Cultural Sensitivity in IAPT Services for Ethnic Minorities

A thesis submitted to the University of Manchester for the degree of Master of Philosophy (MPhil)

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Abbreviations

Abbreviation	Explanation
PWP	Psychological Wellbeing Practitioner
IAPT	Improving access to psychological therapies
CBT	Cognitive behavioural therapy
cCBT	Computerised cognitive behavioural therapy
IA	Indian American
HA	Hispanic American
BME	Black minority ethnic
BSA	British South Asian
TULIP	Cultural Sensitivity Audit Tool IAPT
CMD	Common health disorders
GBD	Global burden of disease
MDD	Major depressive disorder
UK	United Kingdom
ICD-10/ICD-11	International classification of diseases 10/11
COPD	Chronic obstructive pulmonary disease
NSSI	Non-suicidal self-injury
DSH	Deliberate self-harm
NICE	National institute for health and care excellence
GP	General practitioner
AI	American Indian
HA	Hispanic American
VA	Veteran American
GAD	Generalised anxiety disorder
GAD-7	The generalised anxiety disorder score measure (GAD-7)
PHQ-9	The patient health questionnaire
AMP model	The access to mental health in primary care model
ATSPPHS	Attitudes toward seeking professional psychological help scale
ASIAS	Arab self-identity acculturation scale
IRS	Islamic religiosity scale
AIKS	America; psychological help scale

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Abstract

A thesis submitted by Kanza Khan for the degree of Master of Philosophy in the Faculty of Biology, Medicine and Health at The University of Manchester. Entitled 'Cultural Sensitivity in IAPT for Ethnic Minorities'. Submitted 2017.

Introduction: Cultural sensitivity is traditionally viewed as the awareness and facilitation of ethnic minority needs. The optimum delivery of psychological therapy for ethnic minority patients is through ensuring high levels of cultural sensitivity within services. Exploring the levels of cultural sensitivity within the Improving Access to Psychological Therapies (IAPT) services is relevant to this field due to the under-utilisation of treatment in this population where prevalence of anxiety and depressive disorders is primarily high. The aim of this research was to explore contributing barriers to accessing psychological therapy for ethnic minorities and levels of cultural sensitivity within IAPT services in the North West of England.

Methods: A systematic review was conducted to capture barriers to accessing psychological therapy for ethnic minorities residing in western countries. Qualitative methods were employed to explore a patient's journey through the IAPT patient pathway and IAPT staff roles. Semi-structured discussions with an IAPT North West of England Training Commissioner were used to confirm findings and facilitate the recruitment of IAPT staff members for focus groups. A focus group to capture staff perspectives of barriers to accessing IAPT for ethnic minority patients was conducted. Discussions with experts were used to capture opinions for the development of a cultural sensitivity audit tool (TULIP). The next phase aimed to develop TULIP for IAPT services and guidelines for completion. A mixed methods design aimed to conduct the first TULIP audit of IAPT services. Finally, we aimed to capture feedback for TULIP and the TULIP: Guidelines from IAPT services managers completing the audit at each service.

Results: The key findings from the research project include the capturing of barriers experienced by ethnic minorities to western countries accessing IAPT services. The systematic review results found 5 key barrier themes (comprising of 21 sub-themes): Patient related barriers, Community related barrier, Family related barriers, Health service related barriers and Practical issues related barriers. We thoroughly looked into the IAPT patient pathway, qualitatively interviewed staff and an IAPT commissioner, gaining an understanding of the barriers to accessing IAPT for ethnic minorities. We presented the findings to a meeting of experts and developed the final audit tool. The collective stages of the project led to the penultimate development of TULIP: cultural sensitivity audit tool for IAPT services and TULIP: Guidelines. Finally, the researcher's conducted a TULIP: audit of 11 IAPT services in the North West of England. Key audit findings revealed that only 9% of IAPT services facilitated culturally adapted written materials. A specific policy for working with ethnic minority patients was only available at 18% of services and no services had culturally adapted workbooks or manuals.

Conclusions: Key findings highlight barriers experienced by ethnic minorities accessing psychological therapy services in western countries and more specifically in accessing the IAPT services for ethnic minority patients residing in the United Kingdom. The final results of our nine studies led to the development and implementation of the first cultural sensitivity audit tool for IAPT services, capturing areas of decreased levels of cultural sensitivity within and across services included in the audit.

Declaration

I, Kanza Khan, declare that no portion of work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Dedication

I dedicate this thesis to my Mother, Father, Brother and Grandmothers, without whose prayers and support this would not be possible.

Preface of the Author

Kanza Khan completed her Undergraduate degree in Psychology (BSc) in 2015. Following which she continued to pursue her career in mental health by working at the University of Liverpool, as a Child Mental Health Research Assistant. Through which she gained core skills in developing a Psychosocial Horticulture Therapy intervention for young people and mixed methods skills for conducting, capturing and reporting results of the intervention. Kanza continued to showcase her skills in academia by presenting the findings in a symposium at the CAMHS conference, Northampton 2016.

Kanza has the ambition to progress in her career and has been keen to learn about different areas of mental health, while working at the University of Liverpool, she was also working part time at Harvey House (alcohol and substance misuse unit), Lancashire. Here she not only co-facilitated a variety of occupational therapy interventions with patients, furthermore she also conducted an audit which she later presented at an international conference, The European Psychiatry Congress (EPA), Madrid 2016.

Kanza has always had a drive to thrive in the field of mental health, to research and deliver a high quality of care for patients. She understands that verbal and written communication is the fundamental basis to providing support to mental health patients. Paying attention to the rapidly changing political landscape in Europe, NHS financial constraints and shifting of tasks from Secondary to Primary Care, the forth coming years will no doubt be turbulent yet exciting time. With this in mind, with the guidance of her supervisor, she has written this thesis in order to better emphasis the needs of mental health patients, with the broader aim of facilitating a positive impact to provisions of care for mental health patients.

CHAPTER I
INTRODUCTION

Chapter I INTRODUCTION

1.1 Prevalence and burden of anxiety and depression

a) Global Perspective: Common mental health disorders (CMD) is used as a broad term for minor psychiatric disorders such as depression and anxiety. A systematic review and meta-analysis reporting the prevalence of common mental health disorders (CMD) across 155 surveys found a 17.6% prevalence of CMD across 59 countries. Lifetime prevalence of CMD's was estimated as 29.2% across 85 surveys. In low income countries prevalence for CMD's was reported (32.2%) as higher than high income countries (22.7%). Researchers combined prevalence for males and females and found that across 148 studies the average prevalence for period mood disorders was 5.4% and average life time prevalence was 9.6%. A gender difference was found with women (32.1%) reported as having higher period prevalence for CMD's as compared to men (15.2%). Lifetime prevalence was however similar for both genders (females, 32.1%, Males, 31.6%) (Steel et al. 2014).

The global lifetime prevalence for anxiety disorders is reported as 16.6% (Starcevic 2006). A review reporting lifetime and 12 month prevalence rates for anxiety disorders in western countries identified lifetime prevalence rates (13.6% - 28.8%) and 12 month prevalence rates (5.6% - 19.3%) (Michael et al. 2007). A systematic review looking at global prevalence of anxiety disorders reported the results of 87 publications from 44 included countries. Results indicated that the global prevalence of anxiety disorders is 7.3%. The review found that 1 in 14 people globally are affected by a type of anxiety disorder at any given time. Further to this, globally 1 in 9 people were estimated to suffer from an anxiety disorder per year (Baxter et al. 2013). A more recent review of 83 surveys reported prevalence of anxiety disorders was reported as: period prevalence (6.7%) and life-time prevalence (12.9%). Women were found to have higher prevalence for anxiety disorders (period anxiety disorders 8.7%, lifetime anxiety disorders 18.2%) as compared to men (period anxiety disorders 4.3%, lifetime anxiety disorders 10.1%) (Steel et al. 2014).

Researchers have cross-analysed and assessed prevalence and incidence of depression in the 6 regions of the world as used in the Global burden of disease (GBD) 2000 project. These regions included: Europe, Americas, Africa, Eastern Mediterranean, South-East

Asia and the Western pacific. The global prevalence of depression was estimated as 7.28% (depression 12,044/6,045,170,000 global population). Women were found to have a higher globally prevalence for depression (1.97%) than men (1.66%). Global incidence of depression was estimated as affecting every 31 in 100,000 men as compared to the higher incidence in women, every 49 in 100,000 (Üstün et al. 2004).

A systematic review including 120 publications (74 western countries: central/eastern Europe, North America, South America and Australia, 46 non western countries: East/Southeast Asia, South Asia, Asia pacific, high income, Africa and Middle East) investigated global prevalence and incidence of major depressive disorder (MDD). Prevalence of global MDD was estimated as 4.7% and global incidence of MDD was estimated as 3% (Ferrari et al. 2013a). A recent systematic review reported years lived with disability (2005 - 2015). The review reported the percentage of individuals living with depressive disorders (18.2%), MDD (17.8%) and anxiety disorders (14.9%) (Feigin 2016).

Common mental disorders (CMDs) (anxiety and depressive disorders, panic disorders and phobias) are the second leading cause of disability adjusted life years worldwide (DALYs). Further to being a prominent cause of global disability depressive disorders are also ranked as the third highest source of burden of disease (WHO, 2016). Literature suggests that anxiety has a significant influence on the progression of two types of disability (activity of daily living and light housework disability) in older American women. The study investigated the effects of anxiety on baseline disabilities, results showed that women suffering with anxiety were more likely to develop further disabilities (Brenes et al. 2005). The high prevalence of disabilities as a result of anxiety and depressive disorders can extend to affecting patients in their daily working life. Research shows decreased productivity and higher absenteeism in depressed workers as compared to healthy people (Lerner and Henke 2008). Literature suggests that CMD's are the greatest cause of work place absenteeism in developed countries (Joyce et al. 2016). The burden of these disorders does not only affect patients but have also been shown to extend their effect to their children. Children of parents experiencing workless-ness as a result of depression have been found to be at greater risk of psychosomatic symptoms and lower wellbeing (Daly 2016).

b) European perspective: European prevalence of anxiety (14%) and depressive disorders (6.9%) makes them the most common type of mental illness in Europe (Wittchen et al. 2011). Approximately 1 in 15 people suffer from depression annually in Europe and if all common mental disorders are included this figure increases to every 4 of 15 individuals (WHO, 2012; WHO, 2013). An updated review of literature describes the burden of mental disorders in Europe. The review reports that anxiety disorders held the highest prevalence for mental health problems in Europe (14%). Anxiety disorder prevalence accounted for (panic disorder (1.8%), agoraphobia (2%), social phobias (2.3%) and specific phobias (6.4%)). Age differences were found for generalised anxiety disorder (GAD); prevalence with patients above 65 (3.4%) as compared to patients between ages 14-65 (1.7%). Mood disorders in Europe represented 7.8% of the sample with highest prevalence for MDD (6.9%) (Wittchen et al. 2011).

Due to the high prevalence of mental illnesses in Europe the approximate burden of cost in 2005 was 277 billion euros (Wittchen et al. 2011). Literature reveals that anxiety and depressive disorders have had an impact on increasing sick leave, early retirement and increased treatment rates (Wittchen et al. 2011). As research has established, anxiety and depressive disorders have a significant burden on disease in Europe, further research has discussed the influence of these disorders on increased mortality rates. A recent Danish cohort study revealed that the combination of anxiety and depressive disorders significantly increases mortality rates (Meier et al. 2016).

c) United Kingdom (UK) perspective: The estimated UK prevalence of depression in 2007 of 1.24 million was predicted to rise by 17% to 1.45 million in 2026. Prevalence of anxiety disorders in the UK in 2007 were predicted as 2.28 million individuals with an estimated increase of 12% to 2.56 million individuals in 2026 (McCrone et al. 2008). Between 2012/2013 statistics indicated that depression and anxiety affected approximately 6.1 million individuals (IAPT 2013).

The adult psychiatric morbidity survey was conducted in 2007 to capture prevalence of mental health problems in UK private households. This was the third survey of its kind collecting data on adults' aged16-64 residing in a private household. The survey reports prevalence of mental health problems in the UK categorised under the following parameters: gender, age, ethnicity, region, marital status, nature and severity of treatment and service use. Participants were assessed for common mental health disorders (CMD's) using the revised clinical interview schedule (CIS-R). For depression alone 4-10% of the UK population were reported as being diagnosed at some point in their life. Out of the sample 16.2% of participants CIS-R scores reflected prevalence of one or more CMD disorders. Anxiety and depressive disorders were present in 9.0% of these participants. The study reflected that mixed anxiety and depressive disorders were present in over half of participants identified for CMD's. As compared to men, women had higher prevalence of CMD's representing 19.7% of the sample. Gender prevalence of CMD's was found to be most prevalent in women aged between 45-54 years of age (25.2%) and men between 25-54 years of age 25-34 (14.6%), 35-44 (15%) and 45-56 (14.5%) (McManus et al. 2009a).

Literature also suggests that in the UK there is an under diagnosis of anxiety and depressive disorders. As a result, patients' symptoms may increase in severity by the time they access primary care. Literature suggests that these disorders can have an influence on physical, social and occupational functioning (Kessler et al. 2002). If anxiety and depressive disorders are left undiagnosed and untreated these disabilities can become long-term as well as increasing the risk of mortality (Zivin et al. 2015).

McCrone et al. (2008) estimated total costs for mental health disorders (excluding substance misuse) in the UK by taking into consideration direct costs (service costs, health and social care, informal care, criminal justice system) and indirect costs (lack of employment). The study estimated costs for 2007 and the predicted costs for the next 20 years. The total estimated cost for depression in 2007 was reported as £7.50 billion with a prediction of an increase to £8.34 billion in 2026. The combined estimated total costs of anxiety disorders in the UK in 2007 were £8.94 billion with a predicted increase to £9.74 billion in 2026. These findings reflect the financial burden of anxiety and depressive disorders in the UK and the predicted increase in both prevalence and financial burden over the next 10 years. The estimated costs of lost earnings were reflective of loss of employment influenced by these disorders. The difference in estimated cost of treating depression and anxiety disorders (£2.92 billion) as compared to predicted lost earnings (£13.52 billion) highlights the detrimental financial impact of the under treatment of depression and anxiety disorders in the UK (McCrone et al. 2008).

1.2 Symptoms and burden of anxiety and depression

In the UK, Depressive symptoms are categorised according to the International classification of diseases (ICD-10). Symptoms include: low mood, low energy and enjoyment, reduced activity, reduced concentration and interest, tiredness, sleep is often disturbed and appetite is often reduced, reduced self-confidence and self-esteem, mild guilt, feelings of worthlessness. Somatic symptoms often associated with depression include: psychomotor retardation, loss of pleasurable feelings, weight loss and reduced or lack thereof libido(ICD-10 2010;Ferrari et al. 2013b). The severity of depression is determined by the number of simultaneously presented symptoms, the intensity of these symptoms, the duration of symptoms and the extent to which these symptoms impair daily functioning (Haddad and Gunn 2011).

Depressive disorders often occur on a single occasion, single depression episodes are regarded as occurring due to depressive reaction, psychogenic depression or reactive depression. Mild depressive disorder is categorised as having relatively normal functionality in daily activities with two or three presented symptoms. Medium depressive disorder is categorised by difficulty in daily functioning with four or more presented symptoms. Severe depression is categorised by the presentation of several symptoms, including in particular feelings of low self-esteem, guilt, worthlessness and suicidal ideologies. Patients suffering from severe depression often present with somatic complaints. Depression without psychosis can be diagnosed as; agitated depression, major depression and/or vital depression. Depression can also be recurrent; the onset can begin from childhood and endure from weeks to months. Recurrent depression is categorised as: recurrent depressive disorder, current episode mild, recurrent depressive disorder, current episode moderate or recurrent depression and/or current episode severe without psychotic symptoms. Another type of depressive disorder is Dysthymia, described as a chronic type of depressive due to the sustained symptoms for several years. Symptoms are however not severe enough to warrant diagnosis for mild, medium or severe depressive disorders. Dysthymia can include: neurosis, personality disorder, neurotic depression and persistent anxiety and depression(ICD-10 2010). A patient may be diagnosed with MDD when their 5 out of the 9 possible depression symptoms persist for most of the day for most days during a 2 week period (Haddad and Gunn 2011). Depression is well recognised in literature and medical practice as being comorbid in psychiatric, medical diseases and substance abuse disorders. Literature reflects that unrecognised comorbidity of depression with other conditions can have devastating effects not only on the health of the patient but can also more widely effect family and friends (Kupfer and Frank 2003).

Anxiety disorders are categorised by the ICD-10 as including: Phobic anxiety disorders, agoraphobia (agoraphobia without history of panic disorder, panic disorder with agoraphobia), social phobias (anthropophobia, social neurosis), generalised anxiety disorder (anxiety neurosis, anxiety reaction, anxiety state), mixed anxiety and depressive disorder, other mixed anxiety disorders (anxiety depression (mild), other specified anxiety disorders, other specified anxiety disorders and anxiety disorder (ICD-10 2010). The symptoms associated with general anxiety disorder include: recurrent feelings of "nervousness, trembling, muscular tensions, sweating, light-headedness, palpitations, dizziness and epigastric discomfort" (ICD-10 2010).

The ICD-10 acknowledges that other anxiety disorders, panic disorder, phobic anxiety disorders, agoraphobia and mixed anxiety and depressive disorder often coexist with depression (ICD-10 2010). A longitudinal study found that the prevalence of an anxiety disorder significantly increases the onset risk of MDD (Bittner et al. 2004).The results of another longitudinal study supports this, having found that 47.5% of older adults with MDD in the study had a comorbidity of an anxiety disorder (Beekman et al. 2000).

1.3 Comorbidity of anxiety and depressive disorders and physical health conditions

a) Cardiovascular diseases: As the severity of depression increases the symptoms have a more deteriorating impact on an individual's life. Literature suggests the impact of depression as increasing the potential risk of onset of cardiovascular diseases (Chauvet-Gelinier and Bonin 2016). Between 20-30% of individuals suffering with depression have comorbid cardiovascular disease (Chauvet-Gélinier et al. 2013). Another study found that compared to the general population patients suffering from depression are twice as likely to suffer from cardiovascular diseases (Chaddha et al. 2016). MDD has been found to be associated with higher disability adjusted life years (DALYs) for both suicide and ischemic heart disease (Ferrari et al. 2013b). A UK cohort study investigating the relationship between depression and the onset of cardiovascular diseases revealed that out of the 1,937,360 participants, 94,432 had experienced a cardiovascular problem. The cardiovascular occurrences included: stable angina, unstable angina, myocardial infarction, unheralded coronary death, heart failure, cardiac arrest, transient ischemic attack, ischemic stroke, subarachnoid haemorrhage, intracerebral haemorrhage, peripheral arterial disease or abdominal aortic aneurysm (Daskalopoulou et al. 2016). The comorbidity of depression and cardiovascular disease increases rates of mortality to a higher risk than suicidal death (Kozela et al. 2016). Further to this literature reflects that comorbid anxiety and depression can suggest a risk of cardiovascular problems in patients suffering from type 2 diabetes (Bruce et al. 2016).

b) Diabetes mellitus: An epidemiological study investigating the relationship between comorbid anxiety and depressive disorders in patients suffering from diabetes found that there was a high prevalence of depressive anxiety disorders in diabetes patients. Their results reflected that anxiety disorders were only prevalent in patients who recognised their diabetes however depression prevalence was high in both diagnosed and undiagnosed diabetes patients (Meurs et al. 2016). Prevalence and incidence of diabetes was found to be higher in patients suffering from anxiety as compared to the general population (Chien and Lin 2016). Literature suggests that compared to the general population patients with type-1 or type-2 diabetes are twice as likely to suffer from depression. A meta-analysis of 42 studies investigating the comorbidity of depression and type-1 or type-2 diabetes, found that the likelihood of depression is doubled in diabetic participants as compared to non-diabetic control groups. The studies included within the meta-analysis reported 28% of women suffer from diabetes and comorbid depression as compared to the lower comorbidity prevalence in men (18%). This review also identified that lifetime prevalence of depression was higher in diabetes patients as compared to the control groups. Out of the included clinical studies 14% of diabetic participants suffered from MDD and 26% were suffering from elevated depressive symptoms. The researchers suggest that out of the sample approximately 1 in 3 participants were suffering depression to the extent that it was having a detrimental impact on their daily functioning. Comorbid depression and diabetes was found to reduce adherence to treatment, create difficulty in glycaemic control leading to a higher risk of diabetes complications (Anderson et al. 2001). Comorbid anxiety was also found to increase risk of stroke in diabetes patients (Tsai et al. 2016).

c***) Chronic obstructive pulmonary disease (COPD):*** A study investigated psychological distress in patients with COPD as compared to psychiatric outpatients and the general population. The authors found that patients suffering from COPD had significantly greater psychological distress symptoms than the general population (Wagena et al. 2005). Another study found that patients suffering from COPD have been found to have a higher prevalence of anxiety disorders as compared to the general population (Brenes 2003). Depression and anxiety have a damaging impact on fatigue, impairment in social and physical functioning, and utilisation of health care. When COPD patients have comorbidities with anxiety and depression, the likelihood of compliance with a self-managed treatment plan (E.g. taking regular medication) decreases. COPD patients with comorbid anxiety and/or depressive disorders are more likely to report acute exasperations, reduced functionality and greater difficulty in exercising. Anxiety and depression disorders can be disabling and carry the risk of patients developing suicidal ideologies. Depression and anxiety have been found to increase the likelihood of pre-mature death in chronic obstructive pulmonary disease (COPD) patients (Yohannes and Alexopoulos 2014).

1.4 Deliberate self-harm and suicide

There are global variations in the terminology used for self-harm, these include: non-suicidal self-injury (NSSI), deliberate self-harm (DSH), self-harm and self-injury. Literature for global incidence of self-harm is limited due to the cross-cultural differences in defining self-harm. A systematic review of global literature including the variations of terms used for self-harm was published in 2012. This review estimated that the global prevalence of non-suicidal self-injury was 18% and the estimated global prevalence of deliberate self-harm was 16.1% (Muehlenkamp et al. 2012). In the UK annually about 170,000 hospital patients are admitted due to self-harm (Kapur et al. 1998). A UK study comparing rates of self-harm in young South Asian women and young white women found that the likelihood of self-harm was higher in the South Asian participants (Cooper et al. 2006).

Over 1 million people commit suicide every year worldwide (Ferreira et al. 2015). Suicide occurs in approximately 15% of individuals suffering with mood disorders (Hollon et al. 2002). A longitudinal survey of older age suicide in patients with and without comorbid anxiety disorders in the UK revealed that out of the 25,128 depressed patients committing suicide 17.4% had comorbid anxiety disorders. Researchers found that there was a higher prevalence of suicide risk factors in patients with comorbid depression and anxiety disorders (Oude Voshaar et al. 2016).

1.5 Ethnic minorities in the United Kingdom

The most recent national census of England and Wales showed that South Asian (Pakistani, Indian, Bangladeshi & other) accounted for 6.8% of the population; this includes 2.5% Indian, 2% Pakistani and 0.5% Bangladeshi. Other ethnic minorities included Black groups (3.4%), Chinese groups (0.7%), Arab (0.4%) (Office of National Statistics 2011a).

a) Prevalence, presentation and health service access for anxiety and depressive disorders in British ethnic minorities: The 2001 adult psychiatric morbidity study revealed the highest prevalence of suicide attempts in individuals who identified as 'Black' as compared to the 'White', 'Asian' or 'Other' population in the UK. Highest rates of self-harm and suicidal thoughts were found in 'White' population (McManus et al. 2009a). Prevalence of CMD's varied between both genders and ethnicities. Men across 'Black', 'Asian' and 'White' ethnicities had similar prevalence of CMD's which was consistently lower as compared to females. Women in the UK were consistently found to have a higher prevalence of CMD's as compared to their male counterparts of the same ethnicity. Women who identified as 'White' had doubled prevalence as compared to men of the same ethnicity; this trend was repeated in women who identified as 'Black'. South Asian women had the greatest variation in prevalence to their male counterparts with triple the prevalence of CMD's found in South Asian women compared to South Asian men (McManus et al. 2009a). A systematic review reported prevalence of common mental disorders to be higher in multiple epidemiological studies amongst British South Asians as compared to the white population (Waheed 2010). Prevalence of CMD was found to be higher in British Punjabis as compared to English participants (Bhui et al. 2001).

The EMPIRIC study conducted clinical interviews to investigate the prevalence of common mental disorder (CMD) in the UK amongst white, Irish, Black Caribbean, Bangladeshi, Indian and Pakistani individuals. Higher prevalence for CMD'S was associated with middle aged Pakistani and Irish men as well as older Pakistani and Indian women as compared to the white European population (Weich et al. 2004). The study found that depressive disorders were most prevalent in Pakistani women (26%) compared to white Europeans in the UK (19%). With Pakistani men and women (>50 years old) having higher prevalence of depressive disorders (Gater et al. 2009). In a cohort study older ethnic minorities have been reported as having a higher risk for anxiety and depression, with anxiety and depressive symptoms doubled in the older South Asian population as compared to Europeans (Williams 2015).

