**BRIEF CLINICAL REPORT**

**Increasing ethnicity reporting on IAPTus to better understand cultural needs accessing a primary care talking therapy service**

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**Abstract**

**Background:** The COVID-19 pandemic highlighted the under-utilisation of statutory mental health care services by minority ethnic groups in the United Kingdom (UK).

**Aims:** Improve ethnicity reporting to better understand the needs of patients accessing a primary care talking therapies service.

**Method:** We conducted a clinical audit to observe outcomes from pre-COVID (2019), first wave of COVID-19 (2020) and 2021 for three broad ethnic categories: Black African/Caribbean, Asian and White British. The intervention was conducted on staff to improve data recording of ethnicity. A patient survey was sent to those identified as having dropped out of treatment from May 2020 to April 2021. A total of 229 patients responded to the survey. The survey asked for reasons that impacted on not continuing with sessions.

**Results:** Quantitative analysis showed a statistically significant difference on discharge outcome between White British and Black African/Caribbean (*p*=<0.0001), Black African/Caribbean patients most likely to drop out of treatment and in 2020 the Asian population was below the recovery target of 50%. Qualitative analysis revealed that therapist factors included lack of confidence in the therapist, and not being listened to; patient factors included neurodiversity, being unsure whether it would be helpful, and confidentiality concerns; service factors included being notified of discharge from the service, remote delivery of therapy, treatment options, and treatment materials.

**Discussions:** Services must work towards improving service provision by capturing hidden disparities and socialising treatment to meet the needs of minority ethnic groups in the UK. The present study recommends culturally adapted treatment and co-producing therapy materials.

**Keywords:** Common mental health disorders; Ethnic groups; Healthcare disparities; IAPT

**Introduction**

The under-utilisation of statutory mental health care services by ethnic minority groups in the United Kingdom (UK) has been well documented over the years, and subsequent reports continue to reveal the disparities in health outcomes among these groups. Research has shown that ethnic minorities are more likely to have negative experiences of healthcare services and worse treatment outcomes compared with their white counterparts (Mead and Roland, 2009). A government report revealed the disproportionately high incidence of Black Caribbean men with mental health problems being more likely to experience the harsher end of services, either over-represented within the prison system or more likely to be seen at crisis (Fitzpatrick *et al*., 2014). Studies further exposed frequent misdiagnosis, or under-diagnosis of Black and minority ethnic individuals when presenting to their healthcare provider where symptoms were routinely ignored (Dawn and Mackian, 2010; Jones *et al*., 2018).

Furthermore, the unequal distribution of infection and death rates of coronavirus (COVID-19) has become a catalyst for the pre-existing systemic issues of racial inequalities that have persisted over time in the UK (Kapilashrami and Bhui, 2020). Since the COVID-19 pandemic it has certainly become apparent that those who face greater societal disadvantages also face greater health risks (GOV.UK, 2020; Kapilashrami and Bhui, 2020). Previous reports revealed that ethnic minorities were more likely to live in the most deprived neighbourhoods in relation to crime and barriers to housing services compared with white British populations (GOV.UK, 2020). Ethnic minorities were also more likely to express concern regarding accessing medical treatment during the pandemic, suggesting help-seeking insecurities and barriers to accessing support (Women’s Budget Group, 2020). Ethnic inequalities in health outcomes expose the racially biased social structures that institutions such as the UK’s National Health Service (NHS) continue to operate under (Kapilashrami and Bhui, 2020).

However, there has been growing interest in research and guidance addressing ethnic inequalities with the aim to improve access to healthcare services. The Black, Asian and Minority Ethnic service user Positive Practice Guide (Beck *et al*., 2019) provides guidance for primary care talking therapies services when working with racially minoritised individuals, such as offering as much choice as possible in terms of time and place of appointments, being flexible around missed appointments, and keeping people engaged whilst they are on the waiting list through telephone or letter contact (Beck *et al*., 2019). Moreover, importance has been placed on community engagement as a form of accessing under-represented voices to direct service development, particularly those who have not accessed mental health care (Beck and Naz, 2019), and the consideration of reviewing the cultural competence of services and implementing culturally adapted treatment (Naz *et al*., 2019). Moving forward, it is therefore important for services to implement and evaluate their practice to ensure meaningful progress is being made.

