baby groups and kind of things like that” [P.B2]*  *“I think offering groups and for um people from different minoritized groups and yeah, especially for women. Yeah, it's a group sessions. It could be based on ethnic background and-and more specific problems for women from particular backgrounds and-and umm, I think they can be incredibly healing, and they really can, I think be co-created.” [P.B10]*  *“So, I think again, it's very related to access in that sense… I mean, aside from the general routes of GP, self-referral like there aren't really any routes that I'm aware of- this specifically helping my minoritised, kind of, women access our service. Like aside from like the general advertising, it would be good to see maybe specific pathways that kind of inform minoritized women about our services and the services that we offer because we have like perinatal services, we have long term conditions services…So I guess more work and more of a pathway to be set up at service level in terms of that.” [P.B8]* |
| Collect data and use it to inform service delivery | *“And it it's interesting because national identity is not every-. It's kind of in that section of the records that we can fill in, but it's not a required one. So we often have someone's ethnicity, but we don't have the national identity. And I just always us because I just think it's really helpful to know.” [P.B1]*  *“I guess often the question is posed rounding up: 'why are people not um accessing the service?' um but there wasn't much sort of follow up and there was just sort of this sense that this is an ongoing piece of work to increase access and yeah, and but I didn't think that's changed that much in my time…I haven't seen the latest um stats around people who are accessing the service but just based on my own sort of caseload and and I supervise as well…SO I do ask all the people I supervise to, in their supervision summary, to state the ethnicity of the patient that was missed and so it just help the have a sense of just who they're working with on an individual basis and just sort of overall give me a bit of a picture of who might be coming to the service.” [P.B10]* |
| Use research findings to support and improve practices for minoritised ethnic groups | *“I just think like it's really important to have the research to back up the the practice and I think that more, yeah more … I think it's it's really important that this kind of stuff keeps going and that we're getting the evidence to make decisions and have money and put that towards the things that we need.” [P.B3]*  *“ I think quite a lot of research and is is already been done around what what, what can help is backing implementation, its very slow. It doesn't happen at all. So I think so much more needs to be done. And in terms of how we carry forward the the recommendations and suggestions from whether it's the- And like the clinical psychology students who do a a a service related project name during their placement. It's so, so much has already been done there. And it links in and from from what I have observed and looked into doesn't seem like much taken forward. So I think there's been a range of recommendation” [P.B10]*  *“…that extra bit of work to make sure that you're familiar with the Sort of ethnic diversities within your borough that are very likely to come up as well as the sort of ones that are perhaps a little bit less likely, but still prevalent and thinking about where you might need to sort of make those adaptations even from the start...” [P.B11]*  *“there's like, this study, I cant remember when it was done. But there's like a A there's behavior activation for Muslims. So that was they had quite a lot of that had quite a lot of like research and things that worked well etcetera. So that's things- I mean I haven't read it for a while, but when I initially read it was like OK, give me some ideas of how things we could do in terms of adapting and like incorporating people's spiritual needs and particularly if they are following the faith” [P.B13]* |
| Increase the availability of alternative services and treatment options to meet patient need | *“… I've kind of spoken with the management team about, kind of, how can we make things a bit more sort of flexible or a bit more open, but it seems to- I think the management team are supportive when you ask, but it-it will go back to 'yes but we are CBT service' so like the-the system is quite like…So I think I think they're quite kind of mindful of, you know, offering flexibility and that sort of thing. But there's a certain level that you can't go beyond like there's a certain rigidity for sure, yeah.” [P.B5]*  *“So, like we-we might have the sessions, but it won't be the most effective because maybe it's not CBT that they need. Maybe it's counselling.” [P.B4]*  *“So, I think their counselling provision for sure is something that they need to sort out…I think when it comes to women from minoritized backgrounds is that there's that there's a lot of certain age demographics is that there's a-a sense of that, the stigma and being silenced in a way or like not having our mental health difficulty heard and so initially counselling is so helpful because it gives you that space to process some of that stuff and explore it. Yeah, I think the counselling provision would be really good to push.” [P.B3]*  *“Again, I try and work sort of outside of these sort of, diagnostics. You know, OCD, depression, that kind of thing, but the the-I don't know. uh, narrative, let's say, in in the IAPT system is that you need to be treating OCD or you need to be treating a particular condition. And my experience is that people just do not fit on the whole into these boxes. So I think maybe one adaptation is that just being flexible, I think. So, I'm not going to kind of shove the CBT down people's throats if it's not working…. It's trying to be more flexible within a system that I think is quite inflexible.” [P.B5]*  *“So I think again, it's very related to access in that sense… I mean, aside from the general routes of GP, self referral like there aren't really any routes that I'm aware of- this specifically helping my minoritized, kind of, women access our service. Like aside from like the general advertising, it would be good to see maybe specific pathways that kind of inform minoritized women about our services and the services that we offer because we have like perinatal services we have long term conditions services…So I guess more work and more of a pathway to be set up at service level in terms of that.” [P.B8]* |