Historically literature exploring the understanding of the prevalence of mental health problems in South Asians in the UK has been inconsistent. Authors suggest that this may be due to cultural differences in the presentation and interpretations of symptoms thus leading to South Asians seeking alternative mental health support (Hussain and Cochrane 2004). Punjabi women who suffer from one or more physical problems have been found to be more likely to suffer from depression. In this participant group physical problems were more commonly reported to GP's with depression being most common if somatic complaints and/or physical complaints were present (Bhui et al. 2004). The more common somatic presentation of CMD's in Punjabi participants as compared to the English population may suggest why their CMD's were less likely to be picked up by health care practitioners (Bhui et al. 2001). This creates an inherent barrier to access for ethnic minority patients from a Punjabi background in the UK. A study investigating medically explained and medically unexplained symptoms of anxiety and depression and quality of life in participants of a South Asian background found differences in presented symptoms. The study found that participants with medically unexplained symptoms were presenting with somatic symptoms. Out of the sample medically unexplained symptoms were present in 33% of participants (Duddu et al. 2008).

b) IAPT service access in ethnic minorities

Despite the high prevalence of anxiety and depressive disorders in the UK, only 2.5% all ethnicities who required mental health support accessed the Improving Access to Psychological Therapy services between 2012/2013(IAPT 2013). As discussed there is a high prevalence of anxiety and depressive disorders in the British South Asian population, (McManus et al. 2009a;Bhui et al. 2004;Bhui et al. 2001;Hussain and Cochrane 2004;Waheed 2010;Duddu et al. 2008;Gater et al. 2009). Despite the expectation that an ethnic population with higher prevalence of CMD's would have greater access to mental health support literature suggests otherwise (Bécares and Das-Munshi 2013). The most recent national psychiatry morbidity survey in the UK revealed that as compared to the white population, participants who identified as 'Black' or

'South Asian' were less likely to access primary care for mental health problems (Cooper et al. 2013;McManus et al. 2009b). It has been suggested that British women from a Pakistani decent have greater social support than their white counterparts and this may be why they are less likely to access mental health care (Hussain and Cochrane 2004).

c) Psychosocial risk factors for anxiety and depressive disorders in British South Asians: Literature suggests that depressed Pakistanis experience chronic difficulties (housing, marital, health, other relations, financial and work) at a higher rate than white Europeans in the UK (Husain et al. 1997). South Asian patients in central GP practices in Manchester with medically unexplained physical symptoms have been found to have lower health-related quality of life and higher levels of depression and anxiety as compared to patients with medically explained symptoms (Duddu et al. 2008). In a community based survey conducted in Manchester physical difficulties in depressed patients were doubled in the Pakistani population as compared to white Europeans. Depressed older patients from Pakistani origin experienced greater physical health problems and problems with close relationships (Gater et al. 2009). There are 4 factors that have been suggested as being culturally specific to depression in Pakistani women; social isolation, living with extended family, unhappy marriage and inter-generational conflicts (Hussain and Cochrane 2004). Taking the previous literature into consideration, researchers suggest that explanations of depressive disorders require culturally adapting to become relatable and acceptable for Pakistani women during diagnosis and treatment (Hussain and Cochrane 2004).

A hospital based study investigating diabetes and chronic heart disease risk in male British Asians, white men and Indian Asians found that British Asians and Indian Asians had a higher prevalence of Diabetes mitosis as compared to their White counterparts. Risk of heart disease was also found to be higher in British Asian men and Indian Asian men as compared to White men (Dhawan et al. 1994). A community based study in London supported that prevalence of coronary heart disease was higher in the British South Asian population (Pakistani, Indian, Bangladeshi) as compared to the White population (McKeigue et al. 1993). Finally a study comparing the influence of Cardiovascular disease on Type 2 diabetes prevalence between British South Asian and white participants revealed that prevalence of both disorders was higher in the British South Asian population as compared to the White British population (Barnett et al. 2006). A retrospective cross-sectional study found that prevalence of COPD was lower in British Black and British Asian participants as compared to their White British counterparts (Gilkes et al. 2016). A study in the UK found that higher COPD prevalence in British South Asians as compared to British African-Caribbean participants (Calvert et al. 2012). Our previous discussion about comorbidity of anxiety and depressive disorders with the chronic health conditions; cardiovascular disease (Chauvet-Gelinier and Bonin 2016;Chaddha et al. 2016;Ferrari et al. 2013b;Daskalopoulou et al. 2016;Kozela et al. 2016;Bruce et al. 2016) , COPD (Wagena et al. 2005;Brenes 2003;Yohannes and Alexopoulos 2014) and diabetes mellitus (Yohannes and Alexopoulos 2014;Brenes 2003;Wagena et al. 2005) highlighted the influence of such conditions on the prevalence and incidence of anxiety and depressive disorders, furthermore it highlighted how a comorbidity of any of the chronic disorders with anxiety or depressive disorders can increase severity for either condition. Literature highlighting the high prevalence of these conditions in British South Asians may contribute to an increased risk of developing comorbid anxiety and depressive disorders with chronic health conditions in this population. As literature suggests that anxiety and depressive disorders can increase the incidence and severity of chronic health problems and vice versa, an emphasis can be brought to the risk of development and importance of appropriate support of these conditions for the British South Asian population.

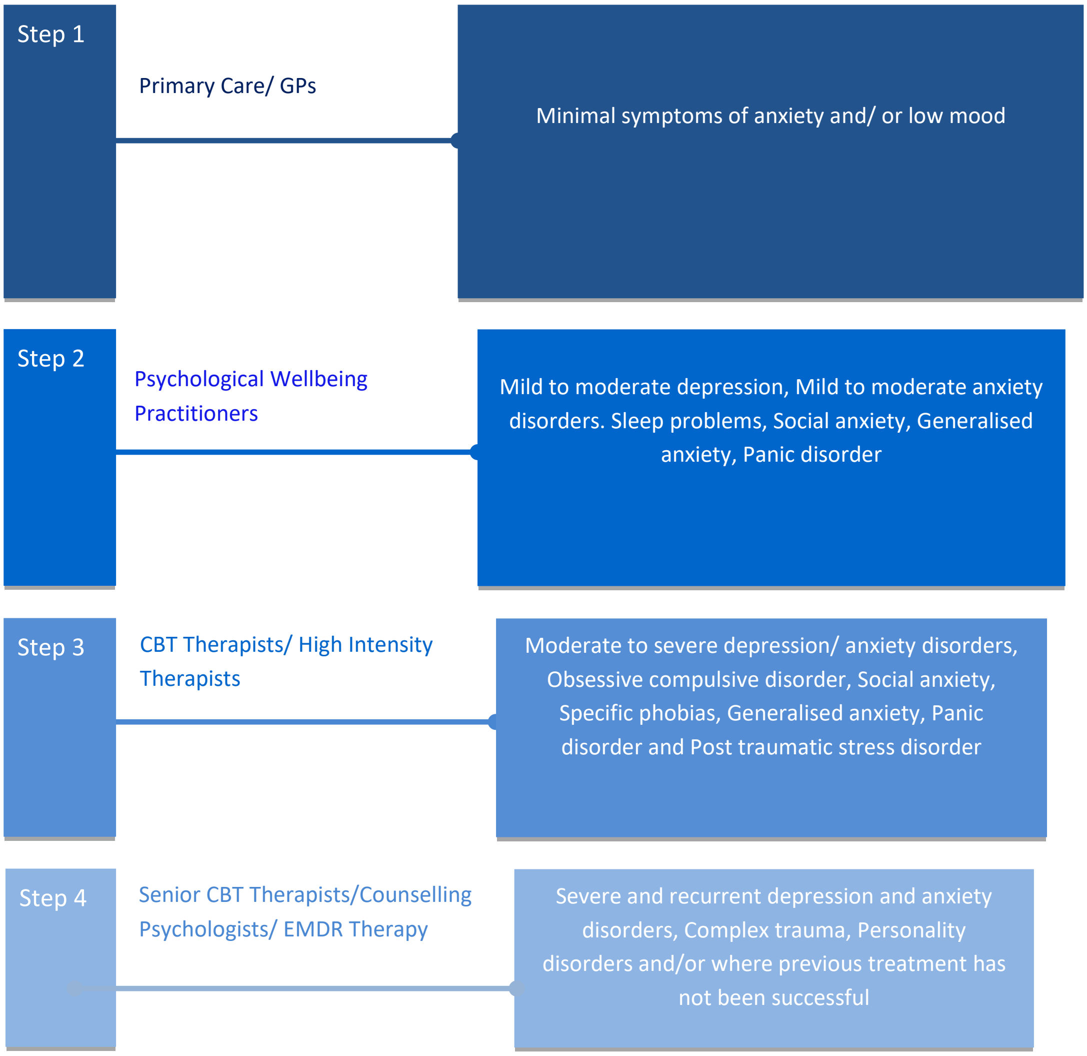
d) Suicide and self-harm in British South Asians: A review paper reports rates of self-harm being consistently higher in British South Asian women between the ages of 16 – 24 years as compared to South Asian men and white women of the same age group (Husain et al. 2006;Cooper et al. 2006;Bhui et al. 2007). Highest rates of self-harm have been found in young Black British women as compared to the South Asian, Black, White, Irish or Other ethnicities included in the cohort study. Although rates of self-harm were found to be higher in young black women the diagnosis and treatment rates within this population were low and under representative of the need (Cooper et al. 2010).

Literature suggests the British South Asian women have high suicide mortality rates in the UK as compared to Black women and women who identified as ‘other’ ethnicity (Till et al. 2015). A study investigating suicide rates in the UK between 1999 and 2003 according to ethnicity revealed that suicide rates in British South Asian women were higher as compared to the general population. Rates of suicide were further elevated in older British South Asian women. British South Asian men were found to have lower suicide rates as compared to the general male population of the UK (South Asian, mixed Asian and white) (McKenzie et al. 2008).

1.6 Treatment options for anxiety and depressive disorders.

The National Institute for Health and Clinical Excellence (NICE) in the United Kingdom recommends psychological and psychosocial interventions as an appropriate treatment for depression alongside anti-depressant medication when appropriate (NICE 2009c). Literature supports that depression and anxiety can be effectively treated with a variety of therapy models including psychological therapy (Manning and Jackson 2015;Delgado et al. 2010). NICE guidelines identify that during a psychosocial or psychological therapy intervention for anxiety and depression it is a requirement to provide patients with information materials on anxiety and depression. Furthermore they recommend that written and audio information be made available in the appropriate language for patients where appropriate. In order to facilitate linguistic matching, a translator not known by the patient may be used. Further to this, NICE highlight the importance of negotiating confidentiality and disclosure of information with family and caregivers of the patient where appropriate. The guidelines suggest that the stepped-care model may be used when delivering psychosocial or psychological therapy interventions for anxiety and depression while also taking into consideration the recommendations above (NICE 2009c).

Please see below *figure 1* adapted from; IAPT Service Stepped Care Model (IAPT 2017).



Step 1 consists of primary care contact and treatment for mild anxiety or low mood, often treated by a general practitioner. Step 2 offers a low intensity intervention for mild to moderate depression and anxiety disorders facilitated by Psychological Wellbeing Practitioners (PWPs). Step 3 is recommended for moderate to severe depression and anxiety disorder treatments, provided by high intensity therapists and Cognitive Behavioural Therapists. Finally Step 4 is recommended for patients who may have been resistant to treatment in step 1-3 and thus receive specialist complex treatment interventions from CBT therapists, clinical psychologists of counselling psychologists (IAPT 2017).

1.7 Barriers to accessing psychological therapy services for ethnic minorities

Despite the higher rate of mental health disorders amongst ethnic minority groups, they appear to have poorer access to mental health services and subsequently, are less likely to receive mental health treatment (Chow et al. 2003;Health and Services 2001;Williams et al. 2007;Tang et al. 2001). The need to understand cultures and ethnicities in order to develop and implement ethnically and culturally relevant interventions has been underreported. The higher risk for mental illnesses such as depression and anxiety associated with ethnic minorities further supports the growing demand to develop a model which is accessible and efficiently implementable, specific to the needs of this population to thus create culturally sensitive mental health services (Roosa et al. 2002). To address this problem, it is important to firstly understand the reasons for poor access from patient, practitioner and service perspectives. Common barriers to accessing mental health services include; lack of awareness and understanding of mental illness and services (Sue et al. 1994), lack of culturally sensitive services including language barriers and poor cross-cultural understanding (Chen and Rizzo 2010;Sentell et al. 2007), cultural barriers (e.g. stigma, religious beliefs, loss of face) (Gary et al. 2004;Lee et al. 2009) and practical barriers (e.g. lack of child care, transport, insurance)(Leong and Kalibatseva 2011). The multifaceted barriers experienced by ethnic minorities accessing mental health services are discussed below.

British minority ethnic patients have reported "lack of friends and relatives nearby", "Lack of official support" and "language difficulties", as one of the highest contributors towards personal stress. The personal stress associated with little family or community support may be reducing a patient's willingness to access care for their mental illness to a greater extent if they simultaneously have a language barrier. A language barrier may not only affect a patient during treatment but may hinder them from initially accessing the psychotherapeutic support they need (Hatfield et al. 1996). Older patients accessing mental health services have reported 'not thinking treatment would help' (Brenes et al. 2015). Adolescents and young people have reflected that lack of knowledge about mental health problems can lead to the under recognition of mental health symptoms and thus not understanding their need for mental health support (Gulliver et al. 2010).

Literature reveals that ethnic minorities have reported experiencing the following personal stress contributing factors, 'housing and employment', the more common of these being “unemployment” and “financial problems” (Hatfield et al. 1996). The difference in socioeconomic class between patient and practitioner may influence a patients preconceptions about services making them reluctant to initially access support (Scheppers et al. 2006).

The clash between a mental health practitioner’s biopsychological approach to mental health and a patient’s religious or cultural approach mental health is often emphasised by racial and cultural differences. GP’s identify that they feel less connected with patients from ethnic minorities, suggesting that this is due to a lack of cultural, racial and religious similarity (IAPT 2009;NHS. 2003). Literature suggests that practitioner related barriers such as skills and attitudes of practitioners, may make access to psychological therapy difficult for ethnic minority patients (Parker and Sommer 2010;Scheppers et al. 2006). Literature suggests that individuals who have grown up in a different culture as well as recent migrants may feel isolated and misjudged in the western culture. This may be attributed to how General Practitioners have reported feeling less involved when working with patients from ethnic minorities who are suffering from mental illnesses (Bindman et al. 1997).

Racism in the context of mental health treatment is seen as the structural integrity a service holds and how it includes or excludes the beliefs of a variety of races (Wellman 1993;Fernando 2010). Diagnosis within institutional mental health systems are currently biased towards westernised needs, with no option of religious flexibility incorporated into the diagnosis process. This can lead to misdiagnosis of mental illness when diagnosis does not take into consideration cultural differences of the presentation of mental health problems (Scheppers et al. 2006;Fernando 2010). Furthermore, differences in cultural etiquettes may vary in patients from British minority ethnic backgrounds, for example a Pakistani woman from a conservative family may have cultural restrictions of entering a mixed gender health care building. (Scheppers et al. 2006)

1.8 Cultural Sensitivity

The ability to be culturally sensitive and communicate appropriately requires having an awareness and an ability to understand and accept the differences and beliefs of individuals from a variety of cultures (Zhu 2011). When communicating with individuals from a variety of cultures, intercultural awareness is necessary in order to deliver treatment which is culturally empathetic. Intercultural awareness has been described as the ability to hold ones' culture while also being aware of the cultural beliefs, values and perceptions of another (Zhu 2011). Cultural empathy is an objective understanding of another's beliefs, these beliefs do not need to be identifiable from the practitioners point of view but identified as different and specific to the patients' cultural background. Cultural Empathy can allow the understanding of a patient's point of view across cultural boundaries. Zhu describes cultural sensitivity as an individual being knowledgeable and accepting of the similarities and differences between cultures. Furthermore ignorance to differences in cultural norms, differences in thought patterns and beliefs may be equated to a lack of cultural awareness(Zhu 2011).

The conceptualisation of what defines 'cultural sensitivity' has varied over time; literature reflects that 'cultural sensitivity', can also be defined as 'cultural intelligence', 'inter/intra-cultural encounters', 'global mind-set' and further labels continue. A systematic review highlights the extensive variations in defining cultural sensitivity in literature, which may lead to confusion in clinical practice and academia (Andresen and Bergdolt 2017). Some views include that the experience of patients or customers accessing services varies across individuals from different backgrounds affecting the extent of perceived difference in what defines a culturally sensitive experience of care/ customer experience. Differences between expectations of service providers and patients/customers can lead to variation in 'inter-culturally determined service encounter quality performance gaps'. Furthermore literature suggests that patients/customers are more likely to experience cultural differences in standard of care in an 'inter-cultural service' dynamic as compared to an 'intra-cultural service' dynamic. Variations in the concept of cultural sensitivity/cultural distance/ inter-cultural encounters and/or intra-cultural encounters and the weight given to this concept, (between and within cultures) results in difficulties in facilitating an appropriate standard of care for patients/ participants/customers (Stauss and Stauss 2016). Furthermore with services becoming increasingly multi-cultural, inter-cultural differences are growing, accentuating differences not only between services and patients but also within service staff. Due to the extensive variance in cultural needs of patients/customers and the understanding of such needs from a service perspective, the facilitation of a greater cultural sensitivity understanding relevant to specific populations is encouraged (Stauss and Stauss 2016).

1.9 Cultural sensitivity and its importance in psychological therapies.

In order to tackle the issues of barriers experienced by ethnic minority patients one must understand the level of cultural sensitivity within psychological therapy services. NICE guidelines highlight that it is essential for clinicians to be culturally sensitive to ethnicities and cultures of patients receiving treatment. This is incorporated into "addressing cultural and ethnic differences when developing and implementing treatment plans"(NICE 2009c).

The ability of a psychological therapy service to facilitate the needs of ethnic minority patients when accessing psychological therapy can be referred to as their level of cultural sensitivity (Zhu 2011). When assessing the cultural sensitivity of a psychological therapy service one must take into consideration barriers to access reflected by the relevant ethnic minority community being referred to. Further to this the service in question must be representative of the local ethnic minority population need, which suggests the need for support of anxiety and depressive disorders due to higher prevalence and lower access rates (Dunlop et al. 2003;Woodward et al. 2013).

It is important to culturally adapt psychological therapy from both patient and service perspectives. Through improving patient, practitioner and service understanding of therapy in the context of culture, cultural sensitivity may be improved in psychological therapy services (Bhui and Bhugra 2002). Although the ideal of all therapists being cultural sensitivity trained is unrealistic, an understanding of how cultural sensitivity can impact the psychopathology of a patient and thus their standard of care emphasises the benefit of improving culturally sensitive standards of psychotherapeutic care (Tseng and Strelzer 2013).

1.10 The rationale for the implementation of the Improving Access to Psychological Therapy (IAPT) services in the United Kingdom

Literature supporting the positive impact of low-intensity interventions for anxiety and depressive disorders and patient preference for better facilitation of mental health and emotional wellbeing support in the UK, partially motivated the implementation of IAPT services (Health 2006;Clark 2011). The National Institute for Health and Care Excellence (NICE) provided guidelines for appropriate treatment and facilitation of anxiety and depressive disorders in the UK (NICE 2007;NICE 2009a;NICE 2006;NICE 2009b). These guidelines were informed by literature supporting the therapeutic benefits of these interventions. Cognitive behavioural therapy (CBT) has been strongly supported as being beneficial patients suffering from these disorders. Other therapies included: couples therapy (behavioural), brief dynamic therapy and interpersonal therapy. NICE suggested the use of a stepped care model to IAPT; this would consist of low intensity, medium intensity or high intensity interventions. NICE suggested that patients would be assigned to the step of intervention that would be appropriate to their needs, for example patients suffering from mild-medium depressive depression would be assigned to step 2 whereas patients suffering from major depressive disorder would be assigned to a step 3 high intensity intervention. Step 1, recommended by NICE is the use of collaborative care with GP's for patients with moderate to severe depression for whom initial high intensity intervention was not effective (Clark 2011).

An additional motivation for the implementation of IAPT services was the potential reduction in costs attributed to mental health related unemployment. Researchers suggest that the costs attributed to benefit claims are £750 per person, per month. Recovery rates are estimated as being effective 50% of the time and with attributed therapy costs totalling £750(Layard et al. 2007). Contiguous to improving access to low-medium severity mental health problems in the UK, IAPT's economic objective was to increase productivity in suffers of depression and anxiety, increase rates of re-employment and reduce benefit claims (Hammond et al. 2012;IAPT 2012;D.H. 2011;Radhakrishnan et al. 2013).

The Improving Access to Psychological Therapies (IAPT) was initiated in October 2008 with the goal of improving mental health support in the United Kingdom by making evidence based psychological therapies more accessible for individuals suffering from depression and anxiety disorders alongside appropriate medications where necessary (Hammond et al. 2012;IAPT 2012;Richards 2012).

In 2008, £33 million were assigned to the first year of IAPT services, these funds would contribute towards the training of 3600 psychological therapists between 2008 and 2011. The primary therapy focus of IAPT was more accessible CBT therapy on a national level. CBT therapists were to be trained for step-2 low-intensity and medium-intensity interventions. For step-3 high-intensity interventions, psychological therapists and counsellors were to be trained. The total estimated cost for the initial three years of IAPT services (2008 – 2011) was estimated to accumulate to £173 million (Turpin et al.

2008). Although IAPT services were developed to improve access to psychotherapies in the UK, evidence suggests a lack of cultural sensitivity and poor ethnic minority access (Dowrick et al. 2009).

1.11 Outcome measures used by IAPT services for anxiety and depressive disorders

a) The Patient Health Questionnaire (PHQ-9) symptom scoring scale (Kroenke et al. 2001)

The IAPT services use the Patient Health Questionnaire (PHQ-9) to monitor patient depression scores over the course of their treatment. PHQ-9 includes 9-item questions discussing depressive symptoms and prevalence of these symptoms. Increased number of symptoms and increased prevalence of symptoms reflects increased PHQ-9 score and severity of depressive disorder. Practitioners were recommended that if depression scores exceed a score of 9, the patient may be suffering from symptoms of clinical severity (Kroenke et al. 2001;D.H. 2011).

b) The Generalised Anxiety Disorder Score Measure (GAD-7)

To assess anxiety levels during clinical interview assessments the IAPT services uses the Generalised Anxiety Disorder Score measure (GAD7). GAD scores can be incredibly useful to monitor anxiety levels pre-mid-post treatment, moreover they have also been shown to be useful for suggesting more severe anxiety disorders such as social anxiety disorder, panic disorder and post-traumatic stress disorder. GAD-7 includes seven items asking about presenting symptoms and the frequency of presenting symptoms. The more frequently the symptoms are experienced the higher the score. The recommended GAD score of 7, suggests patients scoring higher than 7 have a clinically severe anxiety disorder (Spitzer et al. 2006;D.H. 2011).

1.12 IAPT demonstration sites

In 2008 there were 152 primary care trusts. The government aimed to make IAPT accessible throughout all the sites, however initially wants to test the feasibility of integrating IAPT. The government initially used two IAPT demonstration sites in 2006 (Doncaster and Newham) to pilot the feasibility of IAPT as a service. The two sited were provided up to one and a half million pounds to facilitate this (Clark 2011;Clark et al. 2009).

a) Doncaster IAPT demonstration site

The Doncaster site had a primary focus on increasing support through low-intensity interventions and thus aimed to increase the number of trained CBT therapists. The primary focus in this service was to increase utilisation of over the phone interventions. The Doncaster service also improved capacity of CBT therapist for face to face high intensity interventions. The initial point of intervention for all patients was low intensity step-2 over the phone intervention. If patients showed slow, lack of improvement or extended use of the low-intensity intervention they were referred onto high-intensity step-2 interventions. If a patients initial presentation suggested that low-intensity step-2 would not be beneficial for their recovery they were directly placed under step-2 high intensity face to face CBT intervention (Richards and Suckling 2008;Clark et al. 2009).

b) Newham IAPT demonstration site

The Newham demonstration site already had pre-established level based psychological support structure. The service worked in conjunction with the Newham Primary Care Trust (PCT) to provide appropriate psychotherapeutic support for its patients (Clark et al. 2009).Due to the pre-existing focus on low-medium intensity therapies the Newham demonstration site aimed to have a greater focus on implementing high-intensity interventions within their service. The second demonstration site in Newham had a primary focus on high intensity face to face CBT therapy, however also practiced the stepped care model by utilising newly training psychological wellbeing practitioners (PWP's) during Computerised CBT (cCBT), groups, and facilitated 'self-help'. Referrals were primarily obtained from GP's (75%), 25 % of patients self-referred and 4% of referrals were from other health professionals. In the first year both sites had a significant number of patients utilising the low-intensity interventions and thus to accommodate this, in the second year the Newham site increased PWP training and intake (Clark 2011;Clark et al. 2009).

c) Demonstration sites evaluations

The novel addition of a 'session-by-session' method of recording patient progress allowed for data to be available for systematic review, moreover allowing the possibility to evaluate the systematic impact of IAPT on patient progress. It is estimated that although over 6 million individuals in England suffer from depression and anxiety disorders the access rate to IAPT was only 2.5% in the final quarter (4th) 2012/2013 (IAPT 2013).