The present study was conducted in a service located in Brent, a borough situated northwest of London where 33.8% are White British, White Irish and any other White background, 17.5% are Black African and Black Caribbean and any other Black background, and 32.7% are of south Asian and any other Asian background (GOV.UK, 2022). In Church End, Brent saw a devastatingly high number of deaths later related to persistent poverty and racial inequalities (Mohdin, 2020). Pre-COVID-19, the three biggest causes of death in Brent were found to be cancer, cardiovascular diseases and heart disease, all risk factors for COVID‑19, along with obesity especially high in children living in low-income families (Brent Council, 2019). Furthermore, issues around current housing stock have been said to not meet demands, with Brent holding one of the largest temporary accommodation portfolios in the country, an additional risk for overcrowding and poor mental health (Brent Council, 2019).

In addition, whilst high income countries such as the UK had adequate access and supply to the COVID-19 vaccine, it was the hesitancy of vaccine uptake from ethnically minoritised groups which saw more of an emphasis rather than acknowledging the pre-existing lack of trust and accessibility of the public healthcare systems (Khan *et al*., 2021). Studies have reported a longstanding lack of trust for statutory services, lack of culturally appropriate information and advice available, language barriers and prejudice and racism as common barriers for minority ethnic groups (Dawn and Mackian, 2010). Recent national disasters such as the Grenfell tragedy alongside the alarming death rates of COVID-19, where Britain saw with more frequency minority ethnic groups suffering the greatest of loses, demonstrated that statutory services must act with urgency to address the treatment gap.

The aim of the study is to improve ethnicity reporting to better understand the needs of patients accessing a primary care talking therapies service. This study is in response to the National Health Service (NHS) England and NHS Confederation launch to investigate the impact of race and ethnicity on people’s health and will contribute towards informing policy, practice, and service provision.

**Method**

***Study* *design***

This was a cross-sectional study with a clinical audit and online survey.

***Procedure***

This project was conducted within a primary care talking therapies service. The clinical audit was done from September 2020 to February 2021, and the analysis of referral rates and discharge outcomes were done over a 3-year period with the aim of observing trends pre-COVID (2019), during the first wave of the pandemic (2020), and more recent trends (2021). The survey was sent to patients who had been offered or completed treatment between May 2020 and April 2021. These dates were determined by a change in drop-out rates for specific ethnic groups compared with previous years.

All clinical data from the point of referral to discharge are maintained within a single clinical data system, IAPTus (Mayden, Wiltshire, UK), which is used for all record-keeping. IAPTus allows clinicians to securely record all clinical and non-clinical data (e.g. demographic data, referral source, discharge outcome or referral to other services). IAPTus data were used in the clinical audit.

We conducted a clinical audit to better understand referral rates, recovery rates and discharge outcomes across three broad ethnic categories: Black African/Caribbean, Asian, and White British. The present study has used broad ethnic categories for sufficient sample size to support a quantitative analysis of the dataset; however, the authors of the present study acknowledge that these groups are not homogenous and further work must be done to investigate the distinct cultural differences and experiences in relation to the study topic.

***Intervention to improve reporting of ethnicity***

To address our short-term aim we delivered a team meeting presentation in September 2020; to promote the project we conducted an intervention where we encouraged staff to record ethnicity on IAPTus at triage and assessment stage. A follow-up email in October 2020 was circulated to remind staff to continue to ensure routine documentation of ethnicity on IAPTus. In February 2021, we delivered a presentation to the team on the project’s progress and observed changes of ethnicity reporting since first introducing the project.

***Patient survey***

Following on from our findings from the clinical audit, a survey was sent to 2145 patients via Short Messaging Service (SMS) who were identified on IAPTus as having dropped out from treatment over the past 12-month period from May 2020 to April 2021. Participants were reminded that response to the survey was voluntary. Participants were asked if they consented to the survey and that their responses would be anonymous and used as a part of a service evaluation project.