**Workforce**

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| **Second-order theme** | **Third-order themes – suggested improvements** | **Example supporting quotes** |
| Workforce | Increase and showcase diversity in the workforce | *“yeah, I-I just have that mindset that even before any word is spoken, if a service user...and even sees sort of of a diverse team of people in terms of therapists, or I think both sides. We just feel comfortable just, just from that alone.” [P.B9]*  *“…there's one other male, and they're either training or just qualified PWP, and that's it. So yeah, like one of the females is in management in 2 hours clinical time. So it's-it's all.” [P.B9]*  *“I'm thinking about recruitment and actually having a, a diverse workforce that is more reflective of the community that we working within…” [P.B10]*  *“I think It's important that workflow should represent the population that its serving and I think that's what a lot of the issue is. If I'm being honest. Like I don't think there's much representation. “ [P.B13]*  *“…although I say yes, we've got a-we've got colleagues and practitioners you know that that are from BAME background but there-there is still not that- how do I put into words? And there isn't enough still, I don't think. I think it's been increasing over the past few years. Like, we've been, you know, there's been more recruitment into trying to make sure that the place is diverse and that we have a diverse workplace, but some are obviously better than others, some do it great…But it's harder sometimes in some services there might not be a lot of people from BAME backgrounds.” [P.B12]*  *“I think recruitment is very important as well. Just like being across like someone from a similar background. As I mentioned before, sometimes it's not what people want, but at the same time it can be really helpful and add value to-to the-the therapy. So, I think recruitment is-is important.” [P.B3]*  *“…yeah, I just have that mindset that even before any word is spoken, if a service user...and even sees sort of-of a diverse team of people in terms of therapists, or I think both sides. We just feel comfortable just, just from that alone.” [P.B9]*  *“And we're trying to change our website as well to just make it feel more culturally acceptable across kind of all backgrounds. So, we're trying to create a mission statement and so that people can kind of read it even just thinking about, like the way our reception looks and like things like that and having pictures of staff and like showing that we are a diverse team because I think that's just as important in terms of getting engagement from patients and trying to make it look like that. We are like a diverse team who are able to a diverse range of patients as well.” [P.B2]*  *“And I think also at another kind of maybe barrier sometimes is also at HI level is that I think the higher up you go into psychology, the more ‘White’ it becomes or more female-dominated or more, I don't know, the more middle-class-dominated it becomes and so you have to do PWP for two years until you can become an HIT. And so if you find that PWP isn't for you, you-you might not go up to HIT…It's not very minoritized if there are criteria to get further up, that's, I guess, cancelling more people out…But I would say like, the recruitment is important in focusing on” [P.B3]* |
| Allow for patient preference of the provider of treatment (e.g., gender, culture or ethnicity matching) | *“So sometimes I get clients who like want to see only a Black therapist. And there's like ohh there's only two in the service, you know. So it's like things like that I think make it, make it tricky,“ [P.B13]*  *“I have not had it with Black women. I've had it a few times with Muslim women and again, they've kind of said, well, there's this like, yeah, cultural, religious that- So I do get that I think I think I did have a like one or two times where it they didn't want to purely because it it was like a sexual assault which again is like a gender thing.” [P.B7]*  *“…every year new trainees come they get trained on how to do BA [behavioural activation], worry management et cetera et cetera, they get put forward they just see the patients but they're missing that skill on when the patient just come through who was from a BME background. How do they actually support them? Should they have a think about do they need in a different therapist? Do they want to have a therapist that relates more to-? That question is never asked. So that question is actually not asked during, you know, a lot of assessment templates like would you prefer to have a therapist from a similar cultural background to you?” [P.B12]*  *“Sometimes it's more about who they might not want to work with, and I guess I tried to make it feel as safe as possible, that they can stay if things you know in lay terms, just-just say it as it is. What-what would help you feel safe?” [P.B10]*  *“…I think, and this is a bit controversial, but I do think that if like a White therapist is working with somebody from a BAME background, it's a difficult question and I don't know, maybe there's not really a right or wrong, but I do think that there should be something about any concerns that they have about whether-whether they feel like-yeah, there is a power dynamic there.” [P.B6]*  *“If they could of ask in that initial question that there is something that they would like to discuss in terms of their recent culture, we would ask at the end of the assessment, would you have that preference