Out of patients referred into the demonstration sites, 90% were considered to be clinically cases of depression or anxiety disorders upon referral. When evaluating the clinical implications of the IAPT interventions of patients with clinical cases of depression and or anxiety disorders at the Doncaster site, 56% of patients who were initially assessed to have clinically significant cases were discharged having recovered. Rates of recovering were calculated together and separately in accordance with duration of disorder. Patients whose disorder had duration of less than 3 months were found to have a 60% recovery rate. Rates of recovery for three to six month disorder duration were estimated as 63% and lastly, recover rates for disorder duration over 4 years was estimated as 47% (Clark et al. 2009). Impact of duration of disorder on recovery was investigated at Newham found no significant difference. Ethnicity recovery rates were also investigated, reflecting ethnic differences (50% white, 66% Asian, 54% Black and 50% 'other') (Clark et al. 2009).

Supplementary to this the 2012 IAPT three-year report of the initial one million patients summarised that over '680,000' patients achieved competition of their treatment, recovery rates were above 45%. The financial gains on society were also reflected with over 45,000 patients moving away from benefits and sick pay, but retaining jobs and increasing employment at the end of the four quarter report (IAPT 2013;IAPT 2012).

1.13 How to improve cultural sensitivity within the IAPT services

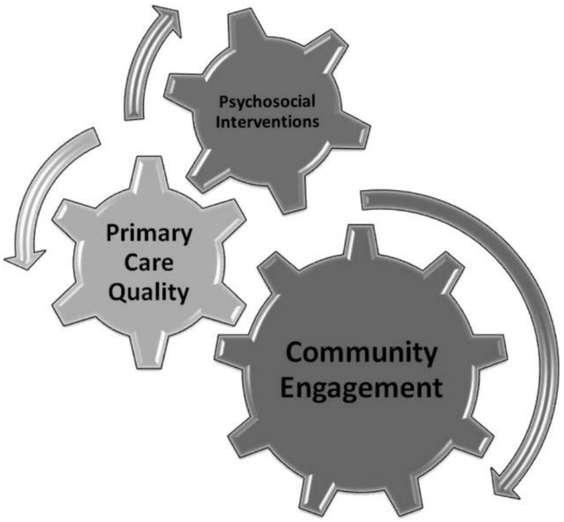
a) Improving access to health services for British ethnic minorities

The Access to Mental Health in Primary Care (AMP) model was developed to improve access and quality of primary mental health care for underserved populations.

There are three key elements to the AMP model which work simultaneously complimenting each other. The first element utilizes a patient centred approach to the delivery of primary care for psychological support (Mead and Bower 2000). The second element focuses on improving cultural sensitivity within primary care services (Wells 2000). Finally the third element is orientated around community engagement (Chew-Graham et al. 2014).

The AMP programme initially investigated barriers and facilitators to accessing mental health services as well as the mental health needs of underserved populations. Informed by these findings the AMP model intervention developed to include three key elements; quality of primary care quality, community engagement and psychosocial interventions(Dowrick et al. 2010).

Please see below *Figure 2* the three cog AMP model(Dowrick et al. 2010) :



The researchers suggested for the three elements to work harmoniously together in order to improve access to mental health in primary health care for underserved populations.

i. Community engagement

The community engagement level involved creating links between researchers and the local community. The community engagement element of the AMP model aims to better engage with the local population in need of accessing primary care mental health support. This element has a focus on increasing awareness on a community level through building links between researchers and locals. Better engagement with the community was aimed to help identify and later facilitate the needs of the local community accessing primary care services(Chew-Graham et al. 2014;Dowrick et al. 2010).

ii. Primary Care Quality

The primary care quality level of the AMP model focuses on the importance of making primary care mental health services more culturally appropriate for hard to reach communities. It was suggested that this could be achieved through integrating better training for staff and service providers. The aim of better training within primary care services is to integrate a better understanding of the needs of hard to reach communities from service staff/providers. Furthermore the focus on primary care quality encourages greater competencies of staff when communicating and engaging with hard to reach populations. Through greater understanding the needs of patients from these populations it is suggested that staff would have a greater understanding of the importance of encouraging access from these communities(Chew-Graham et al. 2014;Dowrick et al. 2010).

The intervention involved training mental health support service providers in a series of training sessions including the understanding of cultural context in a mental health care setting. Further to this the programme assessed areas within a service which created barriers to access for the underserved population.

iii. Psychosocial Interventions

The third and final element of the AMP model is the appropriateness of psychosocial interventions for their target patient group. Moreover the model suggests that psychosocial interventions should be tailored to the needs of the hard to reach population that they are treating in order to be most effective. It is suggested that this may be achieved by making psychosocial interventions more culturally sensitive to appropriately meet the needs of patients from different cultural backgrounds (Chew-Graham et al. 2014).

Lastly the wellbeing intervention focused on cognitive-behavioural participation literature, to train wellbeing facilitators to deliver patient-centred interventions (Dowrick et al. 2016;Chew-Graham et al. 2014;Dowrick et al. 2010).

b) Evidence of successful implementation of the AMP model

i. Community engagement

The community engagement element of the AMP model was broken down into four key components for intervention implementation. The first was 'information gathering', the second 'community champions', the third 'consultative focus groups' and finally the fourth 'community working groups'.

Researchers implemented the AMP model Training*plus* Primary Care Quality Improvement intervention at 7 general practices in the UK. Practices received an initial intervention meeting where the purpose of Training*plus* and results of previous research were discussed with a particular discussion focus on the individual needs of each service. Interventions were tailored to the needs identified by each individual service.
The cumulative training of all 7 services included three key elements (Chew-Graham et al. 2014):

i. Knowledge transfer (Culture and mental health, Leaflet and how to use those, communication skills for non-clinicians, patient presentations, managing asylum seekers with mental health needs (legal issues), working with interpreters, symptom recognition by non-medical staff and Consultation skills for clinicians).

ii. Systems review (The patient journey, working with interpreters, the appointment system, access and triage and communication within the practice).

iii. Active learning (Link with AMP community engagement sites, how to work with community groups, availability of local community groups and resources, referring on and AMP wellbeing intervention).

Results indicated positive feedback from services. A predominant theme throughout feedback was the thorough delivery of training of staff throughout services on all levels of patient contact. Staff indicated that through delivery of training to receptionists, communication during initial patient contact with the services was improved and patient complaints were reduced (Chew-Graham et al. 2014). The IAPT services use the Patient Health Questionnaire (PHQ-9) to monitor patient depression scores over the course of their treatment. PHQ-9 includes 9-item questions discussing depressive symptoms and prevalence of these symptoms. Increased number of symptoms and increased prevalence of symptoms reflects increased PHQ-9 score and severity of depressive disorder. Practitioners were recommended that if depression scores exceed a score of 9, the patient may be suffering from symptoms of clinical severity (Kroenke et al. 2001;D.H. 2011).

c) Applying AMP model to improve access of British ethnic minorities to IAPT services

To facilitate the need of the ethnic minority population in the UK, an appropriate service must be selected which engages the populations needs in terms of psychotherapeutic support to thus evaluate barriers to access which are present within commonly used psychological therapy services. We selected IAPT services as an appropriate psychological therapy service to develop a method of assessing cultural sensitivity relevant to the ethnic minority population residing in the UK. In order to develop a cultural sensitivity intervention within IAPT services to improve access from the British ethnic minority population we focus on 2 out of 3 elements of the AMP model. For the purpose of this intervention model we aim to focus on the primary care quality and psychosocial intervention elements of the AMP model.

The primary care element of AMP suggests further training within existing mental health care services. Through this we focus on the need for further cultural sensitivity training within IAPT services nationally. This includes the multifaceted natures of the IAPT patient pathway including written and verbal communication with patients from a British ethnic minority background as well working with translators.

The Psychosocial intervention element of the AMP model suggests the training of mental health staff on delivering patient-centred interventions. For the purpose of improving access of British ethnic minorities to IAPT services we aim to develop a cultural sensitivity audit tool for IAPT services. The aim of this tool will be to highlight cultural sensitivity awareness within IAPT services in order for them to provide patient centred therapy that takes into account the preference and needs of British South Asian patients.

1.14 Summary of introduction

Literature emphasises the variance in cultural sensitivity across services and ethnic populations. Furthermore, how differences in cultures can precedent the needs of populations accessing services and the impact of care provided. However it may be of importance to highlight that research into barriers to accessing psychological therapy is primarily focused around mental health services. This mental health heavy emphasis in literature can refer to the treatment of mental illnesses of a greater severity in presentation of symptoms and subsequent effect on quality of life, as compared to the psychological therapy interventions received by patients with mild-moderate severity of symptoms accessing primary care.

i. Aim

The purpose of this project is to identify barriers experienced by ethnic minorities accessing primary care psychotherapeutic support.

ii. Key objectives

The focus of my research has no emphasis on inpatient mental health services, thus the reason for excluding mental health services. This thesis aims to identify barriers to accessing psychological therapy for ethnic minorities in western countries and relevant to IAPT services in the United Kingdom. In order to further contribute to the readers understanding of barriers to accessing psychological therapy services for ethnic minorities residing in western countries the author will present findings from study 1; A systematic review.

Study 1: Barriers to accessing psychological therapy for ethnic minorities residing in western countries: systematic review.

To further investigate barriers to accessing psychological therapy services for ethnic minorities residing in western countries we conducted a systematic review. The results describe barriers experienced by ethnic minorities when accessing psychological therapies presented in a themes and sub-themes format.

1.15.1 Aim

To review all published literature reporting the barriers to accessing psychological therapy for ethnic minorities residing in a western country.

1.15.2 Methods

For the purpose of this systematic review the author was supported by two student colleagues.

a) Selecting search terms: To investigate the topic a search strategy was guided by two systematic review experts, an ethnic minority researcher (WW) and a systematic reviewer (MP). Search terms covered three key areas; ethnic minorities, psychological therapies and access. 'Ethnic minorities' was defined as a population group that is in significantly less numbers, different cultural and/or religious beliefs to that of the majority population. 'Psychological therapies' were defined as all psychotherapies expect for 'psychodynamic' therapy. The author and supervisors (WW and MP) modified and combined the search strategies developed and published previously from ethnic minorities (Bhui et al. 2013) and psychological therapies (Ismail et al. 2004) systematic reviews. The author modified search terms by excluding search terms that did not refer to 'psychological therapy', 'barriers' or 'ethnic minorities' as our focus was on psychological therapy services for non-psychotic disorders. Search terms that referred to 'mental health services' or 'psychosis', 'psychiatric', 'dropout', 'communication', 'compliance', 'diagnosis', 'adherence', 'attendance', 'transient', 'deprivation', 'depression', 'mood disorders', 'baling', 'crisis intervention', and/or 'training' were also excluded. The author added the additional search term 'access' to capture literature tailored to the focus of our review. Each stage of search term adjusting to this review was discussed and confirmed with the postgraduate supervisors, to ensure quality and appropriate capturing of relevant literature. Due to this review topic originating from an under researched area the author and supervisors decided to initially keep a broad search, later selecting papers relevant to this review through the inclusion and exclusion process.

Table 1 and *Table 2* describe the process of including and excluding search terms from widely recognised published systematic reviews from the field (Bhui et al. 2013;Ismail et al. 2004).

Table 1 ***Search terms extracted from (Ismail et al. 2004)***

Original	**Included or reason for exclusion**
exp psychotherapy/	Included
counsel*.mp.	
(interpersonal adj5 therap*).mp.	
art therap*.mp.	
aversion therap*.mp.	
behaviour therap*.mp.	
behaviour modific*.mp.	
behavior therap*.mp.	
behavior modific*.mp.	
color therap*.mp.	
colour therap*.mp.	
(cognitive adj5 therap*).mp.	
geshalt therap*.mp.	
music therap*.mp.	
milieu therap*.mp.	
nondirective therap*.mp.	
(problem solvind adj5 therap*).mp.	
(self control adj5 therap*).mp.	
person cent*.mp.	
client cent*.mp.	
psychodrama*.mp.	
paradoxical technique*.mp.	
play therap*.mp.	
rational emotive.mp.	
reality therap*.mp.	
role play*.mp.	
(relax* adj5 training).mp.	
sociotherap*.mp.	
socioenviromental.mp.	
supportive therap*.mp.	
transactional.mp.	
psychosis	Severe mental illness
psychodynamic	Different therapy style
mental health services	Severe mental illness
psychiatric	
dropout	Not access related
communication’	
compliance	
diagnosis	
adherence	
attendance	
transient	
deprivation	

depression	
mood disorders	Severe mental illness
crisis intervention’	Severe mental illness
training	Not patient centred

Table 2 ***Search terms extracted from (Bhui et al. 2013)***

Original	**Included or reason for exclusion**
(BME or black ethnic minorit* or black minorit* ethnic*).mp.	Included
asylum seeker*.ab,ti.	
migrant*.mp. or immigrant*.ab,ti.	
race*.mp. or racial.ab,ti.	
cultur*.ab,ti.	
(multicultural or multi cultural).ab,ti	
(cross-cultural or crosscultural).ab,ti.	
(trans-cultural or transcultural).ab,ti.	
(multi-rac* or multirac*).ab,ti.	
(multiethnic or multi-ethnic).ab,ti.	
refugee*.ab,ti.	
(multi-lingu* or multilingu*).ab,ti.	
(ethno-cultur* or ethnocultur*).ab,ti.	
(socio-cultural or sociocultural).ab,ti.	
(divers* or diverse population* or cultural diversity).ab,ti.	
(South Asian* or bangladeshi* or pakistani* or indian* or sri lankan*).mp.	
(asian* or east asian* or chinese or taiwanese or vietnamese or korean* or japanese).mp.	
(afro-caribbean or african-caribbean* or caribbean or african* or balck* or afro*).mp.	
(islam* or hindu* or sikh* or buddhis* or muslim* or moslem* or christian* or catholic* or jew*).ab,ti.	
ethnic group*.mp.	
((ethnic or linguistic) adj diversity).ab,ti.	
acculturation.ab,ti.	
(faith* or belief* or religion*).ab,ti.	
ethnic minorit*.ab,ti.	
minority ethnic.ab,ti.	
hispanic.ab,ti.	

b) Literature search: Searches were conducted on three electronic databases; Medline (1950), Embase (1980) and PsychINFO (1806) up to 29th February 2016. All databases were searched using multiple combinations and variations of three categories; ethnic minorities, psychological and access. No language restrictions were used and all references were exported to Endnote. For the purpose of this review initial search terms were broad as we wished to capture as much of the relevant literature as available.

c) Eligibility criteria: This review aimed to capture papers that reflected possible barriers experienced by ethnic minority individuals accessing psychological therapy services in western countries. In order to facilitate the identification of appropriate papers the search was not limited to a boundary within which it was published.

d) Inclusion criteria

i. Utilising any type of research design describing barriers to accessing psychological therapies.
ii. Included any psychological therapy excluding psychodynamic therapy.
iii. Included ethnic minority group/s.
iv. Described barriers to accessing psychological therapies from service provider, staff or patient perspective.

e) Exclusion criteria

i. A primary focus on psychodynamic therapy.
ii. No barriers to accessing psychological therapy described.
iii. Focus primarily on mental health services not psychological therapy.
iv. Child or adolescent participant group.
v. No focus on 'access'.
vi. No focus on ethnic minority patients.

f) Data extraction: A data extraction form was developed a priori and was guided by the extraction that had been conducted in a previous review (Brown et al. 2013). In order to capture the relevant data from each paper the following data extraction categories were used; Paper title, authors, year of publication, place of publication, community, service type, description of design (Review, qualitative design or quantitative design), outcomes, participant n =, ethnic breakdown of participants % & n =, participant gender/s, participant age and barriers.

Extracted data included basic information about the paper, population and data collection methods. Barrier descriptions that were specific to psychological therapies were extracted and if they were related to mental health services in general then they were excluded. Data extraction was double completed by the author (KK) and a student colleague (US). When differences arose this was discussed with a supervisor (WW) until a consensus was achieved and all discrepancies were settled. Discrepancies that arose were based primarily on repetition of over capturing barriers from the publication text, whether the paper should be included or excluded. Once a barrier was captured in the text, a description was extracted and a number was given to the barrier.

Table 3 ***Extraction sheet for final systematic review included papers***

Extraction categories	***Description***
Paper Number	Each paper was assigned a number to reduce bias during data extraction.
Title	The title of each paper was extracted to ensure it was relevant to be included in the review.
Author	The only/ or all authors of the paper were extracted.
Year Published	The year the paper was published was extracted to understand how recent the findings were.
Community	The community to which participants belonged was extracted to ensure that they were the relevant participant group for the focus of our review.
Service Type	The type of service being discussed was extracted to ensure that focus lay with psychological therapy services.
Description of Design (Quantitative/Qualitative/Review)	The design of the study was extracted.
Outcomes	A short description of findings was extracted to aid in understanding whether findings were relevant for the review.
Participants n=	Numbers of participants described in the study in each paper were extracted to identify participant group and generalisability.
Ethnic Background & %/number	Ethnic groups included in each paper were extracted to ensure focus was on ethnic minorities.
Gender	Genders of participants in each paper were extracted to compare where differences in gender may contribute to barrier differences or similarities.
Age	Ages of participants were included to discuss differences and similarities between age groups for barriers within the review.
Barriers	Barriers were extracted from papers to discuss barriers experienced by ethnic minorities accessing psychological therapy within our review.

Table 3 describes the rationale for extracting items of data from each included paper. Data was extracted from each included paper by two researchers and disparities were discussed with a third researcher to ensure inter-rater reliability.

g) Thematic analysis and coding(Braun and Clarke 2006)

Thematic analysis is used due to its flexible nature when assessing a combination of papers with varied research methodologies. The steps to conducting thematic analysis include:

Assigning each included paper (data item) with a numerical code.

i. Familiarising with each paper.
ii. Identifying and extracting data (barriers) from each paper.
iii. Analysing the extracted data by coding into themes and subthemes as a reflection of the importance and frequency of extracted data relevant to the research question (Braun and Clarke 2006).

Thematic analysis was used in order to facilitate the thorough extraction of detailed information from each paper to proceed to the coding and development of themes that captured barriers experienced by ethnic minority patients accessing psychological therapy services in western countries. I will describe the themes and subthemes extracted from each paper. The data extracted from each is referring to a barrier extracted from an included paper.

h) Assigning barrier themes categories

i. The author (KK) and student colleague (US) familiarised themselves with each paper in order to have an in depth knowledge of the nature of each included paper.
ii. They (KK & US) extracted data from each paper , which for the purpose of this review were barriers experienced by ethnic minorities when accessing psychological therapy.
iii. Each barrier that was extracted from the included papers was typed onto an index card with barrier number and an assigned paper number.
iv. A direct quote for each extracted barrier was used to ensure no substance was lost from each barrier. Each barrier slip included the barrier number and paper number to allow the researchers to refer back to the paper to ensure a full understanding of what the quote was referring to.

v. Once data extraction was completed the author (KK), student colleague (NM) and a supervisor (WW) categorised each individual barrier (sub theme) according to how it related to access to psychological therapies.

vi. Each extracted barrier was discussed by the author (KK), student colleague (NM) and a supervisor (WW), to come to a consensus as to which sub theme the barrier would be most appropriately categorised to.

vii. If a barrier was deemed to be unclear, the source paper was referred back to for further clarification and reference to context.

viii. The author, WW and NM discussed if the barrier was appropriate to the sub themes already created, in instances where there was no existing appropriate sub theme, a new sub-theme was created, to describe and justify the barrier.

ix. Following this all sub themes were grouped under 5 predetermined overarching main themes, namely 'Patient related barriers', 'Community related barriers', 'Family related barriers', 'Health service related barriers' and 'Practical issues'. These 5 themes were created a priori and linked to previous barriers related literature (Dowrick et al. 2010) and relevance to development of interventions to improve access to psychological therapies for ethnic minorities.

The purpose of creating umbrella themes was to create a collection of barrier subthemes which reflected the point at which during patient's pathway of accessing psychological therapy the barrier could be experienced. For example the sub-themes of; past experiences of treatment and reluctance to disclose were categorised under the theme of patient related barriers. It is important to consider that barrier sub-themes are not mutually exclusive to one theme therefore unavoidable repetition may be present.

1.15.3 Systematic review results

Figure 3 ***Process of selecting papers for inclusion***

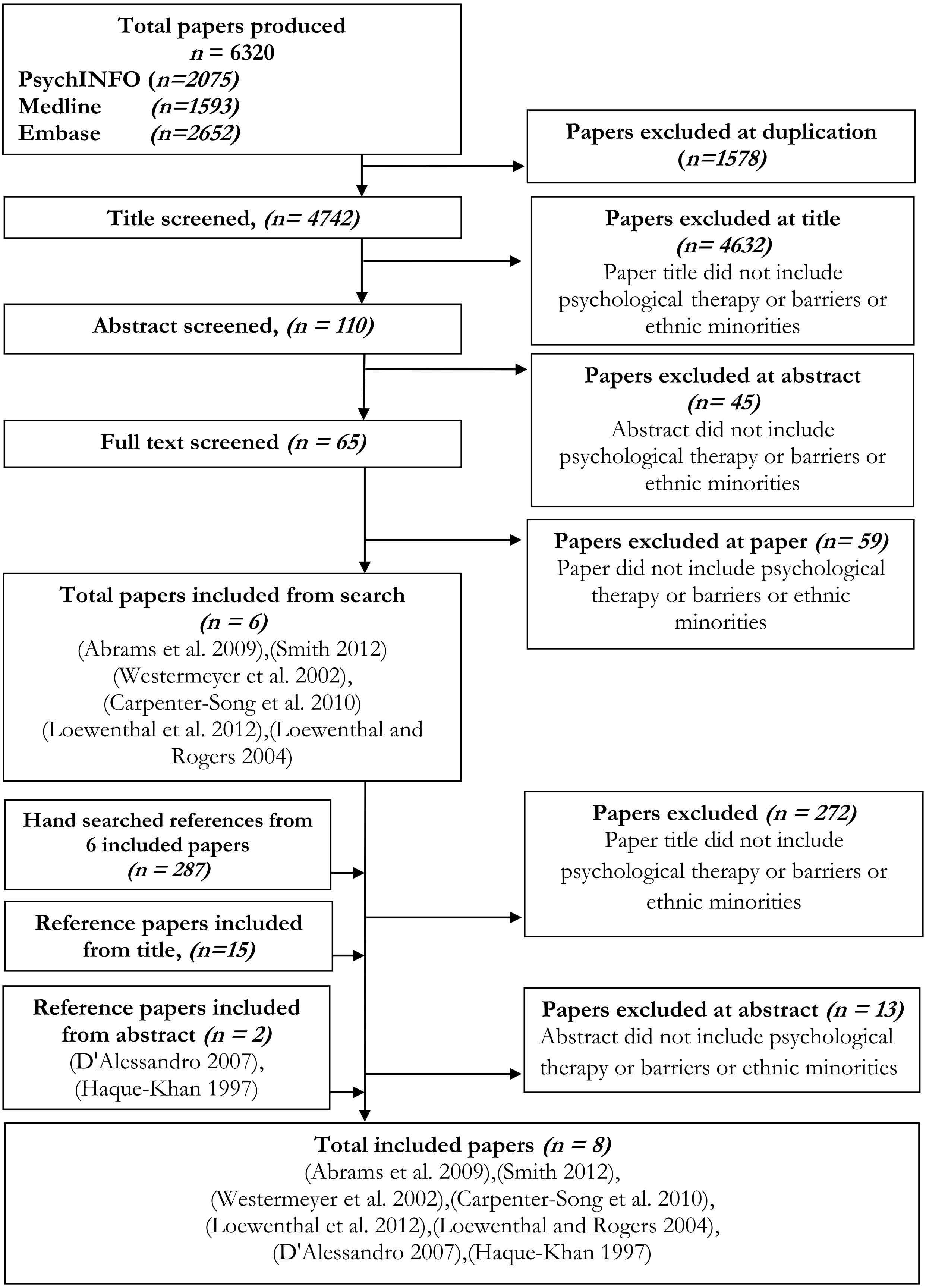


Figure 3 **Process of selecting literature for inclusion**

Please refer to Figure 3 on Page 52.

Figure 3 describes the process of selecting papers eligible for the systematic review in a flowchart. Papers were captured using three databases and a decision of papers eligibility was made using the inclusion and exclusion criteria. Following which papers included from the initial search were further investigated. References from each included paper were reviewed for eligibility to ensure that all relevant literature was captured in this review.

Table 4 **Papers included in this systematic review after inclusion**

Please see Table 4 on Page 54.

Table 4 describes the final included papers in our review. We extracted data for;

i. Author
ii. Year
iii. Research design
iv. Setting
v. Participant ethnic group/s
vi. Participant genders

Table 4 ***Descriptions of included papers***

Papers included in this systematic review after inclusion.