The survey was a semi-structured questionnaire to support a qualitative analysis. In response to the clinical audit outcomes, the questionnaire asked participants their reasons for not continuing with sessions with the option to describe this in open text. The objective for this framework of analysis was to provide the means for understanding access into a talking therapies service beyond our own assumptions as a service. Where service design is often based on the feedback of service users who complete treatment, the synthesis of qualitative data from an anonymous survey can offer what are often under-represented voices to construct their own narrative in relation to reasons for disengagement.

A total of 229 patients responded to the survey over a 7-day period of the survey being live. The survey asked for reasons that impacted on not continuing with sessions, with the option to detail reasons in their own words.

***Data analysis***

A mixed-method approach was adopted to analyse the data. SPSS (version 27) was used to conduct a descriptive analysis reporting frequencies and percentages, and further detailed multivariate ANOVAs. For qualitative analysis, a conceptual framework of synthesis was adopted (Torraco, 2005). Using the synthesis matrix, each source was critically analysed and rigorously evaluated for major themes, strengths, weaknesses, and critical gaps. The synthesis was conducted in four stages: (1) implementation of a relevant literature search; (2) identified key ideas and elements; (3) organising the key ideas and elements; (4) synthesising data and building a case for new research intervention. An ‘index card’-like method was employed to identify and organise the key ideas and elements from stages 2 and 3. Each pile or category of organised ideas was re-arranged into (a) a logical flow of information; (b) compare and contrast; and (c) critiqued primary findings and discussions.

The syntheses allowed for common themes in the literature to be identified. Data were categorised using a thematic coding approach. The key themes selected for analysis were discussed with the wider research team based on their relatedness and frequency concerning the review topic.

**Results**

***Quantitative findings from the clinical audit***

Figure 1 shows the decrease from February to April in ethnicity reported as ‘not stated’ on IAPTus in 2019 and in 2020 following our intervention. This lower trend remained consistent for the remainder of 2020 following our staff intervention and promotion of the project in a team meeting.

A series of multivariate ANOVAs were conducted with the dependent variables therapy outcome (completed treatment and dropped out) and year (2019/2020) as independent variables, and with outcome and ethnicity as dependent variables. Significant associations were examined further by non-parametric testing (Tukey’s *post hoc* test). A statistically significant effect was obtained, Pillai’s trace=*F*4,5888=8.967, *p*=.000. There was no statistical difference on year and therapy level of intensity (*p*=.244, 95% CI [–.058, .015]). There was a statistically significant effect of year on discharge outcome (*p*=.00, 95% CI [–.122, –.054]).

Tukey’s honestly significant difference (HSD) test for multiple comparisons found that the mean value of therapy intensity (Step 2 or Step 3) was significantly different between White British and Asian (*p*=.028, 95% CI [.00, .11]). There was a statistically significant different between Asian British and Black British (*p*=.004, 95% CI [–.13, .02]). There was no statistically significant effect of therapy intensity between White British and Black African/Caribbean group (*p*=.629).

Tukey’s HSD test for multiple comparisons found that there was a statistically significant difference on the discharge outcome between White British and Black African/Caribbean (*p*=.000, 95% CI [–.07, .03]). There was also a statistically significant difference on discharge outcome between Asian and Black African/Caribbean (*p*=.029, 95% CI [–.13, –.02]). There was no statistically significant difference on discharge outcome between Asian and White British (*p*=.065, 95% CI [.00, .09]).

***Qualitative findings***

The survey respondents reported 33.2% White British, 27.9% Asian, 16.1% Black African/Caribbean, and 22.8% mixed heritage.

There were three broad themes with subthemes. Therapist factors included subthemes of lack of confidence in therapist, and not being listened to. Patient factors included subthemes of neurodiversity, unsure whether it would be helpful, and confidentiality concerns. Service factors included subthemes of notified of discharge from the service, remote delivery of therapy, treatment options, and treatment materials.

***Patient factors***

*Neurodiversity*

One patient explained, ‘I have autism and I was treated as not because I don’t have diagnosis from UK. I fail to attend some appointments exactly for the reason above’; another also similarly stated, ‘I have ADHD so the diary was difficult to keep up with’.

Access for patients of neurodiversity requires urgent attention. The present study findings suggest that therapists could benefit from training in adapting materials for this population group which would be valuable for improvement in access.