of your therapist to be from a different background? Oh, sorry. Maybe a person of colour? And in that, we're trying to add value to the treatment because- and arguably-that someone from a similar ethnic background could add a certain level of relatability kind of help to, I guess like, then reduce the-the stigma in their mind about mental health difficulties. And so, I guess in that we're trying to add the add more value to the therapy that we give.” [P.B3]*  *“And sort of, I suppose, going back to basics, then I would always explore whether it would be helpful as well for a client to have somebody that would she either associated or not associated with. And that-that sort of ethnic background, if specifically, if that's a factor in their mental health and it sort of goes both ways. Sometimes I think there's an assumption that somebody will benefit from having somebody who is linked with their ethnic background and provide the support they're looking for. But actually, it can certainly -and I've seen it go the other way where actually, like, can make people more uncomfortable if mental health is viewed in a specific way.” [P.B11]* |
| Attract and recruit bi-lingual therapists (people who are trained and who can speak different languages) | *“So in terms of therapist speaking other languages, if you've got less diversity of therapists, and then you have to find a specific person who speaks a specific language. And it it feels more clunky. It's not just kind of naturally in the system I think.” [P.B4]*  *“…ideally, you'd be hiring therapists who actually speak the prevalent languages in your borough.” [P.B11]*  *“So, I think it would be good if we could maybe encourage like people who speak different languages to offer services in their native language if they were to feel comfortable doing so, because I think as well as one thing going for therapy and kind of- the important so yeah, I think that would be good to kind of encourage or maybe provide more support for staff to offer those kinds of things.” [P.B8]* |

**Team and staff support**

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| Team and staff support | Make use of supervision, staff groups and reflective spaces | *“…And we have this once a month and it they started after the George Floyd incident and it's reflective space where we can bring anything that we feel like it could potentially impact our clinical work. But how we could also improve our clinical work and reflect on these things, whether that's kind of like talking about microaggressions or bringing research that is about improving- and you see [inaudible] for people from ethnic backgrounds or minorities. There was like, the B-. I'm gonna say this really wrong.-The BABCP I think like produced it, like a catalogue of papers that was like ‘becoming an antiracist’ or- yeah ‘antiracist’, like CBT practitioner or something and it was really interesting because I have loads of different papers in there about like adaptations you can make for people within like minoritised backgrounds, adaptations you can make when working in like doing CBT with people from these backgrounds and we like discussed these papers within these reflective spaces. We talk about how clinical practice or how things may affect us personally as well” [P.B2]*  *“We've had a lot of training recently around kind of like being comfortable talking about race and we have, we we have regular reflective sessions where we discuss various topics around like race and culture. And like we recently had a reflective session around race and class and things like that. So the, the, the and it's really helpful” [P.B6]*  *“I think also having a safe space where colleagues can go and talk to someone if they are- If they are struggling or they want to make adaptations. I know we have supervisors, but maybe a general service space.” [P.B2]*  *“And just even like speaking to colleagues, you know quite a share resources with them like whatever you you said one have you know, what would you recommend for this fast you client et cetera, what would you recommend for this client? And then just kind of yeah, share resources amongst us as well would be quite helpful”*  *“…there would be like reflective groups since the-the killing of George Floyd, to just talk about like- yeah, the stuff kind of- that comes up with service users of Black origin or like other staff and stuff, so they-they are like pretty hot on it and I'd say and so that that's really lovely. [P.B7]* |
| Empower and support staff at the management and leadership levels | *“I think there needs to be more training on how managers can be more culturally competent as managers as well and-and as I said, I do think these things trickle down to the-the care that we provide.” [P.B10]*  *“Some sort of, you know managers being trained or-or uh on board or I think that is really, really helpful. It just makes it easier because I just have a feeling right now of like holding it all or holding a lot of it. I've got some colleagues who work with me on equality and diversity, but I think something about managers making space for it, and again, you know, they have so much stuff to do, but it sort of feels like it needs to be embedded, thinking about differences needs to be embedded in the whole system. It shouldn't just be a kind of thing that we think of ‘oh, what about differences?’ It's in every-in every new service development or whatever there needs to be this question kind of ‘how can we make this more accessible to more people?’” [P.B5]*  *“And the reason it [dedicated outreach to minoritised communities] worked in the previous service was because they actually the head of the Trust was actually had, you know, he basically worked with the guy in the community and they kind of came with this, you know, pilot project and obviously works so well. So they can hopefully continue it….It's clear there's a need, but we just need someone, you know, high high up to and the funding and all that stuff to actually get that something similar to to that. [P.B13]* |