Author/s	**Description**	**Setting**	**Ethnic Group**	**Gender**
Abrams et al. 2009	Qualitative (Focus groups &Interviews)	U.S.	African American Latino	Female
Carpenter-Song et al. 2010	Ethnographic (18 month ethnographic study, documenting narrative accounts)	U.S.	Latino African American Euro American	Both
Smith 2011	Qualitative, (Semi-structured interviews)	U.S.	Muslim Arab American (Lebanese, Egyptian, Moroccan, Algerian, Syrian and Jordanian)	Both
Loewenthal & Rogers. 2004	Qualitative, (Semi-structured interviews)	U.S.	Orthodox Jewish	Both
Loewenthal. 2012	Qualitative (Focus groups)	U. K	South Asian Community (Bengali, Urdu, Tamil, Somali)	Both
Westermeyer et al. 2002	Qualitative study (Interviews)	U.S.	American Indian Veterans Hispanic American Veterans	Both
D'Alessandro 2007	Quantitative (*ATSPPHS & **ASIAS)	USA	Arab American	Female
Hague-Khan 1997	Mixed methods Quantitative (***IRS, ****AIKS & *ATSPPHS) Qualitative (Semi-structured interviews and Focus group)	USA	Muslim American (Bangladeshi, Jordanian, Pakistani, Palestinian, Iranian, Afghan, Turkish, Indian, Egyptian, Lebanese, Canadian, American, South African)	

**ATSPPHS: Attitudes toward seeking professional psychological help scale*

***ASIAS: Arab self-identity acculturation scale*

****IRS: Islamic religiosity scale*

***** AIKS: America; Psychological help scale*

Table 5 **Critical appraisal of included papers**

Please see Table 5 on Pages 56-57.

Table 5 describes the results of our critical appraisal of the final included papers in this review. The critical appraisal included 10 questions, aiding to highlight reliability and validity of each included paper((CASP) 2017). The author (KK) and post-graduate supervisor 2(MP) went through each question of the critical appraisal and scored 'yes' if the question was answered, 'no' if unanswered or 'unclear' if an adequate answer was not provided by the paper. For the purpose of this thesis a total score was given to each paper in order to compare quality. However, it must be taken into consideration that the total CASP score does not indicate the quality of each paper accurately due to each question carrying a different weight.

Table 6 **Barrier themes and Sub-themes**

Please see Table 6 on page 58.

Table 6 describes 5 Barrier themes and 21 Sub-themes developed from the data extracted from this systematic review. Following which **1.15.4** ***Description of barrier themes and sub-themes***, describes contributing data from included papers used to develop the content of *Table 6*.

Table 5 ***Critical Appraisal of included papers***

	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was data collected in a way that addressed the research issue?	Has the relationship between researcher & participant been adequately considered?	Have ethical issues been taken into consideration?	Was data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Score out of 10
Abrams 2009	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable	**10**
Carpenter-song 2010	Yes	Yes	Yes	Unclear	No	Yes	Yes	Unclear	Yes	Recruitment strategies not explained. Data collection and data analysis is not described in sufficient data.	**6**
Loewenthal 2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable	**10**
Loewenthal 2012	Yes	Yes	Yes	Unclear	Unclear	Unclear	Unclear	Unclear	Yes	Recruitment strategies, data collection, data analysis relationship between researcher and participant not explained in sufficient detail.	**4**
Smith 2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable	**10**
Westermeyer 2002	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Responses from participants were prompted suggests bias from leading questions. Does not describe participant recruitment	7

Table 5 ***Critical Appraisal of included papers continued***

	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was data collected in a way that addressed the research issue?	Has the relationship between researcher & participant been adequately considered?	Have ethical issues been taken into consideration?	Was data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?	Score out of 10
D'Alessandro 2007	Yes	No	Yes	Yes	Yes	Unclear	Unclear	Yes	Yes	The relationship between participant and researcher were not clearly defined. The process of ethical approval has not been discussed however ethical considerations have been briefly mentioned. A quantitative approach to data collection was used.	6
Haque-Khan 1997	Yes	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	The recruitment strategy described in this thesis is unclear. The author mentions three methods of recruitment however does not give sufficient insight into the procedure.	9

Table 6 ***Barrier themes and sub-themes***

A) Patient related barriers

1. Trust
2. Language
3. Patient confidentiality
4. Reluctance to disclose
5. Stereotype
6. Mental health literacy
7. Patients view of therapist
8. Religion
9. Stigma
10. Past experiences about treatment
11. Presenting symptoms

B) Community related barriers

12. Cultural expectations from community
13. Lack of community support

C) Family related barriers

14. Lack of family support
15. Family influence

D) Health service related barriers

16. Preference for alternate treatment
17. Appropriateness of service
18. Lack of understanding of the referring health service
19. Patients preference for therapists to hold certain characteristics
20. Patients expectations of therapist

E) Practical issues barriers

21. Cost

1.15.4 Description of barrier themes and sub-themes

A) Patient related barriers theme

The patient related barriers theme consists of 11 subthemes including; trust, language, patient confidentiality, reluctance to disclose, stereotype, mental health literacy, patients view of therapist, religion, stigma, past experiences about treatment and presenting symptoms. The patient related barrier theme contains barriers extracted from 8 included papers (Westermeyer et al. 2002;Carpenter-Song et al. 2010;Loewenthal et al. 2012;Loewenthal and Rogers 2004;Smith 2012;Abrams et al. 2009;Haque-Khan 1997;D'Alessandro 2007).

1. *Trust ((Westermeyer et al. (2002);D'Alessandro 2007;Haque-Khan 1997)*

One paper describes the experiences of mental health workers' and their colleagues when working with Hispanic American and American Indian veterans.

> *"Veterans do not trust health clinicians", this sense of mistrust is also carried by "families" who "do not trust the VA system or its providers".*

The barrier of mistrust is multifaceted and created barriers to access on not only a patient level but also from the families of patients, further research is required to assess the extent of distrust, the reasoning behind the mistrust and how mistrust of mental health services can be lessened (Westermeyer et al. 2002). In a second paper, authors discussed how in regards to psychological therapy services, Arab American patients,

> *"said they had no trust in a professional nor a stranger and especially because they didn't understand the Arab culture" (D'Alessandro 2007).*

In the final paper the author reported that Muslim American,

> *"immigrant women spoke of having a "lack of trust" in seeking professional help" and a "fear of the story getting out" (Haque-Khan 1997).*

2. *Language (Loewenthal et al. 2012;Westermeyer et al. 2002).*

In the ethnic minority community, the barrier of language was reflected as a collective experience across the two papers. Patients highlighted that they were,

> *"Not able to converse well in English" and thus felt service providers "did not understand" their problems.*

This barrier can be detrimental in diagnosis and treatment as patients suggested that when accessing services speaking to health care staff the,

> *"Interpretation was not correct" (Loewenthal et al. 2012).*

This paper also commented on patients experiences with interpreters and,

> *"Finding interpreter services unreliable" as they preferred to "talk about their issues directly with the health professional rather than relying on someone to speak for them".*

The result of language barriers discouraged patients from seeking access to psychological therapy (Loewenthal et al. 2012), a paper describing barriers to accessing mental health services commented on Hispanic American Indian veteran experiences. Veterans reflected that mental health staff,

> *"Does not communicate well" with them (Westermeyer et al. 2002).*

As reflected in these two papers the language barrier holds many components: language of the service user, language spoken by mental health staff, use of interpreters, the combination of these elements create a crucial barrier for ethnic minorities accessing psychological therapy. The language barrier can lead to a misinterpretation of patient symptoms and experiences. Patients reflect feeling frustrated at the lack of proper interpretation and direct communication with mental health staff.

3. Patient Confidentiality (Loewenthal and Rogers 2004;Smith 2012)

Patient confidentiality was found to be a multifaceted barrier. Patients expressed that discussing problem outside of the family or community carried stigma and fear that their problems would be discussed with outsiders (Smith 2012). There was a significant emphasis on the importance of keeping problems within the confines of family (Smith 2012).

> *The "importance of being able to trust their therapist not to discuss their problems with others",*

led to patients, feeling apprehensive about therapists not upholding confidentiality agreements (Smith 2012). A paper investigating experiences of the orthodox Jewish community accessing culturally sensitive psychological therapy services found that,

> *"The strictly orthodox are very worried about confidentiality" to the extent that "some clients will only give their first names".*

Fears about breach of confidentiality were shown to be associated with fears of outsiders knowing that an individual was seeking help and often led to patients having'

> *"an aversion to entering group therapy".*

The same view was shared for interpreters. In the Orthodox Jewish community confidentiality fears extended to patients' unwillingness to share full names, and feeling particularly uncomfortable in taking part in support groups. The association with support groups, and fear of outsiders knowing that an individual is seeking help extended to patients opting against well-known community buildings as a venue (Loewenthal and Rogers 2004).

4. Reluctance to disclose (Westermeyer et al. 2002;Smith 2012;Carpenter-Song et al. 2010)

A paper discussing American Indians (AI) and Hispanic American (HA) veterans' experiences accessing mental health care commented that AI and HA veterans were having,

> *"Difficulty discussing personal problems" (Westermeyer et al. 2002).*

A thesis describing removing barriers to therapy for Muslim-Arab Americans reflected the culturally rooted view in women that it is wrong to discuss psychological distress with others. Female patients expressed the,

> *"Importance of keeping things a secret or keeping things within the family".*

In this community there was shame associated with not coping independently and seeking external help for mental illness. Some women described fear of being ostracised from the community if they were to disclose their mental illness which impacted their likelihood of seeking help (Smith 2012). For women who accessed psychological therapy, they feared disclosing information in front of the interpreter (Smith 2012). A third paper, described awareness of mental health problems and responses to health services highlighted how women hoped for an individual who would listen to them. One participant commented,

> *"I can't be pouring my heart out to everyone"…*

…expressing her disappointment with practitioners changing frequently as…

> …*"they don't stay long enough to help"*…

…thus creating a reluctance to disclose (Carpenter-Song et al. 2010).

5. Stereotype (community, family and cultural) (Westermeyer et al. 2002;Smith 2012;Abrams et al. 2009;D'Alessandro 2007)

A paper describing experiences of American Indian (AI) and Hispanic American (HA) veterans described reflections that,

> *"Mental health staff makes false assumptions",* due to stereotyping (Westermeyer et al. 2002).

A second paper described barriers to accessing psychological therapy for ethnic minority women suffering from post-partum depression (PPD). This paper commented on the Latino view of 'familism' as a barrier to providing support to Latina mothers.

> *"Familism"* was described as the view of, "*mothers as strong and self-reliant*"…

…this stereotype affected the likelihood of Latino women seeking formal mental health care" (Abrams et al. 2009).

A third paper describing barriers experienced by Muslim-Arab Americans accessing therapy described the stereotype that,

> *"Therapy was for people who were weak", "who were using is as a fashionable status symbol, or who were self-absorbed"…*

…these strong cultural stereotypes impeded the likelihood of Muslim-Arab Americans accessing psychological therapy services. Patients reflected that if women are,

> *"Diagnosed with a mental illness", "she's not going to get married".*

These stereotypes were often coupled with the view that women were expected to solve problems themselves, creating a stereotype barrier that creates reluctance to accessing psychological therapy (Smith 2012). The barriers extracted from these three papers show stereotype to be underpinned in the beliefs of a community or culture. On the surface they reflect a positive view of women as strong but upon reflection suggest that having a mental illness and accessing support through psychological therapy can damage that stereotype of a strong woman and impact upon future marital prospects.

A fourth paper describes the attitudes of Arab American women accessing psychological therapy. The author comments on how,

> *"Arab American women appear to have positive attitudes towards seeking psychotherapy than other studied groups"…*

…as compared to Caucasian, Chinese American and African American patients (D'Alessandro 2007).

6. Mental Health Literacy (Westermeyer et al. 2002;Loewenthal et al. 2012;Smith 2012;Haque-Khan 1997).

A paper describing the experiences of ethnic minorities accessing the improving access to psychological therapy (IAPT) services highlighted how the lack of mental health literacy can be a contributing barrier. Lack of mental health literacy was often due to language related barriers, for example Urdu speaking patients explained that understanding the,

> *"Concept of anxiety" was difficult due to their being "no directly equivalent concept in Urdu".*

Somali participants commented that they held a,

> *"Lack of understanding of the western conceptions of depression and anxiety".*
> Patients were found to identify better with *"depressive states", "broken spirits"* and *"disappointments"*…

…rather than the western concepts of mental health or problems (Loewenthal et al. 2012).

A second paper investigating Hispanic American (HA) and American Indians (AI) veteran's experiences of mental health care highlighted a lack of knowledge about mental health symptoms amongst this community. Participants felt that they did

> *"Not know if they were eligible" for mental health services "due to the nature of their symptoms".*

The lack of mental health literacy around symptoms and appropriateness of mental health services meant that this community thus "do not seek out" mental health care (Westermeyer et al. 2002). This could be a significant contributing barrier to accessing mental health support if the patient is unaware of the implications of their presenting problems.

A thesis investigating ethnic minority experiences of accessing psychological therapy commented on,

> *"Very sensitive…cultural views of psychiatric patients as lazy, self-absorbed, weak, crazy, inadequate, and deficient".*

This barrier of a lack of mental health literacy creates an inherent barrier to accessing psychological therapy for ethnic minorities (Smith 2012).

The barrier of lack of mental health literacy was also found to be apparent in the female Muslim American community; an author discussed how,

> *"These women expressed difficulty in providing a clear description of what a person experiencing a mental breakdown might look like".*

Furthermore these participants were unable to describe what,

> *"Constituted professional help".*

The author suggested that due to low mental health literacy levels in this community

> *"women echoed that there was not much available" (Haque-Khan 1997).*

7. Patients Views of Therapists (Smith 2012;Westermeyer et al. 2002;Haque-Khan 1997;D'Alessandro 2007).

Hispanic American (HA) and American Indians (AI) experiences in accessing mental health care highlighted that as well as mental health staff being,

> *"Unaware of needs and resources" of this community, "mental health staff does not understand AI/HA culture"* (Westermeyer et al. 2002).

The barrier of these patients' views of therapist may hinder their willingness to access psychological therapy. A paper describing ethnic minority barriers to accessing psychological therapy services commented on patients views that,

> *"Therapists may not be knowledgeable about Islam, Arab culture, or both".*

The barrier of patients view of therapist was rooted in religious beliefs of the Muslim-Arab Americans participants, the authors comment on patients fears that the,

> *"Therapist might encourage them to do something contrary to their religion".*

Participants also reflected concerns about psychologist using,

> *"superficial solutions which do not resolve larger underlying problems"* as *"they make you question yourself a lot, to the point where you become crazy".*

The barrier of patient's view of therapist may be highly influential in a patients decision to access psychological support if they hold the view that the therapist would be less inclined to solve the problem (Smith 2012).

Muslim American women were reported as not having, "much faith in them" when referring to psychologists, the author described the view that.

> *"they would probably not go to a psychologist or mental health professional because of a lack of cultural and religious understanding"* (Haque-Khan 1997).

This barrier was also captured in a paper describing Arab American views of psychological therapy, the author describes how,

> *"they had no trust in a professional…because they didn't understand Arab culture"* (D'Alessandro 2007).

8. *Religion (Smith 2012;Carpenter-Song et al. 2010;Loewenthal and Rogers 2004;Haque-Khan 1997).*

A paper describing the experiences of the orthodox Jewish community accessing culturally sensitive psychological therapy commented on the time consuming nature of working with this community. Patients often spend a significant amount of time…

> …*"clarifying every halachic question";*

This may be due to lack of Jewish religious awareness of the practitioner acting as a barrier. In order to facilitate the delivery of psychological therapy in this community it is necessary to acquire rabbinic approval from the union of orthodox Hebrew congregations. This religious barrier was highlighted as being further accentuated with the requirement of an ongoing link with at least one rabbinic advisor (Loewenthal and Rogers 2004) .

A second paper describing mental health awareness in the African American, Latino and European American ethnic minority community in the USA the barrier of religion is discussed. The conflict between religious views of patients and the medical focused view of practitioners is discussed. A patient highlighted that he,

> *"Interpreted his experiences through a religious lens while his clinicians framed his worry about the end of the world as being 'down' or, possibly, the result of a "drug problem".*

This experience emphasises the religious barrier to accessing psychological therapy for ethnic minority patients (Carpenter-Song et al. 2010). Religious barriers are discussed in a third paper investigating Muslim-Arab American patients accessing psychological therapy. Muslim patients often,

> *"expressed that their illness is in God's plan and that they weren't going to do anything as this was God's choice"* (Smith 2012).

This religious view promotes an external locus of control in patients which conflicts with some pro-active approaches employed by psychotherapists and reduces likelihood of patients accessing mental health care if they feel nothing is in their control. The author speaks of patients views of,

> *"Imams as better sources of advice than psychologists because imams could advise on what was haram (forbidden) or halal (allowed)".*

Patients reflected that psychological therapy with the absence of religious underpinning could be,

> *"Detrimental to someone's spiritual wellbeing";*

this fear may create a religious barrier and reduce access of Muslims to psychological therapy (Smith 2012).

One thesis described how Muslim American patients' religiously inclined views about the causality of mental health problems. The author described how, when presented with the scenario of a mental breakdown, patients reflected that it was due to a "jinn problem". Furthermore the,

> *"Abnormal behaviours"* associated with mental health problems where reflected as an individual *"being taken over by a jinn"*.

One patient was captured as saying,

> *"I always believe if you're strong in your faith you can overcome distress"* (Haque-Khan 1997).

These religiously rooted approaches to mental health problems may act as a barrier to accessing psychotherapeutic care for ethnic minorities, furthermore so if a patient believes that a treatment for such a problem is out of their hands.

9. Stigma (Family stigma personal stigma) (Smith 2012;Haque-Khan 1997).

The author describes the prominent stigma associated with mental illness and accessing mental health care in the Muslim-Arab American community. The stigma is associated with,

> *"Having 'a bad image among the community and…peers'"* as there is *"shame associated with admission of a mental illness or an emotional problem"*.

The author discusses that the stigma is not only associated with the patient but also effects the family,

> *"Reputation and even perhaps on family cohesion within Muslim-Arab culture"*.

In the Muslim-Arab American community the stigma is multi-dimensional as it carries a…

> …*"high amount of shame from the biological, spiritual, and environmental causes"*.

The barrier of stigma associated with therapy carries the weight of shame and this may be a confounding factor in a patients decision on whether to access psychological therapy (Smith 2012). A thesis describing the experiences of Muslim American women accessing psychological therapy reported that,

> *"There is a taboo…if you're going to a psychologist then you're crazy",* participants also reflected that there is *"major, major stigma…I definitely admit that I am under that stigma".*

The author discussed that,

> *"These women revealed holding initial resentment toward the person's behaviour"…*

…this highlights how the stigma associated with psychological illness is not only apparent from the ethnic minority community but also from patients themselves (Haque-Khan 1997).

10. Past Experiences about Treatment (Abrams et al. 2009;Smith 2012;Westermeyer et al. 2002;Carpenter-Song et al. 2010;Haque-Khan 1997).

A paper investigating barriers to accessing psychological therapy for ethnic minority women with PPD discusses patients past experiences of psychological therapy and health care and how they contribute to their expectations and apprehensions towards seeking help. The authors discuss patients' views that mental health care providers are uncaring and that,

> *"Providers do not really want to help you and instead 'want the money'".*

Patients' past experiences with a,

> *"Past mental health service" which "emphasised pharmaceutical approach to mental health problems"…*

…may create a barrier for patients when a medicinal approach may contradict "cultural and religious factors". Authors also touch upon how some participants previously experienced,

> *"Adverse reactions to psychotropic medications"* and thus used this *"as a basis for rejecting this treatment"* (Abrams et al. 2009).

In contrast to the above paper other authors reflected that some patients sought out mental health support with the primary aim of obtaining prescription medications and injections with no interest in psychological therapy. Latino, African American and European American patients also emphasised experiences of mental health staff lacking a level of respect and experiencing prejudice (Carpenter-Song et al. 2010). An interesting aspect of patient experience barriers is the interaction between patient and practitioner. A third paper discussing Muslim-Arab American experiences accessing psychological therapy discusses how the influential past psychological therapy experiences of peers can be on a patient's decision to access psychological therapy. Patients reflected that others had seen no improvement from therapy that it was ineffective and "did not cure" influenced expectations towards mental health support (Smith 2012). A fourth paper investigating Hispanic American (HA) and American Indians (AI) veterans experiences of mental health care highlighted that patients felt the mental health system is,

> *"Too difficult to access"* and *"mental health staff does not treat AI/HA veterans with respect"* (Westermeyer et al. 2002).

A crucial finding to emerge from the sub-theme of "patients past experiences of treatment" is that a patients perception of psychological therapy is not limited to individual personal experience of the patient but the influence extends further to the experiences of others.

A thesis discussing past experiences of Muslim American women accessing psychological therapy described how patients,

> *"really did not feel a connection with" (the) "therapist…she was white American"* (Haque-Khan 1997).

A mixed methods paper describing Arab American experiences of accessing psychological therapy reflected that patients,

> *"Said they had a negative experience",* of accessing services (D'Alessandro 2007).

11. Presenting Symptoms (Westermeyer et al. 2002;Loewenthal et al. 2012).

A paper discussing Somali communities (U.S.) describes how this community often struggle to distinguish the symptoms that are associated with depression from their day to day experiences. Patients often familiarise more easily with terms such as,

> *"'Broken spirits', 'disappointments' or 'depressive states'"…*

…as opposed to the western concept of mental health problems (Loewenthal et al. 2012). The second paper including Hispanic American and American Indian veterans comments on how this community do not seek out help due to the nature of their symptoms, this may be due to lack of knowledge about the symptoms associated with mental health problems (Westermeyer et al. 2002). Literature suggests the 'presenting symptoms' barrier refers to cultural differences in understanding presenting symptoms.

B) Community related barriers theme

The community related barriers theme consists of 2 sub-themes including; cultural expectations of community and family and community support. This theme contains barriers extracted from 2 included papers (Abrams et al. 2009;Westermeyer et al. 2002).

11. Cultural expectations of Community (Abrams et al. 2009).

This paper describes the cultural expectations of US born Latinas, Mexican Immigrants, El Salvadorian Immigrants, African American, Liberian and Belizean mothers, English speaking African American mothers and Spanish speaking Latina immigrant mothers, European Americans and Middle Eastern communities.

Authors discussed how cultural expectations of the community from participants' perspectives created a,

> *"Hesitation to disclose their feelings to others for fear they would be judged labelled as crazy or rejected by family members or friends".*

The cultural expectations of the community hinder this ethnic minority community to access psychological therapy. The researchers discuss how in addition to the psychological cultural expectations of the community, the additional cultural financial view was that,

> *"To pay for psychological support is frowned upon".*

In these ethnic minority communities' women are viewed as strong, independent and self-managing, this view may appear to be positive but upon reflection it created a barrier that,

> *"Impeded the consideration of mental health care"*…

…for ethnic minority women suffering from post-partum depression (Abrams et al. 2009).

12. Lack of community support (Westermeyer et al. 2002).

One paper discusses AI and HA veteran experiences in mental health care. The authors brought to light that the,

> *"AI/HA community does not support veterans' needs".*

This lack of support in the community can create feelings of lack of support amongst patients. Authors comment on how the lack of community support may make AI/HA veterans less likely to access mental health care (Westermeyer et al. 2002).

C) Family related barriers

The family related barriers are assigned into 2 sub-themes including; family support and community, and family influence. This theme contains barriers extracted from 52 included papers (Abrams et al. 2009;Westermeyer et al. 2002).

13. Lack of Family support (Westermeyer et al. 2002;Abrams et al. 2009).

One paper discusses the experiences of American Indian and Hispanic American veterans in mental health care. The authors emphasised that,

> *"Families are unaware or unsupportive of veterans' mental health needs"*…

…this is due to lack of knowledge in the area. This lack of knowledge within the family can create short comings in being able to adequately support the patient. Furthermore, in a second paper findings revealed that family members do not understand how services work and "how to access" support, further reducing possibility of access. Authors reflected that Hispanic American/ American Indian Veteran families and communities came across as unsupportive towards mental health needs (Westermeyer et al. 2002).

14. Family influence (Abrams et al. 2009).

This only paper describes family influence as a barrier for ethnic minority women suffering from postpartum depression. The reluctance of mothers to access psychological therapy…

> …*"unless their husbands approved"*.

This emphasises the importance and influence of a husband for the ethnic minority mothers described in this paper. This may create a barrier to patients accessing psychological therapy as some women,

> *"Would not tell their family members they were seeing a professional counsellor"* (Abrams et al. 2009).

D) Health service related barriers theme

The health service related barriers theme consists of 9 sub-themes including; preference for alternate treatment, appropriateness of service, lack of understanding of the referring health service, patients' preference for therapist to hold certain characteristics and patients expectations of therapist. This theme contains barriers extracted from all 6 included papers (Abrams et al. 2009;Westermeyer et al. 2002;Loewenthal et al. 2012;Loewenthal and Rogers 2004;Carpenter-Song et al. 2010;Smith 2012;D'Alessandro 2007;Haque-Khan 1997).