*Unsure whether it would be helpful*

Some patients also described feeling unsure if the service could meet their needs. One patient mentioned, ‘I wasn’t sure if the service would be helpful at that time’, and another questioning ‘Whether they’d be helpful at all’. Similarly, another mentioned that they ‘Didn’t feel benefit’, ‘I didn’t feel that it could help’ and ‘I don’t know if this is for me’.

The cause of reluctance to engage in therapy from the respondents of the present study is not fully understood and further conversations with patients to better understand will be valuable. There are many barriers to accessing mental health treatment, and often it has been suggested that stigma is associated with reluctance to disclose emotional problems to health professionals (Khan *et al*., 2007). In addition, previous research has shown patient awareness and understanding of self-help interventions take time to develop; particularly, the understanding of the therapist role in guided self-help interventions (Khan *et al*., 2007).

*Confidentiality concerns*

One patient reported, ‘I was afraid of where my information would go and how much I could tell’ and another simply stated ‘confidentiality’.

The stigma associated with accessing treatment for mental health difficulties is very familiar, and consequently comes with increased fear and concern related to data recording, confidentiality and sharing of patient information. A previous review found in a population of first responders the most common stigma-related items reported by participants were fear of services not being confidential and fear of accessing psychological support impacting the individual’s career (Haugen *et al*., 2017).

***Therapist factors***

*Lack of confidence in the therapist*

One patient stated that the ‘therapist did not feel very knowledgable’ and another respondent explained that they felt the ‘therapist was not qualified or understanding/knowledgeable of BDD’.

Patients from the survey also described feeling that they were not being understood. One patient reported: ‘Never felt fully understood’; and another explained the therapist ‘kept misinterpreting what I said, I have never experience this before and never missed an appt before but this was just too much too ask and I felt that she wouldn’t understand me if I told her the truth. She was also a trainee and I think she too text book with learned behaviour rather than genuine and natural’.

For positive outcomes in healthcare, the value of trust as a necessary condition in treatment is well understood (Brown *et al*., 2009). To build on this condition of trust, trust is based on inter-personal interaction; for instance, a professional who smiles, appears to listen intently, and maintains eye-contact are concepts associated with positive outcomes (Brown *et al*., 2009).

*Not being listened to*

Patients also frequently described not feeling heard, one respondent stating, ‘waste of time, constantly had to repeat myself’, and another similarly saying ‘I felt that it was a bunch of questions asked over and over at every appointment and that made me want to disengage’, ‘the therapist did not listen to me properly during the limited sessions we had, and I did not feel confident they understood my needs or situation’. One patient explained that ‘Sessions were very short – often only 20 minutes and some of my concerns or issues felt brushed or explained away and so I didn’t feel listened to’.

One patient reported that ‘the therapist didn’t allow me to talk’ and similarly another recalled their experience detailing that ‘the therapist kept yawning and did not seem interested in the session or engaged to listen. Also referenced spirituality, religion several times in an attempt to comfort me. Made me feel worse’.

The condition of trust also relies upon good communication, in that ideas provided by the professional is congruent with that of the patient and to achieve this that communication is bi‑directional. Research has shown the value of the professional playing the listening role to allow for the patient to have adequate space to convey their concerns and experiences (Brown *et al*., 2009).

***Service factors***

*Notified of discharge from the service*

Patients also described their experience following discharge from the service due to a missed appointment. One respondent explained, ‘was not able to make the appointment and was given a discharge letter. Which I felt was disgusting considering there is a long process for actually getting started’. Another stated that, ‘One time I have an appointment but did not contact me and I did not hear from the service’ and similarly another patient reported that they ‘didn’t hear from the service’. Finally, some reported that ‘the therapist didn’t call me back’, ‘rejected me from missing one phone call’, and another detailing ‘I missed the email and forgot to respond back in time’.

It has been estimated that the financial cost of missed appointments is around £360 million per year in the UK (Stone *et al*., 1999) and most of this accounted for by non-attendance in primary care and hospital out-patient clinics (Mitchell and Selmes, 2007), studies proving that early non-attendance increases the risk of further non-attendance and disengagement with services, but reasons for this are complex and not fully understood.