15. Preference for alternate treatment (Smith 2012;Abrams et al. 2009;Loewenthal et al. 2012;Loewenthal and Rogers 2004;Westermeyer et al. 2002;Haque-Khan 1997;D'Alessandro 2007).

Two papers described the cultural and society tradition for discussing small problems with trusted family members, friends and other social support. The availability of strong social networks and family support in the ethnic minority community surpassed the need for external support for these women, however in the instance of no close social network being present; individuals would seek external aid in the form of therapy (Abrams et al. 2009;Smith 2012).

A third paper comments on the American Hispanic and American Indian veterans' preference to,

> *"Obtain mental health services from traditional healers", "social welfare officers"…*

…as opposed to veteran mental health workers (Westermeyer et al. 2002).

One paper discussed Muslim-Arab American patients' preference to seek help primarily from a doctor rather than a therapist due to the biological grounding of mental illness(Smith 2012).

A common alternate treatment in five papers was religion. Authors discuss patients' preference for speaking to a religious figure such as an imam or rabbi (Loewenthal et al. 2012;Loewenthal and Rogers 2004;Smith 2012). One paper discusses the common Islamic belief that by being a good Muslim through faith, prayer and submission to God, the healing powers of religion prevent the onset of mental health problems (Smith 2012). Authors discuss the Islamic view that the guidelines within the Quran provide solutions for mental health treatment (Smith 2012;Loewenthal et al. 2012). Authors comment on how the majority of patients in this study,

> *"Turn to religion as a meditative and therapeutic outlet" and "use Quran to deal with mental illness".*

For some patients seeking help from a respected religious figure, for example an Imam, would provide a psychotherapeutic approach which is in line with their religious beliefs, by interpreting problems that incorporate behavioural world and the din/ soul realm together. Patients reflected that the availability of psychological therapy that advises on what is halal (religiously appropriate) and haram (religiously forbidden), can create,

> "*beautiful examples of psychotherapists*" (Smith 2012).

A paper describing Arab American experiences of accessing psychological therapy describes the barrier patients' preference for alternate treatments. The author discusses that,

> *"out of the 53 participants, 21 (39.6%) said they'd talk to a friend, 18 (33.9%) said they'd speak to a family member, 9 (17%) said they'd deal with it on their own, 5 (9.4%) said they'd talk to someone they trust"(D'Alessandro 2007).*

Religious preference for alternated treatment was indicated by Muslim American participants in the seventh paper. Authors discussed the patient preference of needing a,

> *"Muslim counsellor here…it is very important for this counsellor to counsel according to the Shariah" (Haque-Khan 1997).*

16. Appropriateness of service ((Carpenter-Song et al. (2010);Loewenthal and Rogers (2004);Westermeyer et al. (2002)).

One paper discussed that African American patients were unified in their expectations of mental health services holding a medication focused approach to care;

> *"They feared that health care providers", "principle concern is medication compliance"…*

…as opposed to helping them to solve their problems (Carpenter-Song et al. 2010). Patients also felt that the inappropriate focus on medication orientated treatment drew away from finding the reasoning behind their problems and thus treating the problem. However opposite of the African American patients, male Latino patients expressed that they sought out health care professionals to primarily to gain psychotropic medications with no concern for psychological therapy (Carpenter-Song et al. 2010). A second paper comments on Hispanic American and American Indian veterans reflections that veteran mental health services were too,

> *"Inflexible, rule-bound".*

Authors also discuss that the veteran mental health service either does not have adequate outreach in their communities or is difficult to access. Another element of this barrier is that patients feel that the service does not understand their needs (Westermeyer et al. 2002). A fourth paper discussed that in the Orthodox Jewish communities, individuals felt that by accessing a mental health service they would be seen as a failure. Authors also discussed the need for this community to have approval from a religious official (Rabbi), even with the presence and approval the process was time consuming as clarification of halachic questions was required at each stage (Loewenthal and Rogers 2004).

17. Lack of understanding of referring service (Loewenthal et al. 2012;Westermeyer et al. 2002;Smith 2012).

A barrier that was evident across all three papers was a lack of understanding of patient needs among staff members who were referring ethnic minority patients to psychological therapy. This included insufficient knowledge of Islamic guidelines which lead to feelings of shame, conflict, and guilt with family members of patients (Smith).Furthermore, the needs of patients were often misunderstood due to clinicians being unaware of appropriate resources required by patients (Westermeyer et al. 2002). This cultural insensitivity resulted in mental health staff making,

> *"False assumptions"* regarding patients (Westermeyer et al. 2002).

Patients felt that practitioners,

> *"Were not able to clearly understand the concerns and distress from participants perspective"* (Loewenthal et al. 2012).

The overall lack of cultural sensitivity of general practitioners has been suggested as being the reason for disparities in referral rates of BME patients to psychotherapies being low (Smith 2012).

18. Patients' preference for therapists to hold certain characteristics (Loewenthal et al. 2012;Westermeyer et al. 2002;Smith 2012;D'Alessandro 2007).

One paper described patient preference for health care providers from "*outside the community*" (Loewenthal et al. 2012). A second paper discussed patients' preference for gender matching with therapist. Mothers from ethnic minority communities described that they had a gender preference for a trustworthy female to discuss their depression with. Authors comment on patient specification for a therapist who was non-critical, expresses concern, cared and an individual that was able to sit and discuss problems with no time restraint.

> *"mothers described the "ideal" person to talk to about depression of PPD as a trustworthy woman who takes the time to sit and talk in an open, noncritical way, who listens, and who expresses care and concern"* (Abrams et al. 2009).

The third paper describes patients' preference for psychotherapists to have religious knowledge. Authors discussed that patients' felt that if psychotherapeutic principles were combined with religious understanding,

> *"they can be beautiful examples of psychotherapists"* (Smith 2012).

In a paper discussing Arab American experiences of psychological therapy "participants were asked to indicate if they would be more inclined to get outside help if the psychologist were Arab American, out of the 53 participants…(37.7%)" of women responded yes(D'Alessandro 2007).

19.Patients expectations of therapists (Smith 2012).

Patients reflected that they felt a therapist would not be able to incorporate the beliefs of the physical realm 'dunia' with the beliefs of the soul that is referred to within Islam within scripture. The author discusses the patient view that "therapist 'won't understand' or that a therapist might encourage them to do something contrary to their religion". Patients felt that to gain appropriate guidance this would only be possible to access from an imam. Negative attitudes towards therapists often arose from cultural beliefs as opposed to religious background. Patients often emphasised the strict rules of their religion and how they feared that a therapist may lead them astray from their religious beliefs and recommend a treatment "contrary to their religion" due to the therapists lack of knowledge about Islam. This barrier was further discussed by the author discussing how,

> *"following the advice of a doctor who is not culturally sensitive to the guidelines of Islam could cause a great degree of guilt, shame, and conflict"* (Smith 2012).

E) Practical issues related barrier theme

The theme of practical issues related barriers includes barriers extracted from 3 papers contributing to the subtheme of Cost (Smith 2012;D'Alessandro 2007).

19. Cost (Smith 2012;D'Alessandro 2007).

Authors comment on the financial concerns associated with accessing psychological treatment arose because patients were,

> *"Unsure if their insurance provided covered mental health services".*

An evident theme within this paper was that the majority of patients in this study were,

> *"Living on limited financial means",* cost is discussed as a *"major barrier"…*

…to accessing psychological therapy for ethnic minority patients in this paper. Lack of financial availability may create a barrier in paying for transport to access psychological therapy (Abrams et al. 2009). Reflections captured from Arab American experiences of psychological therapy further emphasised the barrier of cost, with patients who,

> *"said that it was the financial aspect that stopped them seeking outside professional help"* (D'Alessandro 2007).

CHAPTER II
METHODS

Branding of the project and development of the LOGO

2.0 TULIP: Acronym and Logo development

I aimed to develop a recognisable and concise acronym and logo for, “Cultural sensitivity audit tool: IAPT”.

i. I separated letters from “cultural sensitivity audit tool for IAPT” creating combinations of letters from each word.

ii. I chose letters from the words until I found a combination that was widely recognisable and representable with an image.

cul**TU**ra**L** sensitivity aud**I**t tool ia**P**t

2.1 TULIP logo

Image 1 TULIP logo

I used the logo throughout documents in the following stages of the project.

Study 2.0: Understanding the IAPT patient pathway: Methods

2.2.1 Aim

To summarise the IAPT patient pathway from IAPT handbooks and published literature.

2.2.2 Methods

The researcher searched for IAPT handbooks electronically.

IAPT handbooks

Inclusion criteria

i. IAPT publications that describe the recommended IAPT patient pathway.

Exclusion criteria

ii. IAPT publications that do not describe the IAPT patient pathway.

Data collection

i. I searched the IAPT website to locate IAPT handbooks (NHS 2016a).
ii. I thoroughly read the IAPT handbooks to understand the IAPT patient pathway for treatment.
iii. Following this I extracted data about the IAPT patient pathway.

Please refer to Chapter III Page 103 for the results of Study 2.0.

Study 2.1: IAPT site visits to conduct semi-structured discussions with staff members and North West of England Training Commissioner: Methods

2.3.1 Aim 1

To conduct semi-structured discussions with IAPT staff to understand their roles and the pathway within services.

2.3.2 Aim 2

To liaison with an IAPT North West of England Training Commissioner to discuss the recruitment of IAPT staff members to take part in a focus group and confirm adaptations made to the IAPT patient pathway.

2.3.3 Methods

The author (KK) conducted semi-structured discussions with IAPT staff members to capture the process of the patient pathway within the service. Following which the author conducted a topic guide led discussion with an IAPT North West of England Training Commissioner supported by the primary postgraduate supervisor (WW). *Please see appendices 1 & 2 on pages 203-204 for the topic guides.*

Facilitators

i. Site visits and semi structured discussions with staff: The author
ii. Meeting with Training Commissioner and topic guide led discussion: The author (KK) and supervisor (WW).

a) Participants (IAPT services)

Inclusion criteria

i. IAPT services in the North West of England
ii. High density of Ethnic minorities within the services catchment area
iii. Provides step 1, 2, 3 & 4 of the IAPT patient pathway/ all intervention intensities (receptionists, psychological wellbeing practitioners, Cognitive behavioural therapist and Manager).

Provides both face to face and telephone interventions.

Exclusion criteria

1. IAPT service that does not provide all 4 of the patient pathway steps.
2. Outside the North West of England
3. Not in a high ethnic density area.

The exclusion criterion was put in place to ensure that the sample included staff members who had direct contact with patients during the patient pathway. Members of IAPT staff with no direct patient contact were excluded as we aimed to capture the role of staff members and interactions with patients during the patient pathway.

Protocol for IAPT service and Training Commissioner recruitment

1. The author made a list of IAPT services in North West of England within a high density ethnic population and Training Commissioners using the NHS website that details the contact information of all IAPT services(NHS).
2. The author emailed potential participating services and commissioners with a brief description of the purpose of the site visit.
3. Potential participating services and commissioners were approached to arrange a site visit through email or telephone contact.
4. Potential participants were provided with an email address and phone number for the author to identify whether they wished to facilitate a site visit/ meeting.
5. If they agreed to participate, a site visit, a date, time and location was agreed upon to the convenience of the participating service/commissioner.

b) Participants (Staff and a *North West of England Training Commissioner*)

Inclusion criteria

1. Member of IAPT staff responsible for facilitating a step of the IAPT patient pathway with direct patient contact.
2. IAPT senior service manager (Training Commissioner) with an oversight over several IAPT services

Exclusion criteria

1. IAPT service staff with no patient contact (telephone/ email or face to face).
2. IAPT service manager (Training Commissioner) with oversight over only 1 service.

Protocol for IAPT staff recruitment

i. Potential participants were approached through the service manager.

ii. The author arranged a meeting with the service manager to discuss the purpose of the site visit and to discuss who the service would like to use as a representative in the semi-structured discussions with staff from each step of the IAPT patient pathway.

iii. Participating staff members were met according to the service manager's preference of time, date and location.

Documents used

Each semi-structured discussion required:

i. The IAPT patient pathway (D.H. 2011) to use as a discussion guide.

   Please see Figure 4, Page 101.

ii. A participant topic guide sheet to capture the role of each participant within the IAPT patient pathway. *Please see Appendix 1 on Page 203.*

The research proposal for the development of a cultural sensitivity audit tool for IAPT services in the form of a Microsoft PowerPoint was presented to the Training Commissioner.

Procedure

The location, date and time of the site visit was dependent on the convenience of the participating service. I hand wrote notes during the semi-structured discussions with IAPT staff members.

i. Upon arrival the author introduced themselves and gave a brief description of the purpose of the site visit (IAPT site visits and Training Commissioner).

ii. Participants were thanked for their participation (IAPT site visits and Training Commissioner).

iii. Participants were asked to discuss the responsibilities and extent of their role within the patient pathway (IAPT site visits).

iv. The researcher observed steps of the IAPT patient pathway by shadowing the receptionist that work in Step 1 or conducted a semi-structured discussion with Step 2/3/4 staff (IAPT site visits).

v. Participants were asked to describe any extra effort they may make to facilitate ethnic minority patients within the service (IAPT site visits)

vi. The previous results collected in the systematic review and site visits were discussed (Training Commissioner).

vii. The author and primary supervisor (WW) presented the research proposal of the development of a cultural sensitivity audit tool for IAPT services. (Training Commissioner).

viii. The aim to conduct a focus group with IAPT staff members was presented, encouraging the discussion of how best to facilitate the recruitment of appropriate participants (Training Commissioner).

Data collection

i. Hand notes of discussions with IAPT staff and the Training Commissioner to document discussions with IAPT staff members.

ii. Understand whether IAPT services within the local geographic sample area adhere to the patient pathway guidelines or whether it is deviated from during practice.

iii. Enquire whether IAPT services within the local geographic sample area make ethnic provisions for ethnic minority patients accessing their services.

iv. Add further detail to the IAPT patient pathway from staff reflections if appropriate.

v. Confirmation of the further detailed IAPT patient pathway.

Data collection procedure

The author made hand notes documenting the IAPT patient pathway from the perspective of IAPT staff members from each step of the IAPT patient contact pathway, IAPT managers and discussions with an IAPT Training Commissioner.

Data analysis

i. Discussion notes were used to define staff roles within the IAPT patient pathway by the author.
ii. The author created themes from the hand notes.
iii. Themes were summarised and linked to the IAPT patient pathway, to highlight any variations from the patient pathway within included services.
iv. Further detail was added to the IAPT patient pathway where appropriate.
v. The Training Commissioner discussion was typed up by the research student onto Microsoft Office Word.
vi. Feedback to make any further adjustments to the IAPT patient pathway was documented and applied if necessary.

Please refer to Chapter III Page 108 for the results of Study 2.1.

Study 2.2: Barriers to accessing IAPT services for ethnic minorities: Methods

2.4.1 Aims

To conduct focus groups with IAPT staff members.

2.4.2 Methods

I conducted a qualitative study by facilitating focus groups with IAPT staff members.

Participants (IAPT staff)

Inclusion criteria

i. IAPT staff members with direct patient contact.

ii. Members of staff from IAPT services in the North West of England.

iii. Participants who consent to participating in the focus group.

Exclusion criteria

i. Services not in the North West of England

ii. No patient contact.

The exclusion criteria was used to ensure that participants contributing to the IAPT staff focus group would have the relevant experience to share their opinions and experiences working with ethnic minority patients accessing their services.

Protocol for Recruitment

i. Participants were sent an invitation to participant in the IAPT staff focus group.

ii. Invitations were sent via email using through three mediums (phone, email or through the internal IAPT mail stream facilitated by senior IAPT manager).

iii. The invitation briefly described the purpose of the group, potential dates and location of the focus group.

iv. Participants were requested to identify their preferred date of participation using an Eventbrite page.

v. Once participants responded they were sent a confirmation email of the location, date and time of the focus group.

IAPT staff focus group planning procedure

Prior to the IAPT staff focus group researchers had a meeting to discuss the topic guide and procedure that would be used.

i. The author and supervisor (WW) discussed and confirmed materials required for the focus group.

Documents used

Each participant in the focus group required the following materials:

i. A participant information sheet *(Appendix 3, Pages 205-207)*, created according to the University of Manchester guidelines.
ii. A participant consent form *(Appendix 4, Page 208),* created according to the University of Manchester regulations.
iii. A participant demographics sheet to capture participant details and previous experience working in IAPT *(Appendix 5, Page 209).*
iv. An A3 copy of the further detailed IAPT patient pathway from Study 3 (*Figure 5, Page 114).*

Additional documents required for the facilitation of the IAPT staff focus group included:

i. Participant sign in sheet.
ii. Microsoft PowerPoint presentation of the IAPT patient pathway used to discuss each step of the patient pathway *(Appendix 6, Page 210).*
iii. A document of the Barrier themes and subthemes extracted from the systematic review used by the facilitators *(Table 6, Page 58).*
iv. Distress protocol used by facilitators in the event of a patient experiencing physical or psychological distress during the group *(Appendix 7, Page 211).*

Procedure for conducting focus group

a) Participants were welcomed to the focus group and thanked them for their participation.
b) Participants were asked to read the information sheet and consent form and sign if they consented to participate.
c) Participants were encouraged to ask about any queries they had relevant to the information sheet and consent form.
d) Participants were verbally explained the purpose of the focus group.
e) Participants were verbally reminded that the group would be audio recorded for the purpose of data collection.
f) The author initiated the focus group IAPT staff members at the University of Manchester.
g) The author and supervisor (WW) described a brief overview of the results from the systematic review which investigated "barriers to accessing psychological therapy for ethnic minorities residing in a western country".
h) The further detailed IAPT patient pathway was presented participants using a Microsoft PowerPoint presentation.
i) The researchers described each step of the IAPT patient pathway in detail.
j) Discussions at each stage of every step of the IAPT patient pathway were suggested and participants were encouraged to share experiences and knowledge about possible barriers experienced by ethnic minority patients.
k) Half way through the group researchers a 15-minute break was facilitated.
l) Participants were provided with contact details for any further questions they may have had after the focus group, or if they wished to withdraw.

Data collection

i. The focus group was tape recorded on two Dictaphones.
ii. A student colleague (NM) took notes simultaneously.
iii. The tape recording of the focus group was transcribed onto Microsoft Word Office by a second research student after the focus group.

Data analysis

Tape recordings of the focus group were saved onto an encrypted USB. Tape recordings were transcribed verbatim by the author and compared to the notes made during the group to ensure accuracy and consistency. The author became familiarised with the data collected through transcribing. Thematic analysis was used to code the collected data, forming themes and subthemes. Thematic analysis was used to allow flexibility during analysis of the qualitative data (Braun and Clarke 2006).

i. The author and supervisor identified themes and subthemes from the transcriptions. Focus was given to identifying participant reflected barriers that may be experienced by ethnic minority patients along the IAPT patient pathway to create themes and subthemes.
ii. Barriers extracted from the systematic review were used as an initial guide for themes that may arise during analysis.
iii. Quotes that reflected each theme or subtheme were extracted from the transcriptions.
iv. Upon creating barrier themes and subthemes from participant reflections, the researchers categorised them according to each appropriate step of the IAPT patient pathway.
v. Barrier themes and subthemes were reviewed, refined and summarised within steps of the pathway, extracted quotes were used to support each theme.

Please refer to Chapter III Page 116 for the results of Study 2.2.

2.4.3 Ethical considerations Studies 2 – 2.2

Due to the nature of studies 2- 2.2 having a focus on staff role and experiences within IAPT services and the feasibility of this project, there was no formal university of NHS ethical approval required. Within each study there was no discussion of identifiable patient experiences.

To ensure gained approval from a national Training Commissioner for the recruitment and participation of IAPT staff in the North West of England, thus further approval was not needed.

To ensure consent was received from all participants followed the following ethical procedures were conducted;

i. The focus group aims and procedures were verbally explained by the research student as well as being explained in detail within the standard participant information sheet.
ii. Verbal and written consent was received from all participants.

Participants were informed of;

i. Participants were reinforced not to disclose any identifiable patient related information.
ii. Participants were reassured of the confidentiality of their comments during discussion.
iii. The author gained verbal consent from each participant prior to conducting discussions within each study.
iv. If a participant wished not to discuss a certain topic they were free to refrain from commenting.
v. Study 2 - Tape recordings were not used for the purpose of this study due to hesitations of noise disturbance impeding the quality of recording and to ensure patient information being discussed within the office was not unintentionally captured.
vi. The author reinforced that any discussions that were documented would be referred to during results anonymously.
vii. Participants were allowed to withdraw at any point during the study.

viii. A two week withdrawal period was provided after the focus group, where participants could identify if they wished for their contributions to be removed.

During analysis all names were removed and references to specific services or persons were anonymised. Each participant was assigned a numerical identifier (e.g. Participant 1). This number was used on participant consent forms and demographic forms, and later used for identification within transcriptions. All encrypted audio recordings, transcriptions and notes were kept on encrypted USB's and a University encrypted computer system. This was done to ensure data protection. Original documents such as consent forms and demographic sheets with any identifying information were blacked out using a marker where appropriate and stored in a locked university filling cabinet which only the supervisors (WW, MP and the author could access.

The results of the IAPT staff focus group can be seen in Chapter III Results Study 2.2 Page 116).

Study 3.0: Expert discussion meeting: Methods

2.5.1 Aims

a) To capture expert opinions about the formatting and inclusion of questions to explore barriers within the cultural sensitivity audit tool for IAPT.

2.5.2 Methods

The author and a supervisor (WW) facilitated a qualitative study through conducting a discussion meeting with experts.

Participants (Experts)

Selection procedure

i. The author and postgraduate supervisor (WW) arranged a meeting to create a list of experts to invite to the expert consensus meeting.

Inclusion criteria

i. Past academic or clinical experience within the field of mental health.
ii. Experience working with IAPT
iii. Participants who consent to participation in the experts consensus meeting

Exclusion criteria

i. Participants with no clinical or academic experience working with ethnic minorities.
ii. Participants with no experience of working in a mental health.

The exclusion criteria was used to ensure that participants involved in the expert discussion meeting had appropriate knowledge and experience in the field of mental health, to aid the development of a cultural sensitivity audit tool for IAPT services.

Recruitment strategy

i. Participants from the list recommended by the supervisor were emailed a personalised invitation letter detailing the purpose of the discussion meeting; dates and times for them to select their availability.
ii. Participants responded with their availability and a mutually convenient time and date was selected for the meeting.
iii. Participants were emailed a confirmation email detailing the date, time and location of the meeting.

Expert discussion pre-planning meeting procedure

i. The author and a supervisor (WW) had a preliminary meeting to discuss the procedure to be used in the expert discussion meeting. The researchers discussed how best to present previous and future progressions of the study in order to best capture expert opinion.
ii. The author confirmed documents that would be required for the meeting to ensure that all materials were available for the participants and facilitators.
iii. The expert discussion meeting was to be facilitated using a discussion guide. (A*ppendix 8, Page 212).*

Documents used

Each participant in the expert discussion meeting received the following materials:

i. A standard participant information sheet created according to the University of Manchester guidelines *(Appendices 9, Pages 213-215).*
ii. A standard participant consent form created according the University of Manchester guidelines *(Appendix 10, Page 216).*
iii. A participant demographics sheet to capture previous experience and participant details *(Appendix 11, Page217).*
iv. An A3 copy of the further detailed IAPT patient pathway *(Figure 5, Page 58).*
v. A list of barrier themes and subthemes extracted from the systematic review.

Additional materials required for the meeting included:

i. A participant sign in sheet.
ii. A Microsoft PowerPoint of the further detailed IAPT patient pathway to be presented to participants *(Appendix 6, Page 210)*.
iii. Distress protocol to be used by facilitators in the event that a participant experienced physical or psychological harm *(Appendix 7, Page 211)*.

Expert discussion meeting procedure

a) The author and supervisor (WW) welcomed and thanked participants for their participation in the expert consensus meeting.
b) Participants were encouraged to read the information sheet and consent form and discuss any queries, prior to signing consent.
c) WW presented findings from the systematic review and our further detailed IAPT patient pathway on a Microsoft PowerPoint presentation and discussed each step in detail.
d) Following which the results of barrier themes from the IAPT staff focus group were presented to participants by the author (KK).
e) Each potential barrier was discussed systematically at each step of the IAPT patient pathway followed by participants being encouraged to discuss how best to phrase a question for the audit.
f) Participants and researchers discussed each barrier and how best to capture it in a concise question.
g) The author and WW suggested a draft question to the group.
h) The participants suggested rephrasing if appropriate.
i) WW encouraged the group to come to an agreement on the phrasing or inclusion/exclusion of a question.
j) The author and WW facilitated a 15-minute break half way through the group.
k) Participants were provided with contact details should they wish to withdraw up to a two week grace period after the group.

Data collection

i. The expert discussion meeting was tape recorded using two Dictaphones to ensure all data was captured in the event that one failed.

ii. A second research student took notes simultaneously.
iii. The Dictaphone tape recording of the expert meeting was transcribed by the author after the group.

Data analysis

Tape recordings of the expert consensus meeting were saved onto an encrypted USB. Any documents containing personal identifiable information such as consent and demographics sheets were blacked out using a marker and stored in locked cabinets in the University of Manchester. These cabinets were only accessible by the supervisor and researcher. All participants were assigned a numerical identifier (e.g. Participant 1) on their consent and demographics sheets. The numerical identifier was used during transcription and analysing results.

i. The transcription was compared to notes from the group to ensure all discussions were captured accurately.
ii. Thematic analysis (Braun and Clarke 2006) was used to code and theme the focus group transcriptions.
iii. Themes and subthemes were created under each step of the IAPT patient pathway as well as additional points of potential barriers within IAPT services.
iv. Themes and subthemes were supported by participant quotes extracted from transcriptions.
v. Transcriptions were used to formulate questions to be used within the audit tool.

2.5.3 Ethical considerations

Due to the nature of the study no extensive ethical approval was required. The study aimed to capture expert opinions to facilitate the development of an audit tool and we thus used consent forms and a distress protocol to ensure ethical procedure was employed. We also had a distress protocol in place in the event that a participant experiences psychological or physical distress *(Appendix 7, Page 211).*

To ensure ethical protocol was followed researchers;

i. Verbally explained the purpose of the meeting and consent.
ii. Requested participants read the information sheet and consent form that followed the University of Manchester standard format. Following which participants were requested to sign the consent form.

Participants were reassured that;

i. Discussions within the group were confidential and would be anonymised during analysis.
ii. Participants were free to withdraw at any point during the meeting or within a 2 week grace period after the meeting.
iii. If a participant was hesitant to answer a particular question they were free to refrain from participating.

Please refer to Chapter III Page 132 for the results of Study 3.0.

Study 3.1: Development of TULIP: Cultural sensitivity audit tool Staff perspective: Methods

2.6.1 Aims

i. Draft TULIP: Cultural sensitivity audit tool
ii. Draft TULIP: Cultural sensitivity audit tool guidelines

2.6.2 Methods

The author and a supervisor WW created a draft of TULIP: cultural sensitivity audit tool and TULIP: Guidelines from a staff perspective using data captured in studies 2-3.

Procedure for drafting TULIP: cultural sensitivity audit tool and TULIP: Guidelines

i. The author and supervisor (WW) collated questions agreed upon in the expert discussion meeting and the results from previous stages to formulate a sequence of questions in a cultural sensitivity audit tool for IAPT.
ii. The author and WW used barrier themes and sub themes to create categories within the audit tool that reflected the steps of the IAPT patient pathway.
iii. Following which the author (KK) wrote a detailed descriptions for any person that may be completing the audit tool independently to be used in the TULIP: Guidelines.
iv. The author wrote a detailed explanation of each audit question, which included an example answer where appropriate.
v. The author and a supervisor (WW) reviewed the draft tool and guidelines to ensure that all barriers had been captured and that the TULIP: Guidelines were concise and sufficiently explanatory.

Data analysis

i. The author discussed each section of the audit with a supervisor (WW) to ensure that all barriers were captured appropriately within the tool.
ii. The tool draft was confirmed by the primary post graduate supervisor (WW).

Please refer to appendices 12 and 13 on pages 218-230 for the results of study 3.1.

Study 4: TULIP: cultural sensitivity audit of IAPT services in the Northwest of England: Methods

2.7.1 Aims

To assess cultural sensitivity of IAPT services in the North West of England.

2.7.2 Methods

The author conducted an audit of IAPT services in the North West of England.

Participants (IAPT services in the North West of England)

Inclusion criteria

i. IAPT service in the North West of England.
ii. Services willing to participate in the audit.

Exclusion criteria

i. IAPT services outside the northwest of England.

Protocol for recruitment

i. The author created a database of all IAPT services in the North West of England from the NHS website (NHS).
ii. The author used two methods of recruiting IAPT services: Email or Phone call.
iii. Initially the author called each service to arrange a telephone meeting with the service manager, number of contact attempts were recorded at each point.
iv. In the instance that the manager was unavailable the author made a request to send an invitation and some information via email.
v. Upon having contacted the service the author arranged a meeting with the IAPT service manager.
vi. The author reassured participants during the initial call that approval for conducting the audit had been received from the Training Commissioner for their catchment area.

vii. The meeting Meetings was facilitated either at the service or over the phone to the convenience of the participant. At this point each participant was sent a copy of the audit tool and guidelines electronically via email.

viii. The author asked service managers for their preference for audit completion which included Phone audit, Email self-audit, over the phone audit.

ix. If a participant indicated that they wished to complete the audit independently they were sent an electronic copy of the audit tool and guidelines for completion.

x. Participants were requested to send feedback about the audit tool and guidelines.

Data collection

a) Email

i. Audits completed electronically were accompanied by tulip guidelines. Participants completed and returned these via email.

b) Phone

i. Participants were sent the audit tool and guidelines for completion prior to the telephone meeting.

ii. Audits completed over the phone were facilitated by the author.

iii. Verbal consent was described and taken from every participant.

iv. The author reinforced that the copyright for the audit tool will be held by the University of Manchester and that further distribution and use of the tool internally or externally would be prohibited without approval from the University.

v. Each question in the audit was asked systematically, if required the example from the guidelines was read to further explain the question.

vi. The author made hand notes on a printed copy of the Audit tool for each service simultaneously.

vii. Participant feedback was discussed and noted after audit completion.

viii. Each participating IAPT service was asked if they would like to be involved in future developments.

c) Face to face

i. Participants were sent the audit tool and guidelines via email prior to audit meeting.

ii. Verbal consent was described and taken from each participant.

iii. The author commuted to each service and met with the service manager.
iv. The purpose of the audit was discussed.
v. Participants were asked each question in the audit systematically, with an example from the guidelines used where appropriate.
vi. The author made hand notes of the answer on the audit tool.

Data analysis

i. The author typed up quantitative data onto SPSS and analysis using …
ii. Qualitative audit questions were analysed using thematic analysis.
iii. Feedback from services using thematic analysis of their reflections was analysed by the author.
iv. All feedback was categorised into themes and codes.
v. The data from feedback was used to make any necessary alterations to the original TULIP audit tool and guidelines.

2.7.3 Ethical considerations

No formal ethical considerations were required for this study other than approval from an IAPT Training Commissioner in the catchment area. To ensure that ethics were taken into consideration we ensured that all participants were verbally made aware of their role within the study and that they would only be able to take part if they had given their consent.

i. All participants were required to give verbal consent prior to participating.
ii. The author verbally explained to participants that their feedback and contribution towards the study would be anonymised.

Please refer to Chapter III Page 152 for the results of Study 4.

Study 4.1: TULIP: Cultural sensitivity audit feedback from service managers: Methods

2.8.1 Aims

To document the feedback from IAPT service managers who completed the TULIP audit at each service.

2.8.2 Methods

The author discussed feedback for the TULIP: audit tool and guidelines with IAPT service managers.

Procedure

i. Participants were asked for feedback about the tool and guidelines after audit completion.
ii. Feedback was noted by hand and services were asked if they would wish to be involved in further participation in the future.

Please refer to Chapter III, Page 165 for the results of Study 4.1.

CHAPTER III

RESULTS

Study 2.0: Understanding the IAPT patient pathway: Results

Summarise the IAPT patient pathway from the IAPT handbooks and published IAPT literature.

3.0.1 Literature selection

The author hand searched the IAPT and NHS websites to find published IAPT literature most commonly used by services. The author selected published IAPT literature that is widely used by IAPT services in order to understand the recommended IAPT patient pathway and recommendations for working with ethnic minority patients.

iii. Talking Therapies: A Four-year Plan of Action (D.H. 2011).

This handbook contains a detailed plan of how the government aimed to use £70 million of funding to support the further implementation of IAPT services for a third year. There were three key elements of focus for the improvement of IAPT services including:

1. Improving access to IAPT with a focus on older adults, children and young people.
2. Improving application and delivery of clinical interventions.
3. Through the implementation of IAPT, improved rates of employment.
4. Increasing patient satisfaction.

This handbook aimed to detail evidence based reflections from the previous two years of IAPT in practice. After discussing the results of the first two years the handbook discusses, how best to implement IAPT in the third year by implementing improvements to the service. The handbook discusses evidence for greater focus on improved access from older adults, children and young people. Detailing of the plan extends to training of staff members within the service as well as how the impact of such training can passively benefit the wider population.

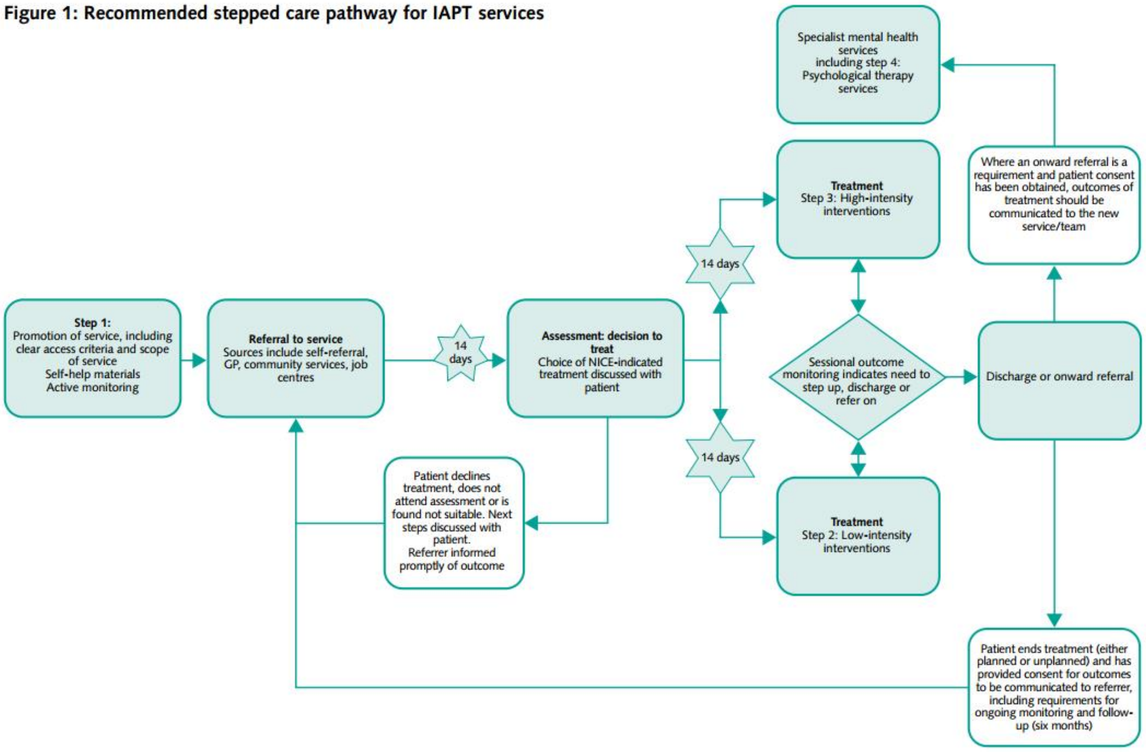
Not only does the handbook discuss the need for improvements but it also discusses the rights of age variant, ethnically diverse populations and the importance of improving access to care for these patients. Having discussed the need for treatment and access, the handbook expands onto the strategic method of intervention delivery. The handbook discusses in detail the recommended IAPT pathway. The handbook extended to discuss how the monitoring of service delivery and performance may improve the likelihood of changing wider policies of service delivery in mental health care (D.H. 2011).

Below I have added *figure 3*, the IAPT patient pathway recommended within IAPT handbook, for the stepped care model to be used in services (D.H. 2011).

Figure 4 ***IAPT patient pathway from recommendations***

Talking therapies: A four-year plan of action

Figure 1: Recommended stepped care pathway for IAPT services



Summary of a patient's journey within IAPT through the patient pathway

Step 1a

Step 1 is primarily focused on the promotional aspect of IAPT service. This step is firstly focused on how patients can be made aware of the service and the provisions it provides. The original pathway contains two options for promotion:

1. Promotional Materials
2. Active monitoring

The two options for promotion in step 1 are crucial in increasing awareness within communities for patients to know where and how to access psychological support.

Step 1b

The second element of step 1 is a patient's referral into IAPT services. There are 4 options detailed in the original patient pathway:

1. *Self-referral:* A self-referral form can be accessed either on site as a paper copy or electronically on IAPT service websites. 'Mindsmatter' IAPT services in Lancashire Care NHS Foundation Trust have online self-referral forms on their websites (NHS 2016b).
2. *GP referral:* a GP referral which may be used in the instance that a GP identifies a patient's need for psychological support, in this instance a GP may fill in the form with the patient during an appointment and send it on their behalf.
3. *Community services:* Staff may fill in a referral form with a patient and send it into IAPT on their behalf.
4. *Job centres:* Job centre staff may identify a patient's need for psychotherapeutic support and fill in a referral form with them and send it to IAPT from the service.

The patient will have an estimated 14 day waiting period prior to entering step1c.

Step 1c

The final stage of step 1 of the patients' journey within IAPT is an initial assessment of the patients' psychotherapeutic needs. Once a patient has been assessed the service will make recommendations of an appropriate intensity of suggested treatment to go onto either step 2 or step 3 of the pathway. It is here that a patient may accept treatment and move on to the recommended step. In the circumstance that a patient refuses the recommended treatment, misses appointment or is not found to be suitable for the recommended step the patient is re-referred back to step 1b. Patients moving onto step 2/3 will have a 14 day wait before entering treatment.

Step 2

Patients who enter step 2 interventions receive low-intensity intervention facilitated by a Psychological wellbeing practitioner (PWP). This will continue for a 6month period. Once a patient has completed their intervention their outcomes will be measured and depending on this a patient may move to step 3 for further treatment or step 4 (referred back to step1b/ Discharged/Onward referred to specialist service).

Step 3

Patients referred to step 3 of the IAPT patient pathway will receive 6 months of High-intensity psychological interventions facilitated by a Cognitive behavioural therapist (CBT). Once the 6 month intervention is completed patients' progress is assessed and a decision is made as to whether a patient requires referral onto step 2, back to step 1b or step 4 (referred back to step1b/ Discharged/Onward referred to specialist service).

Step 4

When a patient enters step 4 of the IAPT patient pathway they have 3 options:

1. Onward referral onto a specialist service
2. Re-referral into IAPT step1b
3. Discharge from IAPT including continued monitoring for 6 months.

iv. Black and minority ethnic (BME). Positive practice guide (NHS 2009).

This handbook firstly focuses on the mental health support needs of Black and ethnic minority patients in the UK. Leading onto what the best possibly procedure would be to investigate the representative ethnic minority population numbers in a services catchment area.

a) Having understood the need and number of possible patients the handbook goes on to discusses how the needs of this population can be met.
b) Authors suggest that IAPT and third sector organisations may be able to work better together to meet the needs of the BME patient population.
c) The handbook discusses the potential for barriers experienced by BME communities when accessing IAPT services and highlights that not only staff members but also Training Commissioners and managers should be aware of such potential barriers. Barriers are briefly discussed highlighting that there was a need to further investigate what barriers may be in relation to IAPT and that staff members may require training to understand and appropriately handle them if they arise.
d) The handbook suggests that community engagement with local services and voluntary organisations may help to reduce barriers within communities but on a service level also.
e) Furthermore the handbook suggests that Training Commissioners should liaison with speciality culture related specialists in order to effectively make a positive change.

Three key initial points were:

1. "Producing leaflets, pamphlets and flyers in languages representing the local community"
2. "Providing therapists able to speak other languages"
3. "Ensuring that interpretation and translation services are available."

To further facilitate the needs of BME patients the handbook recommended that IAPT commissioners have knowledge of the catchment area population and needs of the population in order to train staff appropriately to work with the community. Emphasis has also been payed to the importance of employing staff members from the BME community / background/ or religious matched to help to make patients feel more comfortable. As a result the key role here lay with the commissioner to be aware of the needs of ethnic minorities in the catchment areas of their services, to enable the adequate and appropriate training of staff (NHS 2009).

Study 2.1: IAPT site visits to conduct semi-structured discussions with staff members and topic guide led discussion with an IAPT North West of England Training Commissioner: Results

Semi-structured discussions with IAPT staff to understand the roles and pathway within services and topic guide led discussion with IAPT North West of England Training Commissioner to confirm any further detail added to the IAPT patient pathway.

3.1.1 Site selection

Catchment area: Greater Manchester and East Lancashire

Criteria: Northwest IAPT service in high ethnic density area

The author used the NHS website to locate IAPT services in the catchment area that were located in high ethnic density areas. The purpose of selecting Blackburn and Rochdale services was because of the similarities and differences in the ethnic populations within their catchment areas. Rochdale and Blackburn services are both located in South Asian density areas however the population in Blackburn is primarily Indian and Rochdale is representative of mostly Pakistani (Office of National Statistics 2011b). IAPT has a recommended pathway that is used across all IAPT services, thus the selection of these services was aimed to be representative of UK IAPT sites. The purpose of selecting ethnically diverse services was to highlight and discuss any barriers that these services may experience when working with ethnic minority patients representative of UK services.

3.1.2 Recruitment

The author contacted Blackburn and Rochdale IAPT services via email and phone, both agreed to participate in a site visit. IAPT has a standard structure across the United Kingdom and thus a small sample was appropriate as commonalities of patient pathway are replicated across all sites. I recruited services by either:

i. Emailing the service to arrange an over the phone discussion about the site visit.
ii. Verbally providing information about the purpose of the site visit.
iii. Then arranging a date and time for site visit to the convenience of the service.

Table 7 **IAPT staff interviewed demographics: Site visits**

Table 7 describes the demographics of IAPT staff interviews during site visits.

Service	***Professional role***	***Gender***	***Ethnicity***	***Other languages spoken***
1	Receptionist	F	Caucasian	No
1	Receptionist	F	Caucasian	No
1	CBT* Therapist	F	South Asian	Yes
1	Service manager	M	Caucasian	No
2	PWP**	F	South Asian	Yes
2	PWP**	F	South Asian	Yes

*CBT (Cognitive Behavioural Therapy)
**PWP (Psychological Wellbeing Practitioner)

3.1.3 Method of data collection

The author used hand notes to document topic guide led discussions with IAPT staff members.

Please refer to appendix 1 for Topic guide for discussions with IAPT staff: Site visits, Page 203.

i. IAPT patient pathway (for own reference)
ii. Role of staff member within IAPT pathway
iii. Deviation from standard IAPT pathway
iv. Facilitation of ethnic minority needs within IAPT service

3.1.4 Data analysis

After each site visit I immediately typed up and summarised the notes from discussions with each staff member.

3.1.5 IAPT service 1 results

Service providers in service 1 (n=4) provided a detailed insight into how a patient initially accesses IAPT services at the first point of patient contact, Step 2 and Step 3, medium and high intensity interventions, onward referrals, follow-ups and provisions for ethnic minority patients.

Staff role within the IAPT patient pathway

IAPT Service 1

Receptionist (Step 1)

The role of a receptionist within IAPT services is to receive initial referral, and welcome calls/forms from patients wishing to access the service. Receptionists will input data onto the IAPT database. Once an initial introductory call has been completed the receptionist will arrange a 30 minutes welcome call with the patient at their preferred date and time.

a. Receptionists discussed that patients often either self-refer using a self-referral free postage form, ring in, or have GP's complete and send in a referral form with them, referrals also occasional came from community or job centres.
b. If patients calling in had requirements of a language other than English, the service would facilitate this with staff members within the service that could speak the language or with the use of translators to facilitate.
c. Self-referral forms were not available in any language other than English.
d. If the service received a self-referral form it would be input into the IAPT service data base and patients would be called using the contact number they had provided. The purpose of this call is to organise an initial 30 minute introductory call. The introductory call is used to assess the level of need of the patient and thus to organise a face to face meeting at either step 2 or step 3 of the IAPT patient pathway.
e. During self-referral patients can identify their preferred method of communication which can be;
    i. Phone,
    ii. Email,
    iii. Letter
    iv. Or face to face.

    Patients can also identify whether they wish to restrict family from confidential IAPT information.
f. If patients identify that they wish to be contacted via email they are sent a standard IAPT invitation letter to call in and organise an introductory meeting, the service cannot facilitate this in any language other than English. Once an introductory

meeting has been arranged, IAPT patients will receive an appointment confirmation email.

g. Once the patient has been initially assessed they are provided with a treatment option of either low intensity intervention (Step 2) or High intensity intervention (Step 3), if agreed upon a relevant appointment will be arranged with the patient.

Provisions for ethnic minorities

The two IAPT receptionists the author conducted semi-structured discussions with reflected that IAPT had little information materials available in languages other than English or Urdu. Further to this the receptionists reflected that they could not confirm the accuracy of translations. When requested for examples of translated materials they were not available to hand.

CBT therapist (Step 3)

Patients with severe symptoms would be recommended step 3 high intensity intervention with a cognitive behavioural therapist. The CBT therapist provided step 3 high intensity psychological interventions. The CBT therapist highlighted that their service would not facilitate onward referral to external service, however if patients required further support they would be referred back into the service at step 1.

Provisions for ethnic minorities

The step 3 CBT therapist was one of the multilingual members of staff at their service would facilitate the needs of Urdu speaking patients where necessary. If languages other than those spoken by their team were needed the service would externally source a translator to come to the service for a face-to- face appointment.

Service manager

The service manager's key role is to oversee all staff in the service and ensure that all targets are being met. The service manager reflected that the service struggled with sourcing translated materials, and thus this was a barrier for ethnic minority patients accessing their service. He commented that the IAPT pathway was not always representative of practice within their service as they did not refer externally to other services once patients were ready to be discharged.

3.1.6 IAPT Service 2 results

Psychological Wellbeing Practitioners (PWP's) (Step 2)

The PWP provided low intensity interventions for patients with mild to moderate depression and anxiety disorders.

Provisions for ethnic minorities - ***Psychological Wellbeing Practitioners (PWP's) (Step 1)***

In order to facilitate the access of ethnic minority patients within their service PWP's at service 2 (n=2) were involved in step 1 as well as step 2 of the IAPT patient pathway. At IAPT service 2, the two female, South Asian, PWP's had a specific role for community engagement within the local South Asian community which was complimented by their multi-lingual skills. This additional role expanding from the standard IAPT pathway was developed due to their struggles at step 1 to deliver outreach of educational and promotional materials to the British South Asian community.

Psychological Wellbeing Practitioners (PWP's) (Step 2)

PWP's also highlighted that the British South Asian community accessing their service were predominantly reluctant to engage in one-to-one psychological therapy and had a preference for psychological therapy interventions in a group setting at a generic community centre or place of worship. Thus Service 2 created initiatives for their PWP's to deliver educational workshops and plays in the local community to raise awareness about mental health and also IAPT service. Further to this the delivered regular psychological therapy and wellbeing groups in the local community which deviated from the generic IAPT patient pathway.

3.1.7 Development of IAPT patient pathway based on reflections from IAPT site visit discussions

For the purpose of this research the author felt it was necessary to add greater detail to the original IAPT patient pathway. The site visits and discussions with IAPT staff created a first-hand insight of the elements of each step of the patient pathway that required further elaborating. The author added detail to the patient pathway in order to allow discussion and capturing of barriers experienced by ethnic minorities accessing IAPT at each stage of the pathway during focus groups.

The author added further details to the IAPT patient pathway shown on in *Figure 5, Page 114* from the IAPT onsite observations and semi-structured discussions:

a) The author broke down each step into separate tabs to improve visual clarity of each stage of patient contact during the pathway. The author colour coded each step for ease when visually identifying a step.

Step 1 consists of 5 key steps;

i. Exposure to IAPT service promotion (Online, Flyers, Self-help materials and GP).
ii. Referral (Call, form, Self-referral, GP, Job centre and Community services).
iii. Introductory call.
iv. Welcome Call.
v. Initial assessment.

b) The process of step 1 ii to v is recommended by IAPT to take approximately 14 days. Upon completion a patient is provided with treatment options. If the recommended option is refused the patient is referred into the service at Step 1 ii.

c) After initial assessment the author also added a 14 day waiting period as recommended by IAPT, between initial assessment and treatment in step 2/ 3.