The present study revealed a common reason for disengagement was patients stating that they did not hear from the service following a missed appointment. In addition to the present study, previous research has shown significant predictors of non-attendance were related to forgetting about the appointment, getting the date wrong, lower socioeconomical status, poor communication between the referring practitioner and the patient, longer delay between the referral and the appointment (or between assessment and treatment), and poor quality of therapeutic alliance as reasons for missed appointments (Miller and Ambrose, 2019; Mitchell and Selmes, 2007;).

It has been suggested that text message reminders were found to be useful, reminding patients of clinic appointments via SMS or telephone calls to improve attendance (Miller and Ambrose, 2019). A previous study reported that 94% of patients contacted directly by their therapist attended compared with only 43% attendance when there was no contact (Miller and Ambrose, 2019).

*Remote delivery of therapy*

The service underwent changes in how we delivered therapy during the COVID-19 pandemic and government enforced restrictions, and alternative options included video call and telephone. One patient recalled their experience explaining that ‘phone talking I felt isn’t the same and my anxiety would always be so bad as it would be an early call and just could ignore it easier or be distracted with something else if I was physically there maybe then I would’ve followed through’. Another patient mentioned that they ‘felt weird to talk about difficult things on Zoom’ and one person reported ‘they will only do online sessions’.

Although there is growing evidence to support the effectiveness of the use of digitalised therapy for the treatment of common mental health disorders, evidence remains very limited on the long-term impact and its effectiveness in maintaining longer term change in patients (Rauschenberg *et al*., 2021). Moreover, further research on the response to digitalised treatment would need to be conducted on diverse populations and those with additional needs such as learning disabilities would need to be considered.

*Treatment options*

The service offers self-guided help based on CBT techniques either via telephone, group or an online computerised course; the service also offers cognitive behavioural therapy (CBT) and counselling as additional treatment options. One patient recalled, ‘I felt pressured to choose CBT over counselling and it wasn’t the right fit for me’. Another patient reflected, ‘I don’t think the right type of therapy was offered. I was given CBT for my anxiety but for me, trauma is a much bigger problem and that wasn’t bring addressed at all’.

One patient explained, ‘I was only offered group sessions. This is not useful nor did I feel comfortable which U expressed before being referred’. One patient mentioned, ‘Did not like the help being offered’ and similarly another reported ‘I don’t like CBT’.

A previous cross-sectional survey revealed that those who reported their needs were unmet are more likely to experience poorer treatment outcomes than those with a preference met (Williams *et al*., 2016). The study concluded that routinely assessing and meeting patient preferences, where feasible, can contribute towards improved outcomes of psychological treatment (Williams *et al*., 2016).

*Therapy materials*

During treatment, patients are provided with additional therapy materials and information to support their treatment. Patients reported that ‘the material was hard to relate to, I don’t think the mood tools workshop was right for what I was dealing with’ and another stated ‘focusing on one area mostly and I felt it was not the right approach or perhaps therapist’.

During treatment, patients are also at times asked to complete tasks in between sessions. One patient described their experience of this, ‘Had previous sessions, too much homework/practical sessions which made my situation worse – too much overload’ and another patient similarly explained that the ‘therapist kept giving me homework which I recorded on the day and completed and kept telling me I was doing it the wrong way’.

A major aspect of self-guided therapy is homework and often there is an expectation for patients to implement cognitive behavioural techniques outside of the sessions. This concept relates to viewing the self as the mechanism for change in therapy (Khan *et al*., 2007). This perception of requiring the patient to take on an active role may not be expected or familiar to many accessing support, and certainly takes time (Khan *et al*., 2007). However, this may conflict with the short-term nature of guided-self-help in a primary mental health care setting and relate to disengagement. A possible solution suggested in previous research is providing information on the nature of treatment prior to the start of sessions and this then reinforced by the therapist during the first session (Khan *et al*., 2007).

**Discussion**

Our study is a response to the Advancing Mental Health Inequality Resource (National Collaborating Centre for Mental Health, 2019) which recommends services to use data and research to identify the needs of the local population and draw upon their community as a valuable source of knowledge and guidance to advance equality.