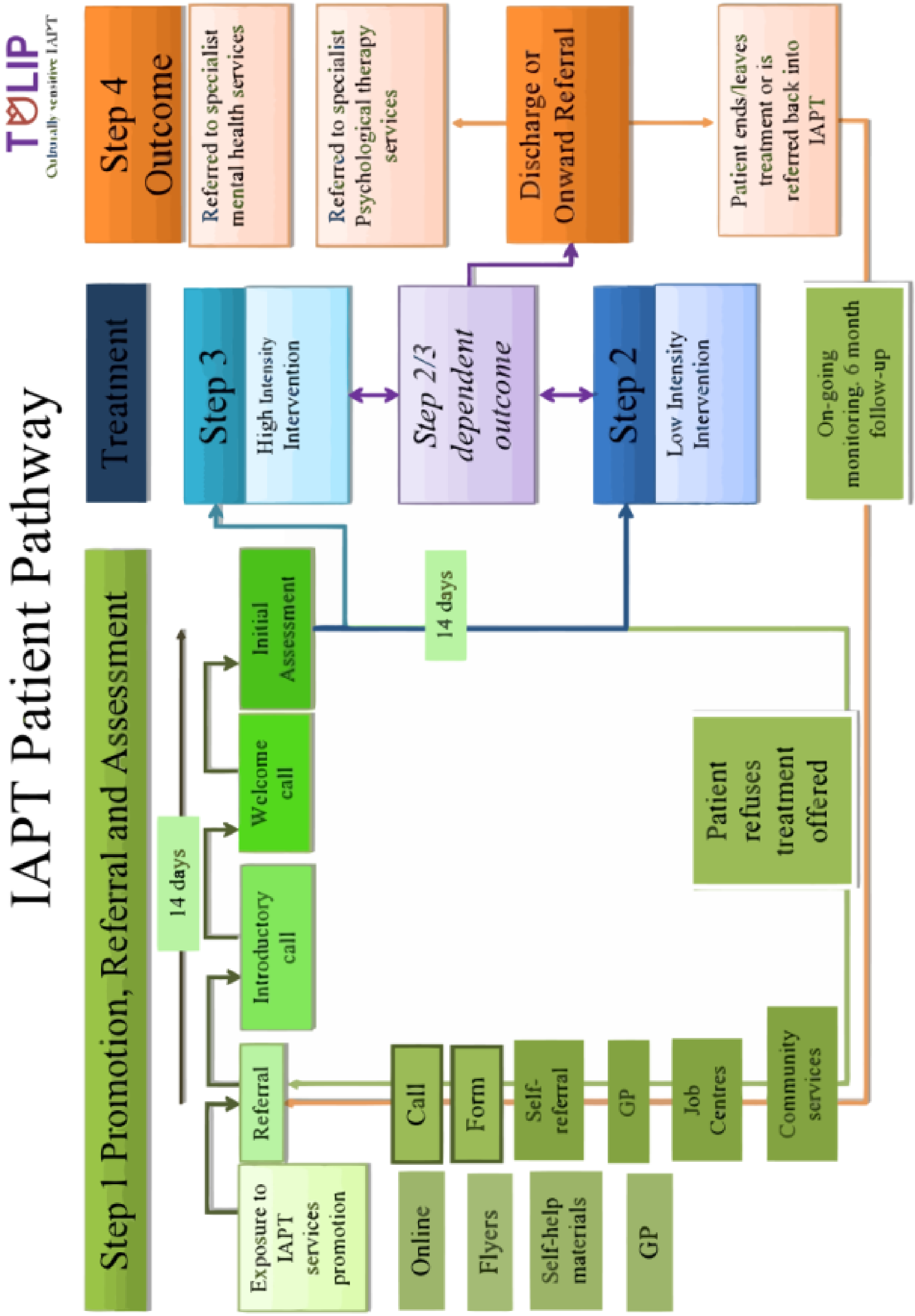
i. The author highlighted the treatment options within the IAPT patient pathway step 2 and step 3 in the colours blue and purple.
ii. The author removed the sessional outcome monitoring as staff reflected that this was dependent on patent participation and is thus not always consistent.
iii. Once a patient has completed their step 2 or step 3 interventions they are assessed to see which step would be most appropriate for them next.

d) Step 4 was colour coded as orange and consists of 3 options.

i. Referred to specialist mental health services.
ii. Referred to specialist psychological therapy services
iii. Referred back to Step 1 ii within IAPT services
iv. Discharged.

e) The author separated each stage into individual tabs creating variation from the original IAPT pathway to make it easier to discuss barriers experienced by patients at each stage of patient contact during the pathway in the following stages of the research.

Figure 5 **IAPT patient pathway with added detail**



3.1.8 Topic guide

Please see Appendix 2 for 'topic guide IAPT North West of England Training Commissioner, Page 204.

i. IAPT patient pathway *Figure 5, Page 114.*

ii. Facilitation of further research.

The author conducted a topic guide led discussion with one IAPT Training Commissioner for the North West of England. The author presented and discussed the accuracy of *Figure 5* IAPT patient pathway. The primary supervisor (WW) and author presented the research proposal and discussed the feasibility of implementing the project within IAPT services in the North West of England.

3.1.9 Results

The Training Commissioner provided her confirmation of the further detailed IAPT patient pathway and reflected that it was representative of the stepped care model employed by IAPT services. The Training Commissioner was keen to identify that our proposal for developing and conducting the audit had the potential to meet the needs within IAPT services to increase access for ethnic minorities. She agreed to assist for the duration of our project.

Study 2.2: Barriers to accessing IAPT services for ethnic minorities: Results

Focus groups with IAPT staff members.

3.3.1 Focus group preparation procedure

In order to facilitate the IAPT staff focus group the author developed the following materials which are attached as *appendices 3 – 7, pages 205-211*:

i. *IAPT staff sign in sheet.* A form for participants to confirm their attendance upon arrival.

ii. *IAPT staff participant information sheet.* The information sheet detailed the background and purpose of the focus group. Within the details I had explained any ethical considerations that were made and that we had a distress protocol in place. The author details contacts for herself and WW as well as external psychological support for participants in the instance that they require further support after completion of the focus group. I also mention the importance of participant confidentiality at the University of Manchester. I explained that all data would be stored in secure storage at the University of Manchester with all names blanked out and anonymised using numbers.

i. *IAPT staff consent form.* A form to be name, dated and signed by participant and researcher after having read the participant information sheet, to confirm their agreement and understanding in taking part in the group.

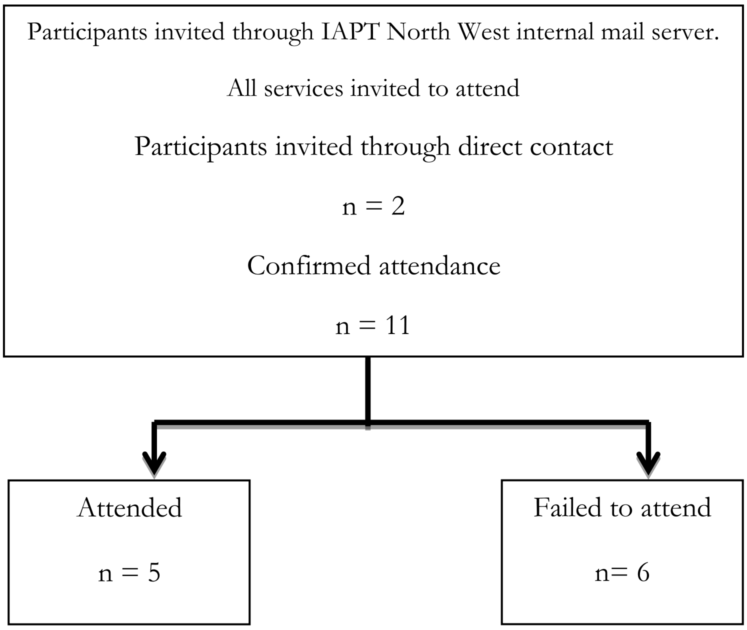
ii. *IAPT staff demographic sheet.* To be completed upon arrival, answering relevant questions about profession, languages spoken, ethnicity, service, training, IAPT experience, age, job role and gender.

iii. *IAPT staff distress protocol.* In the instance of a participant feeling psychological or physical distress this protocol would come into play and guide researchers on what to do.

iii. IAPT patient pathway. An A3 copy of the electronic version on a PowerPoint presented during the group. This will be handed out to each participant as an aid to refer to during the group discussions.

Each participant was distributed a materials pack including the materials listed above.

Figure 6 **Recruitment of IAPT staff members**



The author initially organised two focus groups, the first (June 28th 2016) had 6 registered attendees however only 4 participants attended. The second focus group was due to be conducted on July 6th with 5 participants however no one attended; we suggested that this may have been due to the clash with Muslim Religious Eid festivities on this day or due to it being a working day.

IAPT staff focus group

Date: June 28th 2016

Time: 10:00 – 12:00

Venue: Williamson building, Centre for primary care, University of Manchester.

Facilitated by: Dr Waquas Waheed and Kanza Khan

Sample demographics:

Participants included (n=4, Male = 2, Female = 2), 1 IAPT service manager, 1 senior psychological wellbeing practitioner (PWP) and 2 junior PWP's. Participant ages ranged between 30-50 years of age (Mean age = 37, Standard error = 3.937). Participants had varied ethnic and linguistic backgrounds as well as levels of expertise within the IAPT service and thus captured varied levels of experience. The sample varied in levels of training to work with ethnic minority patients from no specific training to specific training of working with this client group. The sample represented four services across the North West of England.

Table 8 **Participant demographics: IAPT staff focus group**

Participant number	***Age***	***Gender***	***IAPT professional position***	***Ethnicity***	***Languages other than English***	***Clinical case experience***	***Training to work with ethnic minority patients***	***Service***
P1	37	Female	Junior PWP Low – medium intensity CBT therapy	Black British	Yoruba	4-5 years	Mandatory cultural competency training	Halton & Widnes
P2	48	Male	Service manager & CBT therapist	White British	None	8 years	Mandatory cultural competency training	Oldham
P3	33	Male	PWP Junior Low – medium intensity interventions	Other British	Hebrew, Arabic, Yiddish, English	5 years	Mandatory cultural competency training	Salford
P4	30	Female	Senior PWP	British Pakistani	Urdu, Punjabi, English	3 years	Mandatory cultural competency training	Bury

3.3.2 IAPT staff focus group results

I will be presenting focus group results in a themes format. I will discuss each stage of patient contact within the IAPT patient pathway and comment on the emerging themes of barriers captured from IAPT staff members in the focus group discussion. Each theme will be supported with quotes extracted from the focus group transcription. Four participants attended the IAPT focus group. Please refer to the IAPT patient pathway used in the focus group for further details of each step (*Figure 5, Page 114).*

i) *Step 1 (Promotion, Referral and Assessment): IAPT patient pathway*

a) IAPT service promotional materials (Online, flyers, self-help materials, GP)

One participant reported non availability of promotional materials,

> *"I don't think they really have material to attract them or know what IAPT is" (P1).*

This was further supported by the lack of available resources that IAPT staff can access, staff discussed that they often use what they *"can find on the internet"* (P2).

> *"There's a lapse in provision of online services, links to flyers and self-help services. In five boroughs they're just about to go into CBT, no online therapy" (P1).*

Where information was available it was reflected that *"each individual service will develop own promotional literature" (P2).* Services often develop materials, however a service related barrier is that there is *"red tape around all NHS"* and that each document requires NHS approval.

Participants expressed that a major barrier for IAPT service promotion is language.

> *"Exposure is there but there's not enough language" "…generic material available…they need to be more readily accessible. Not just Hebrew and Polish but other languages as well" (P3).*

The language barrier was also captured for online materials, including IAPT information, mental health educational materials and self-referral forms.

> *"Very little. Bottom line. Website is in English" (P2).*

This is however where the barrier of literacy levels was reflected. Participants discussed throughout the focus group that a dominant barrier was that of low literacy levels within the British ethnic minority community.

> *"Issue with how many people in community read Urdu…sometimes we get told people don't read Urdu, might speak but don't read" (P2). "some of the translated material like Urdu… quite a high level of reading required"* (Participant 3).

Along with the literacy and language related barriers, participants reflected that ethnic minority patients may experience cultural barriers to accessing online services where,

> *"Communities don't encourage or advocate online use"* (P3 referring to the Jewish community).

b) Engaging the community

Participants discussed engaging the community from a promotional step 1 level. Participants reflected that there was no effort made in the NHS to recruit ethnically representative staff members.

> *"I think staffing is an issue. People see it as predominantly white staff for white service for white majority".* Participant 2 highlighted that within the NHS, *"you don't see that in recruitment. Adverts online, NHS Jobs. No attempts to go in the community" (P2).*

One participant reflected that their service has taken its own initiatives to engage the ethnic minority community. This service recruited volunteers from the local community to increase ethnic outreach and engagement. The service,

> *"Went on to pay them full time. 30-40% work force was mainly South Asian. Most of that was women" (P2)*

> *"We're trying to work with mosques…Friday prayers, things like that. Community groups…groups in the communities…BME. All sorts of things…There's no reason why Imam's can't support" (P2).*

This may suggest that having an ethnically representative workforce may be a barrier and need within the ethnic minority community in the UK.

c) General practitioners (GP's)

We encouraged discussion around the relationship between IAPT services and GP's during step 1 of the IAPT pathway. Participants reflected that a major barrier of lack of IAPT knowledge within GP's was present and that,

> *"Some GP's don't even know what IAPT stands for" (P1)* and further to this that *"GP's are prescribing antidepressants and not actually referring patient s into the service" (P2).*

On a GP level the barrier of cultural/community related stigma was highlighted. Two participants discussed this barrier:

> *"It's a massive barrier in terms of GP's and GP's from the community. Don't trust mental health services and neither does GP. They discourage IAPT." (P3)*

> *"in high BME areas 100% South Asian communities… some GP's are from the same background and have similar prejudices" (P2).*

Participants also commented on how within*,*

> *"Ethnic groups, (there is) a lot of stigma around… (what is on) on GP records"* (P4).

It is here that the barrier of preference for alternate treatment arises when,

> *"GP recommends in house…private" treatment (P3).*

Lack of cultural awareness within GP's was also commented on by one participant:

> *"I saw the husband lately… off anti-depressants lately because BME group and beliefs in God can sort it out for us and GP didn't pick up on that" (P3)*

Discrepancies in communication between GP's and IAPT services can cause problems in provisions of interpreters,

> *"You go to GP for a referral and they say you need a Farsi interpreter or Urdu. Sometimes they don't. Sometimes there's no interpreter booked. They come down, no English." (P2)*

d) Influence of family or community

The importance of family and community support during step one was briefly touched upon by one participant:

> *"More symptoms she's been experiencing in the past and due to support from family and husband prompting her. You still need to take medication. Someone like them encouraging them would foster to promote IAPT services" (P3)*

e) Self-referral

Barriers during self-referral included literacy levels and language barriers while communicating with patients from an ethnic minority background.

One participant discussed referral rated in the BME population compared to the BME population in their catchment area:

> *"My understanding we don't get enough referrals from BME to start. Oldham is about 22% in terms of South Asian and we get 8% referrals from South Asian community not being referred" (P2)*

> *"Self-refer. They can phone us and we'll put them through. We'd have to book an interpreter and arrange a face to face" (P2)*

This suggests that the time for receiving psychological support for an ethnic minority relying on a translator would be longer than that of an English speaking patient.

> *"It's a massive barrier because of literacy because it's paper heavy so if paperwork's all in English, you don't read English, it's not first language or poor literacy…" (P3)*

This restricts access to the English speaking population,

> *"You're out the door straight away unless someone reads for you and you may not want them to know. 20% of the population right away…" (P2)*

The provision for language facilitation would be provided through,

> *"Interpreter"* (P2), *"Friends or family" (P1).*

Participants reflected the difficulty in accessing IAPT services for ethnic minority patients with a language barrier,

> *"I sometimes think from patient's perspective. Is it worth it, all these barriers and hurdles just to get a brief assessment which probably doesn't meet their needs and just have to do this hullaballoo again and again?" (P3).*

f) Phone calls

IAPT Staff reflected that patients will often refer through,

> *"An online portal…further details get sent off email acknowledgement. They'll get a letter asking to ring us so again… can't read English for whatever reason, that's a barrier" (P2).*

I will now discuss the barrier of lack of service awareness that leads to incorrect referrals.

> *"We do get referrals but these community services for people who are long term… service to get people off benefits. Already they have interventions, psychological therapy services, that's what they're there to do" (P2) "And the ones I've come across think we're there to reinstate their benefits. They're trying to get back to work. Clients I've seen say I can't work, you're supposed to*

> *write a letter" (P1), "We have people coming from job centre to GP to us" (P3)*

The barrier of trust was discussed from a step 1 perspective that often,

> *"Jewish communities"…"people don't trust NHS" (P3).*

The participant reported that often within the Orthodox Jewish community there is a lack of trust towards the NHS; this may hinder access from this community.

g) Patient introductory call

One service reflected that they do not follow the standard IAPT referral process and have instead accommodated the needs of the ethnic minority community in their catchment area. Participants discussed the restrictive nature of the standard protocol and how it time restraints limit the facilitation of adequate treatments.

> *"We've stopped doing step 2. Staff in Oldham… because 45 minutes isn't enough. A normal assessment is 30 minutes. They now see a counsellor or CBT service. Doesn't make sense. They need more time", "Screening appointment… so if someone comes through, English isn't first language, they get screened at step 3 rather than step 2. So they can step them down… this person needs CBT or counselling or psychology" (P2).*
>
> *"The barrier itself, even before we come… the issue is you're not seeing the person. Only 20 minutes and something might have been missed and you can't pick up on something.*" (P1).
>
> *"If you've got them time and usually we can't see them face to face, we usually get permission to give them extra time. 45 minutes" (p4).*

ii) *Step 2 & Step 3 (Treatment): IAPT patient pathway*

For greater detail about the stages of Step 2 and 3 of the IAPT patient pathway please refer to *figure 3, Page 115.*

a) Outcome measures

We encouraged the discussion of provisions of ethnically appropriate outcome measures within IAPT services. Participants commented that,

> *"Main South Asian languages"* are *"available… off IAPT website" (*P2).

b) Educational Materials

Discussion about mental health educational materials was opened to the group; one participant reflected that other than English,

> *"The NHS has different materials in languages, depression, anxiety booklets"…"that we use in sessions" (P4).*

A cultural patient related barrier at step 2/3 identified by one participant was that,

> *"People in BME communities don't access straight away, wait till things get worse. And I don't think there was a brief assessment or 20 minutes. They want step 1, step 2, step 2, step 4 to get where they want to"* (P3).

c) Ethnic minority drop outs, time keeping and missed appointments

We encouraged a group discussion about time keeping, missed appointments and drop-outs in ethnic minority patients as compared to the general population.

In regards to time keeping there was no difference indicated between ethnic minority patients in comparison to the general population, a participant commented that,

> *"Time keeping in South Asian communities- sometimes people don't arrive on times but sometimes all ethnicities" (P2).*

Comments on religious reasons for missed appointments were discussed such as,

> *"Things like Friday prayers, things like that. Sometimes people don't turn up, might tell you one reason" (P2).*

One participant when discussing drop-outs at their service said that they,

> *"Have a small number of BME coming through the surface…they won't complete it"* the participant enforced that this may be due to a *"language issue" (P3).*

d) Patients understanding of therapy principles

There was no direct emphasis on barriers from a patient understanding of therapy principles perspective however one participant discussed methods used to explain these principles in lay terms.

> *"Whenever they experience… use diagram. Less volume of words. Also as much as possible, use my own personal experience. Not other. Not too much because of professional boundaries. That sort of makes them feel relaxed" (P1).*

e) Trust

The major barrier of trust was emphasised throughout the IAPT staff focus group. In regards to step 2 and 3 participants discussed community level barrier of trust and well as methods of overcoming the barrier.

> *"There's a bit of mistrust. I live in the area. I know people from the same community. They're worried about information getting passed on. I assure" (P3).*

> *"Sharing information wouldn't affect professional barriers. I would share to the extent that they're now supporting me. It's just to let them know that somebody, like a clinician has gone through a similar situation. Makes them believe this can work for me. Road to recovery. So it's worked for me. It's not just people from like… the um low spectrum of the society. You come across even managers coming to see you. There's no shame in it" (P1).*

f) Patients asking for personal experiences and information

We facilitated the discussion of practitioner opinions on sharing personal information with patients if requested.

> IAPT staff members discussed that often the information patients seek is to develop a *"common ground"* and a sense of *"reassurance"* Participants were happy to *"share personal experience"* however would keep it "relevant and quite brief" reinforcing that they *"can keep within boundaries"* (P3).

One patient commented on the inevitability of some personal information being shared as,

> *"We have 4-6 sessions. They would have come to know you maybe towards the end of the session"* (P1).

g) Ethnic Matching

We encouraged the discussion of provisions for ethnic matching within IAPT services. Participants discussed whether their service can or do provide ethnic matching for patients. The barrier of lack of provisions for ethnic matching of patients with practitioner appeared across participants in the focus group. This was highlighted by all patients,

> *"When patients get screened they may ask for a male or female therapist or someone from the same ethnicity, not often" (P2)*

This participant also highlighted that there service does,

> *"Accommodate but it's not easy…some staff are BME, South Asian, but they're all female. I don't have an Asian male therapist anymore…the choice is very limited" (P2).*

Contrary to this participants commented,

> *"I've had the opposite, where they didn't want to be seen from someone with the same background. Trust issues" (P1)*

The participant commented that, *"these choices are available".* Contributing that an additional *"waiting period"* was identified when participants *"want specific conditions"* such as *"female practitioner only" (P1).*

h) Lack of IAPT staff cultural awareness

When the discussion was opened to IAPT staff cultural and religious awareness the discussion was opened to how,

> *"I don't think everyone's aware of Friday prayers, Ramadan" (P3)* where P2 highlighted that *"it's useful to understand other cultures."*

This reflected that there is a lack of awareness within some IAPT services about religious or cultural beliefs of ethnic communities however that some services recognise the importance of having awareness.

i) Differences in therapeutic response and need of time and number of sessions between ethnic minority groups as compared to the general population

Participants discussed that ethnic minority,

> *"Patients have more demands" (P3),* and *"need more sessions, need longer sessions" (P2).*

Furthermore the discussion continues to how,

> *"People might come a bit later. They might present more complexity"* and thus *"may need longer amount of sessions"*(P4 agreeing with P2 and P3).

j) Provision of interpreters within IAPT services & translation of psychological terms

Participants were asked to discuss their experiences facilitating the use of and working with translators,

> *"Generally we're okay with South Asian languages. Its things like interestingly… Czech problems finding interpreters" (P2)…*

…however reflected that they were unsure about the quality of translation being provided when they did access translating services,

> *"The interpreter won't interpret accurately and you won't know what's being said. You see the conversation, what's going on here. You don't know how it's being interpreted back" (P3).*

This barrier of communication between practitioner, patient and translator may be a cause for concern. IAPT staff who does not speak the language of the translator would be unable to establish whether the translation is accurate.

There are additional costs related to the provision of translators. Comments included that they have a,

> *"£7000 budget but if we go over that, we go over that".*

Essentially through internal budgeting IAPT services are spending,

> *"As much as…"* they *"need to spend on it to meet the bottom line".*

iii) *Step 4 (Outcome): IAPT patient pathway*

For further detail about the stages of Step 4 of the IAPT patient pathway please refer to *Figure 3, Page 115.*

a) Past experiences of therapy

We facilitated the discussion of the influence of patients past experiences of therapy and how that affects ethnic patient access and engagement. Comments included,

> *"Predominately people have good experiences. I think you get extremes, people who are very unhappy and complain and people who are happy. People who say nothing" (P2).*

Discussion on this topic was limited and thus did not have substantial data to draw from.

b) Symptoms for consideration of onward referral

Three barriers arose when considering onward referral on the basis of patient symptoms. These included: The first religious and cultural stigma associated with mental health symptoms.

Referring to the Jewish community,

> *"Our community don't talk about it much outside. They always get shocked. Have to ask everyone we see. Surprised when we talk about suicide" (P3).*

However another participant commented that,

> *"Religion comes into it. Muslim will say it's against my religion".*

These religious and cultural barriers to discussing mental health problems may create a barrier to access for ethnic minorities to psychological therapy if they feel shocked or religious hindrance towards discussing them.

Further to this the Muslim,

> *"Beliefs in jinns"* are *"not acceptable in terms of a white western view" (P2)* were commented on.

Participants also commented on the second barrier within Step2/3 as patient preference for alternate support for psychological problems,

> *"If people don't believe in western approach to medicine they'll look for help elsewhere." (P2)*

The third barrier captured in step 2/3 of the IAPT patient pathway was associated with family and community support. Participants discussed the influence of family and community support on a patient's likelihood to access therapy.

> *"it also goes back to family support. Homework they have to do, they might need some support. Let's acknowledge positive qualities to help with self-esteem. Templates with… website ask friends and family. So if the… if the environment they're coming from that's not one that supports… that you make*

> *yourself… have this confidence in yourself that might be a barrier for the client to promote self-esteem."* (P1).

The difficulties of discussing certain experienced within ethnic minority communities was commented on,

> "*Sort of conflicting feelings about…see women in arranged marriages, there might be domestic violence and unsupportive or violent partner. You're going to counselling to talk about this stuff. Divorce in South Asian communities being taboo and I think sometimes that's difficult for women especially" (P2).*

Facilitators suggested the discussion of barriers to signposting to other services. Participants commented that,

> *"If it's internal, it's not too bad"* (P4) however *"Access to secondary care is virtually impossible" (P2).*

They went on to discuss that,

> *"When signposting, sending out into community services… issues, funding for those services"* there is only a certain *"amount of support they can provide" (P4).*

Other than the practical issues of referring onto external services practitioners discussed how,

> *"We have 3 month waiting list. So, you want to refer them out. They don't call them" (P1*).