Our results suggest that there was a difference in service performance during the pandemic for ethnic minority individuals where the clinical audit revealed recovery rates gradually declining pre-COVID-19 pandemic (2018) compared with the years during (2019 and 2020) for all ethnic groups. More specifically, the service saw a significant drop-out and recovery rate for the Black African/Caribbean population. The present study shows similar findings to a report conducted in a south London primary care talking therapies service that found all racial and ethnic minority groups were less likely to be treated (Harwood *et al*., 2021). These findings suggest that services need to be better equipped to address minority ethnic mental health difficulties at a primary care level.

Qualitative analysis revealed therapist factors included lack of confidence in therapist, and not being listened to; patient factors included neurodiversity, unsure whether it would be helpful and confidentiality concerns; and service factors included being notified of discharge from the service, remote delivery of therapy, treatment options, and treatment materials.

People with learning disabilities are more likely to develop mental health problems than the general population, studies reporting prevalence rates of between 20.1 and 40.9% (Bailey, 2007). Having a learning disability can often mean that the individual has fewer psychological and material resources accessible to them to deal with adversity (Gravell, 2012). The Improving Access to Psychological Therapy (IAPT) Positive Practice Guide suggests guidelines and recommendations on developing materials to better improve access for those with a learning disability. For instance, ‘Easy read’ refers to the presenting of text in an accessible, easy-to-understand format. In an IAPT service, this means that referral letters, leaflets about the service, minimum data set questionnaires and maps to the venue need to be adapted (Dagnan *et al*., 2015), and clinicians should consider this before sharing standardised therapy materials with those who have disclosed a learning disability.

Our findings also show how a patient’s experience of their therapist impacted reasons for disengagement. Here, it is important to acknowledge whether IAPT offers conditions for therapists to flourish under the pressures of recovery rate targets and outcome measures (Naz, 2020). Services should adopt spaces where therapists can be creative and have more agency in sharing how best the delivery of care could be, particularly if the workforce is reflective of the local community (Naz, 2020).

Nonetheless, IAPT services are making huge improvements towards access. The present service is currently working on projects in response to the COVID-19 pandemic and health inequalities, particularly introducing the Brent Health Inequalities Project which sees working collaboratively with faith leaders, community workers, working with colleagues from the Grenfell Health & Wellbeing service and other statutory services within the local community to provide better integrative and tailored care.

Moving forward with the idea of tailored, targeted care, treatments that account for cultural values, beliefs, norms and practices have been shown to lead to better health and treatment outcomes (Jones *et al*., 2018). The service is now working towards developing and improving the availability of translated materials for therapists to provide to patients, and to also consider alternative methods of delivering information such as pre-recorded links for better access to service information for patients. Further work and research, however, will be required to better understand the processes and suitability of applying culturally adapted and culturally sensitive talking therapy in practice.

Psychological services are encouraged to increase their cultural knowledge and awareness so that healthcare providers can better understand the varying forms of expression and approaches to managing mental distress among different ethnic groups. Cultural competence involves a broad awareness of culture and the skill to be able to effectively treat ethnically diverse clients (Jones *et al*., 2018). Cultural competency in therapists who demonstrate culture-specific knowledge regardless of ethnic background is valued and hence representation of recruitment of therapists from the local community who share similar lived experience as the patients can provide valuable knowledge into the barriers patients may face.

A limitation to the present study is that the data were collected from one service which may not be generalisable to the wider population. Another major limitation is that the present study used broad ethnic categories in the quantitative analysis where these groups are not culturally homogenous and have distinct cultural differences and experiences. In addition, the online survey may not have been accessible; for instance, the survey was in English and individuals who have literacy difficulties may not have responded.

Future aims will be on focus groups to better understand differences in experiences of a primary care service across more specific ethnic groups, and to consider alternative forms of contacting people to ensure voices such as refugee and asylum seekers do not go under-represented.

***Future recommendations***

To address the higher drop-out rates in Black African/Caribbean populations, further research and consideration of the application of culturally adapted CBT is necessary to progress towards treatment that is appropriate and sensitive and in line with the values and norms of the patient. One approach for IAPT services could be to consider cultural consultations among staff with leads from difference services within the trust to create a space to reflect on how diversity, culture and race might impact our interactions, using this space to adopt lessons learnt from the community and instilling the value of culture in a meaningful way. The aim would be to improve cultural competence and reduce unconscious bias and prejudice assumptions. This process requires working collaboratively across policy makers, service leads and individual caregivers.

Another method of improving cultural competency is from the involvement of service users. Following the internal audit and qualitative survey of disengaged service users, one of the actions will be the recruitment of service-user consultants to guide service planning and treatment offers. Services could work to involve patients who disengaged from the service to help improve service provision, co-produce service materials and address what change can be made to better meet the needs of the local community and to further ensure appropriate cultural adaptations to treatment are made.

Improved guidance and information related to what therapy is, how the service works and its policy on attendance, co-produced with service users to ensure this information is accessible to patients accessing care are further suggestions. Finally, a possible timeline of events from referral to discharge patients may be useful, and will serve the purpose of providing clear guidance to help manage expectations and ease patient uncertainty.

**Data availability statement.**The data that support the findings of this study are available from the corresponding author, M.M., upon reasonable request.

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**Ethical standards.**The Trust’s information governance team conducted a review for both the clinical audit and online survey. This assessment determined that NHS ethical approval for the present study was not required as it was a part of a service evaluation and quality improvement project. Treatment was not denied to anyone eligible for access to this service over the duration of the project, and informed consent was obtained from the participants involved in the present study. This material is the authors’ own original work, which has not previously been published elsewhere.

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**Figure 1.** Graph showing ethnicity recorded as ‘not stated’ on IAPTus in 2019 and 2020.

**Table 1.** Percentage recovery rates across three years

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2018 | 2019 | 2020 |
| Asian | 52.4 | 51.3 | 47.3 |
| White British | 60.5 | 59.3 | 51.9 |
| Black African/Caribbean | 54.8  | 54.5.  | 53.3 |

**Table 2.** Percentage treatment adherence in 2019 across three broad ethnic groups

|  |  |  |  |
| --- | --- | --- | --- |
|  | Asian | White British | Black African/Caribbean |
| Low-intensity treatment, completed treatment | 31 | 30 | 23 |
| Low-intensity treatment, dropped out (unscheduled discontinuation) | 16 | 13 | 18 |
| High-intensity treatment, completed treatment | 34 | 40 | 34 |
| High-intensity treatment, dropped out (unscheduled discontinuation) | 19 | 17 | 25 |

**Table 3.** Percentage treatment adherence in 2020 across three broad ethnic groups

|  |  |  |  |
| --- | --- | --- | --- |
|  | Asian | White British | Black African/Caribbean |
| Low-intensity treatment, completed treatment | 38 | 34 | 30 |
| Low-intensity treatment, dropped out (unscheduled discontinuation) | 14 | 11 | 12 |
| High-intensity treatment, completed treatment | 35 | 42 | 39 |
| High-intensity treatment, dropped out (unscheduled discontinuation) | 13 | 13 | 19 |

**Table 4.** Means of dependent variables and independent variables

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Dependent variable  | Ethnicity  | Year | Mean | Standard error | 95% Confidence interval Lower Upperbound bound |
| Therapy level of intensity  | White British | 2019 | 2.570 | .020 | 2.531 | 2.608 |
|  | 2020 | 2.533 | .020 | 2.514 | 2.592 |
| Asian  | 2019 | 2.528 | .023 | 2.484 | 2.572 |
|  | 2020 | 2.479 | .025 | 2.430 | 2.527 |
| Black African/Caribbean | 2019 | 2.582 | .024 | 2.548 | 2.616 |
|  |  | 2020 | 2.583 | .025 | 2.534 | 2.631 |
| Discharge outcome | White British  | 2019 | 1.301 | .018 | 1.266 | 1.337 |
|  | 2020 | 1.238 | .019 | 1.202 | 1.275 |
| Asian  | 2019 | 1.353 | .021 | 1.312 | 1.394 |
|  | 2020 | 1.270 | .023 | 1.224 | 1.315 |
| Black African/Caribbean | 2019 | 1.430 | .023 | 1.386 | 1.475 |
|  |  | 2020 | 1.313 | .023 | 1.267 | 1.353 |