This can be a barrier in itself, if a patient is apprehensive about engaging with a psychological therapy service and receives no contact from the service prior to starting this may hinder their access.

c) Discharge

When discussing discharge comments indicated that they,

> *"Tend to get people with more severe issues late to support" (P3),*

Thus refer patients on to an external service for more severe mental health problems. In this circumstance the service carried the view that they,

> *"Do need to carry on planning what will happen after they've worked with us" (P3).*

d) Extra initiatives/support for ethnic minority patients

When discussing any extra initiatives IAPT services have to support ethnic minority engagement one participant highlighted that their service have provision for tokens. These tokens are often for,

> "£1 or £5, you have to pay" *(P1)*…

…out of your own service funds to help the engagement of ethnic minorities with little access to financial support.

e) Policy

Participants discussed policy within IAPT for ethnic minority patient engagement. The group agreed that IAPT is *"target orientated"* (P2, P3). The target driven approach was seen as a major barrier within IAPT.

> *"We try and see people as much as we can. Some of that is about… that's gaming. That means you've had two treatment sessions so you've had treatment. You're gonna hit your targets".* In *"some respects I need more referrals in to the service so I need more ethnic minorities" "there are some soft targets around underrepresented groups and we need to report on that and I think it's important we do increase the numbers so we're representative of the population of Oldham. But IAPT is target driven. If you look at that IAPT report that came out last year or this year the first million patients, half of them only had one appointment. If you looked at the numbers it's about one contact. Referrals which are great. One off contact so I can say I've hit my access rate and that is a national issue and that's not gonna help BME access services" (P2).*
>
> *"It's sad this gaming business and I think it's more about dropping targets. I don't think it's possible but I dream of the idea to have open access where people drop in. They're formal but people drop in, have all these barriers and hurdles come in and say what's going on in their lives." (P3).*

This policy discussion indicates that IAPT service providers are aware of the benefit of a target driven IAPT however also identify the barrier that the target driven IAPT policy is creating for ethnic minority engagement.

3.3.3 Conclusion

Reflecting upon the experiences and opinions of IAPT staff members it is evident that their reflections are on par with the barriers extracted from the systematic review. These findings further emphasised the need to capture levels of cultural sensitivity within IAPT services. Reflections from the IAPT staff focus group indicate that there are consistent barriers throughout the IAPT patient pathway for ethnic minority patients. The greatest consistent prevalence of barriers was that of language (patient and staff), patient's literacy levels, Practitioner religious and cultural awareness and stigma within the community. In order to develop a cultural sensitivity audit tool to assess cultural appropriateness of IAPT services an expert opinion is needed. I will now discuss the next stage of this project in which I conducted an Expert discussion meeting presenting the findings from the systematic review and IAPT staff focus group to facilitate the development of an IAPT cultural sensitivity audit tool (TULIP) and TULIP: Guidelines.

Study 3: Expert discussion meeting: Results

Discussions with experts, structured using a topic guide and findings from previous stages of the project to agree upon question topics to include in the final cultural sensitivity audit tool.

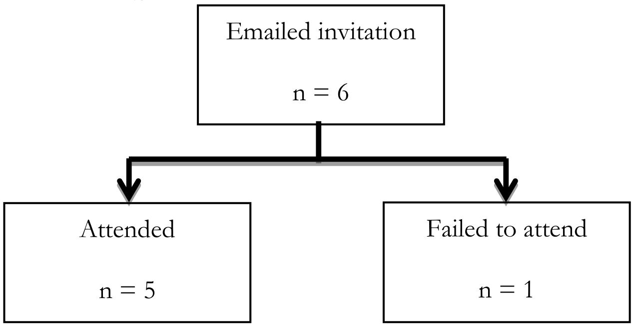
3.4.1 Selection criteria for experts

Participants were selected based on their experiences of working with ethnic minorities in clinical and academic mental health settings.

Table 9 Expert discussion meeting participant demographics

Participant number	Gender	Age	Ethnicity	Profession	Qualifications	Experience working with IAPT services
1	Male	48	White British	IAPT service manager	Mental health Nurse, MSc	5 years
2	Female	33	White British	Psychologist	PhD, Health service research.	5 years
3	Female	49	Pakistani	Psychologist, CBT therapist	PhD, Psychology.	9 years
4	Female	35	Iranian	CBT therapist	MSc, PhD candidate.	6 years, 4 months
5	Male	59	Pakistani	Psychiatrist	MD, MBBS.	9 years

Figure 7 Recruitment of experts



3.4.2 Recruitment

Participants were directly emailed invitations to participate in the expert discussion meeting. Out of the six participants invited, 5 participants were available to attend the expert discussion meeting on Friday August 19th 2016. One participant was unable to attend due to a commitment to a clashing research work meeting. Please refer to *Table 9* above, detailing participant demographics.

Expert discussion meeting August 19th 2016:

Date: August 19th 2016

Venue: Williamson Building, Centre for Primary Care, University of Manchester.

Time: 10:00 to 13:00

Facilitated by: Dr Waquas Waheed and Kanza Khan

I will be presenting the expert discussion meeting results under different emerging themes reflecting the IAPT patient pathway. I will discuss each barrier theme with reflections from participants (n=5) about how to best phrase questions to be included in the cultural sensitivity audit tool (TULIP). Each theme will be reinforced with the use of quotes from the expert discussion meeting transcriptions.

Please refer to Table 6, Page 58 for barrier themes and subthemes.

3.4.3 Expert discussion meeting results

i) Step 1 (Promotion, referral and assessment): IAPT patient pathway.

Please refer to Figure 5 on page 114 for the IAPT patient pathway.

a) Marketing of IAPT

Firstly, we wanted to establish what the best practice to market IAPT services is.

When discussing the benchmark of what is needed for marketing IAPT to the ethnic minority community?

Participants discussed that a pivotal aspect of marketing to perspective patients are the,

> *"The materials you use"* and whether these *"materials are printed in different languages" (P1).*

One participant further described *"challenges in Oldham" (P1)* and how these were facilitated by their service using marketing materials that were ethnically appropriate for their catchment area.

> *"Our business cards are now printed in community languages so that is something that we are trialling." (P1)*
> *Additional to this (P1) reflected that they, "in terms of marketing itself, we have done community events so we leaflet about 10,000 properties."*

These aspects of the group discussion lead the group to an agreement on the inclusion of a question about:

i. Availability of marketing materials
ii. Whether marketing materials are culturally adapted.

The discussions lead to participants describing aspects of cultural sensitivity which may be required when creating marketing materials.

When discussing the content of materials used to market IAPT participants discussed that,

> *"In the background of all this will be the issue of stigma. What is going to be acceptable to the population coming to IAPT … so what are you saying to them in that?"(P1).*

Further to this participants discussed the limitations of translating due to lack of availability of appropriate vocabulary in other languages.

> *"It's the issue also of the language used to describe mental health there isn't a great deal, there's 'pagal' which of course encompasses a whole range of things." (P1)*

The group discussion highlighted that some services where there was an immediate greater need for culturally adapted and or translated materials it was something they would take an initiative to create and facilitate independently to other IAPT services. These alternate methods to improve access for ethnic minority patients in their catchment area, provides an example of how this can be achieved in practice.

b) <u>Mental health literacy</u>

Is it the responsibility of IAPT to increase mental health literacy?

When asked about the importance of IAPT's role to improve mental health literacy participants were in agreement. Participants agreed that,

> *"It's about building mental health literacy in the community" (P1).*

Further to this participants discussed how this can be achieved on a community level,

> *"It is important when working with IAPT to inform and work with community leaders"* (P3).

The element of improving mental health literacy as part of IAPT's responsibilities was reflected as a requirement,

> *"To have people that when someone picks up a flyer that there is someone to explain what the service is about" (P3).*

Participants were asked where the following questions should be included:
Are there any translated materials available?
Is the content of materials being changed to meet the needs of local groups?
Are you working with local community organisations to market and make people aware of IAPT?

The group was in agreement for the inclusion of the above questions. Upon discussion the participants reflected that further to this,

> *"There needs to be someone to deliver this information to them and to explain these things to them and encouraging them to access this service" (P3).*

c) Community engagement

We went on to suggest that perhaps we could add the question:

Have you got a community engagement lead or somebody with special interest or a designated person?

One participant reflected that the services she has worked in have previously done this by,

> *"Linking with voluntary organisations" (P3).*

To which we suggested the question: **"Are you linking with local community organisations?"** as a question to be included in the audit.
When discussing the topic of ethnic matching participants highlighted that it is essential to see what the needs of the target population are and whether they require ethnic matching. One participant also mentioned that it may be more appropriate to see whether IAPT staff requires,

> *"Training in cultural sensitivity" (P5).*

Next we discussed educational materials including IAPT, pamphlets on mental health literacy, flyers on depression anxiety etc. We opened discussion to whether the same principles as discussed for IAPT promotional materials also applied to educational materials.

Participants discussed the problems that arise when translating materials.

> *"Sometimes the language we are using to translate materials is so difficult that people can't actually understand what is being written because people can't actually understand what is being written because it is at quite a high level of literacy".* (P3)

One participant highlighted that it was first important to understand the literacy level of the target population,

> *"Are there enough literate people there to be able to read, if not then could there be some other way of communicating with them" (P3)*

Another participant mentioned that improving access to educational materials is less about the language and more about making them culturally appropriate and relatable for patients who are,

> *"Second and third (generation) population… (whose) first language is English" (P5).*

Another participant suggested that materials produced,

> *"Should be majority pictorial and the rest small bits of writing so that anyone can pick it up and understand." (P3)*

We brought into discussion whether services guide and educate carers and community and participants felt was the best way to engage them.
One participant brought into discussion that when,

> *"Looking at the culture where it is more collective decisions, family decisions about a work with South Asian women, they would have to have the approval" (P5).*

It was suggested that a solution to this may be,

> *"A taster session where people can come and experience that what happens in each session" (P3)*

We opened the group to discuss the possibility of making these educational taster sessions available on the website.

Participants highlighted that there was a paid facility available on a website developed by,

> *"Chris Williams"* that *"gets 20 million hits a year" (P5).*

However accessing these online resources can cost £2 per pamphlet. Participants suggested looking at the *"overall costs" (P5)* and whether it was feasible to purchase these materials for IAPT services to use. Participant NF, an IAPT manager responded that all materials on and off the IAPT website are,

> *"Funded and monitored by the trust. So you are often limited to doing what you want to do due to the democracy of the NHS" (P1).*

This discussion suggests the need for more accessible and appropriate materials for IAPT to use that would be used on a broader scale as they would require authorisation from the trust.

ii) Step 1 (Promotion, referral & assessment): Communication

We opened the group to a discussion about communication within IAPT services which includes; phone, website, written, how we should audit, translation, culturally sensitive and adapted. We discussed letters that are used to communicate with patients. A participant mentioned that letters are sent to patients,

> *"Post to assessment and discharge, these letters are standardised. Thus there is no option to send a translated or culturally adapted letter. However patients are given the option of highlighting their preferred method of communication through, email, call, text or letter…that is assuming that they have access to a website in a suitable language" (P1).*

Participant 5 highlighted that it is not only the language that could cause hindrance for a patient but also the language used within communication materials. It was mentioned that it is important to be,

> *"Careful, careful, for example not calling therapies, therapies but instead training programmes. Looking what the content of that letter is in case someone is reading it." (P5).*

Participants discussed that if a letter is being delivered at home it is important to take these things into account.

Participants discussed other elements that are involved when communicating with patients such as facilitating the preference of the patient about contacting,

> *"GP or next of kin" (p4)* mentioned that, *"IAPT referral forms include…a yes or no…option on the bottom".*

Here it was commented upon that it is important to know,

> *"If the family is on board",* and that by ensuring this an ethnic minority patient *"may be less likely to dropout" (p5).*

We presented the inclusion of the following question to the group**,**

"Do you have any provision that if someone asks to speak to someone in another language, can you organise that?"

a) IAPT team composition

Participant 1 suggested that facilitating this need is dependent upon if,

> *"There is someone in the office at the time" (P1)…*

…who can speak the requested language. Alternatively the service can,

> *"Use telephone interpreters…have a three way conversation but you'd probably have to phone back and organise that" (P1).*

This suggests if a resource is unavailable on demand it can result in a further delay in treatment for the patient. Therefore we could suggest here that it is important to assess whether a service has the inherent tools available to facilitate the needs of patients when they first access a service.

The following question was suggested for inclusion in the audit,

> *"How diverse is the IAPT team?"* (P1).

This was a question we had aimed to present to the group for a discussion about its inclusion. The independent suggestion of this question reinforces that the experts saw this as an important element to include in the cultural sensitivity audit.

Another question for inclusion was suggested,

> *"How many times (a service has) seen a need but still not used language line" (P5).*

He suggested that patients would often,

> *"Rather call their sister or somebody anybody to do that for them than to pick up the phone".* He reinforced that, *"language is a small bit, culture is the key" (P5)*

When discussing multilingual staff we proposed the question:

"Is there any provision to recruit multilingual staff within the service?"

b) IAPT staff training

The inclusion of question about the following was suggested,

> ***"About their training and cultural sensitivity" (p5).***

The participant mentioned that,

> *"The trust provides cultural sensitivity training" (P5)…*

…however this training is generic mandatory diversity training.
It was also commented upon that,

> *"They do offer CS training to staff in Pennine but that's not the same as in terms of the language which you use in a therapy session."(p1).*

This suggested that there is a need for greater provisions of cultural sensitivity training for working in a psychotherapeutic environment.

c) Staff cultural sensitivity supervision

We wished to discuss the provisions of appropriate supervision within IAPT services for staff who may work with ethnic minority patients. We asked how we could phrase a question around whether there were any,

"Resources within the team or outside the team…if a staff member needs some supervision".

It was identified that,

> *"There are so many cultures that one training cannot cover everything...so there should be a pool of supervisors so he or she can access that pool of supervisors if he or she needs to discuss anything." (P3)*

A participant reinforced the importance of supervision for IAPT staff and identified that at his service,

> *"At the moment (he is) flying in (a) CBT supervision from America because (they) haven't got anyone here."(P1)*

Two participants highlighted the time restrictions for staff within IAPT due to high demand for turn around.

> *"Targets are so tightly packed in the sessions…People are worried about the target sessions they have to have … it would be good to have something flexible."(P1 & P2)*

One expert suggested that,

> *"It may be beneficial having …in house additional training for supervisors on cultural sensitivity and one separately for the therapists, so that when you go in with a client there is that level of understanding there" (P1).*

d) Multi-ethnic, gender and linguistically matched IAPT staff

We proposed whether an ethnic and gender matching of staff question should be included in the audit. It was suggested that the **"multi-ethnic staff"** *(P5)* question covers this. He suggested that sustaining gender-matching across IAPT services,

> *"May not be sustainable".* He later also commented that perhaps sustaining *"ethnic matching may not be feasible as the migration rate is likely to change frequently"*, it comes down to the question of *"whether it is a need." (P5)*

We then proposed the question:

"Are we saying that is there no need of having a multi-ethnic workforce?"

The discussions lead to the importance of having a multi-ethnic workforce,

> *"In an ideal world it would be most beneficial to have multicultural staff that represents the local community. But at the moment we don't have the staff for this as there is an education barrier to find qualified persons." (P1)*

The identification of the difficulty of facilitating such the need for multi-ethnic staff reinforces that services wish for this facility to be available however they don't have the time or the funds to accommodate it.

One expert mentioned that they felt,

> *"Language matching is more essential" (P1).*

Participants discussed the difficulty of,

> "*Measuring language skills of staff"* in order to assess *"how appropriate staffs language abilities are in a therapeutic setting"* (P1).

This problem can occur during a therapy setting is the translator is not adequately training to translate in a therapeutic setting. Raising the question of whether translators also require cultural sensitivity training for working in a psychotherapeutic setting.

When discussing if **"everyone should be culturally aware and trained, and that there should be a small unit accessible for a team to access if needed?"**

Participants commented that an alternative to ethnic matching could be that a service could,

> *"Can train people on cultural sensitivity and … provide online supervision for that." (P1)*

Participants commented that is may be important to ask *"how many requests"* for ethnic matching are received by services independently if,

> *"It is a rare occasion"* at a service then a service *"may struggle to match staff" (P1 & P5).*

e) Scope for a cultural sensitivity specific IAPT service

We asked whether there could be **"scope to have a specific IAPT service, where a part of it is imbedded within your team? This would be a specific BME Cultural sensitivity specialist team. They have an independent supervision and management structure but say for instance split into 4"**

Participants highlighted previous examples of such a service in London for ethnic minority patients,

> *"Nafsiath means psychology…it didn't take off." (P1)*

Another example that was presented to the group was of a specific service that accommodated the needs of the LGBT community, however the participant highlighted that it came down to whether,

> *"Money is there then you can" for this particular example "CCG commissioned a counselling service" (P1).*

We went on to suggest how the needs of ethnic minority patients could be facilitated. The group came to an agreement that,

> *"a central pool that can provide training and support to the rest of IAPT and this sort of tool can be embedded within that team and they can be the implementation of that tool" (Facilitators and participants).*

The next question we reached a group agreement on, **"are you able to accommodate interpreters, how often are family members asked to be interpreters"**

One participant commented that it may be beneficial to add a question about,

> *"Are the people trained to working with interpreters?" (P5)*

The group came to an agreement that there is a need for a "standardised glossary" of translated psychotherapeutic terms.

> ***"We need a glossary of terms used in CBT so that interpreters can use this key"***

Participants also drew on past experiences of working with *"link workers cultural consultants",* commenting that,

> *"Manchester used to have link workers, they were excellent I have used them with acute inpatients so I was able to access the way they were translating because I am bilingual myself. Those are sustainable models." (P5).*

Negative experiences of working with interpreters also contributed to the group discussion,

> *"Often you would find that the interpreter themselves would require debriefing after the CBT session. 9/10 interpreters hadn't experienced providing interpreter in a therapy session. Are the interpreter's equipped to do this? We used to provide a compulsory session for all staff for working with interpreters" (P4).*

This was reiterated,

> ***"****It's difficult to sometimes find a skilled interpreter for the appropriate language." (P1)*

iii) ***Step 2/3 (Treatment): Therapy materials***

Next we moved on to the availability of materials used during therapy, whether they are accessible, translated, culturally adapted and/or include animations.
Participants discussed that at one IAPT service,

> *"We have a collection of translated booklets but they're not organised… if we have a supply they aren't standardised" (P1).*

We proposed a question about **"whether (materials) are available and whether they have been developed themselves"** to the group.

Participants discussed that literacy levels of patient can be a problem, due to IAPT being,

> *"Paper heavy and wordy" (P1)*

IAPT services often first ask whether patients,

> *"Reading skills are poor"* and whether they *"need someone to help (them) with reading letters"* (P1).

Discussions continued onto how cultural sensitivity training is,

> *"Not just about non-white person, it's about education in cultural sensitivity" (P5).*

a) <u>Improving engagement of the ethnic minority community with IAPT services</u>

Next we discussed **"improving engagement – what should we expect a service to do to improve engagement".** We proposed the question, **"What happens if someone doesn't turn up to their appointment regardless of their ethnicity".** Two participants commented that,

> *"They're off the list discharged. They can get referred back in."* however *"the new NHS contract says you can't do that you need to offer them more contact. The patient has to miss two DNA to be out. (If there is a) cancellation (within) 24 hours (a service can) still …reoffer sessions. (However if a patient) Cancellations without notice, two of them they are out" (P1 & P4).*

We discussed the following question: **"In order to improve engagement is there anything specific done to general populations".**
A participant suggested that IAPT can only provide,

> *"Standardised texts the day before the appointment" (P1).*

There is no facility within IAPT itself that can,

> *"Provide transport or crèche".* Low intensity interventions are facilitated *"normally at GP practices."* If a patient *"can't get to GP appointments either then we can arrange a phone visit, we offer step 2 telephone treatment" However "Step 3 are not trained to do this. Step 3 wouldn't just do over the phone therapy. We tried email therapy and we found that it wasn't very successful"* (P1).

Another participant identified that their IAPT service,

> "*Do telephone therapy at step 3"* (P4).

These varied provisions across services show that there isn't a standard procedure being employed by IAPT services across the nation, often the ability to facilitate the needs of patients is underpinned by the funding and practically of implementing such a service at services independently. However this shows that telephone interventions are possible across step2 and step 3, lessons may be shared and implemented in difference IAPT services if they work together.

When asked about whether **"anything else (needed to be included) for engagement?"**

It was mentioned that it may be beneficial to include a question in regards to,

> *"Whether service users are aware about the options available to them" (P5).*

We suggested that this would be included in the IAPT user audit tool.

b) Working with other IAPT teams

We asked: **"is it possible to cross reference between teams?"**

Experts discussed the possibility of multiple sites working alongside one another, commenting that,

> *"It comes down to your local community and what's applicable and appropriate there…often we have found that staff have located themselves according to where there is a need." (P4)*
>
> *"No (this not possible due to) team targets. Another service may say no. We would use an interpreter. A patient can refer themselves to a service of their choice"* (P1)

c) Extra incentives or facilitation for ethnic minority patients accessing IAPT services

When discussing the topic of extra provisions for ethnic minorities as an element of the audit participants highlighted that,

> *"There are now food bank vouchers available" (P4)* at their service.

This shows that different services have access to different facilities that may aid in improving engagement from patients.

When discussing the possibility of using a community facility within the target population catchment area participants discussed the availability and benefits of offering such facilitation.

> *"If the venue is available, yes. There's a boozing club around the corner we can use we use the local fire station as they have a room, it's about availability" (P1).*

Further supporting this point, participants identified,

> *"Patients feel fearful going to a hospital environment inpatient unit style building." (P4)*

> *"Stigma and reluctance to access buildings associated with mental health" (P3).*

d) Outcome measures

Participants came to an agreement about including a question about,

"Outcome measures, whether locally translated or centrally provided."

iv) Step 4 (Outcome): Dropouts

When discussing measuring of patient engagement and discharge, participants identified that dropouts are recorded also commenting that is a patient is reluctant to engage and,

> *"Don't come often they're not ready" (P1).*

The group came to an agreement that that there is nothing specific done to engage dropouts.

a) Funding

We discussed the funding source of IAPT services where an agreement was met that funding comes from CCG.

b) Sign Posting

We opened the discussion to including a question about **"signposting patients if their needs cannot be met by IAPT interventions."**
Reflections from participants indicated that both services represented in the group would signpost patients if they felt their needs could be met better at another service,

> *"Some patients who are quite clear who need to be referred to an alcohol and drugs team, can refer them to self-help and* ROBI*" (P4).*

At one service,

> *"(They) work in partnership with Mind, they do groups around anger management, building self-esteem, other than that there is not much else." (P1)*

However also indicated that they were,

> *"Not sure if there is much to signpost to in Oldham" (P1)…*

…this reflected a lack of knowledge about other services in the community.

c) Policy

We felt that it was important to include a question about whether IAPT services have a specific policy on ethnic inclusion and culture.
Participants highlighted there is,

> *"No specific policy"* however it is in the *"over-arching organisational policy" (P1).*

d) Confidentiality

We proposed the questions "**where should we ask as part of the audit tool about confidentiality and how it is being ensured."** We explained that we felt it should be included under materials, as it may be reiterated by the therapist and within letters/ information sheets etc.

Participants agreed,

> *"Yes"* (P1, participants nodding in agreement).

We asked if confidentiality is mentioned for the general population.
Participants highlighted the differences in approaches to ensuring confidentiality. Some commented that there is a,

> *"Generic contract patients initially read and sign",* whereas others identified that *"at times there is too much confidentiality"* (P5).

Participants mentioned that it is more important to focus on how a service is,

> *"Working with South Asian women and how much information (they) would share with the family (and) how involved are family members" (P5)* are in the process.

It was mentioned that within the IAPT services there is an option to,

> *"Add an alert onto the system that says about whether the case can be discussed with patients/ family." (P1)*

Participants touched upon past experiences working with family of South Asian patients and shared that,

> *"In early intervention we spoke to family they refused the treatment as they were not on board" (P5).*

This highlights the importance of working alongside family and or carers of ethnic minority patients if they indicate this preference. Family may have an influence on a patients' participation in an intervention. It is therefore important to audit whether an IAPT service accommodates this need.
Here a participant commented that content of materials is important when dealing with confidentiality**,**

> *"Information sheets, it needs to be made clear, the therapist went to explain to the family members and explain … confidentiality to reassure them" (P3).*

Here we can interlink the problems that may arise during confidentiality with the underlying lack of mental health literacy in the community. If there is a lack of mental health literacy within the patient's family they may struggle to understand the importance of positive impact of the intervention, creating hindrance to the patient's participation.

We asked the group whether they felt it was necessary to include a question in the audit around whether the service may receive compensation for extra costs.
Participants reflected in agreement that this was not relevant within IAPT.

We finally proposed the final questions to the expert group; we wished to ask about the numbers of ethnically diverse staff within services and what the majority ethnic minority population is within a services catchment area. Participants responded in agreement that these questions should be included in the audit.

Study 3.1: Development of TULIP: cultural sensitivity audit tool IAPT Staff perspective: Results

Please see appendices 15 and 16.8, Pages 221-233 for the TULIP: cultural sensitivity audit tool and TULIP guidelines.

3.5.1 TULIP

We finalised the TULIP: cultural sensitivity audit tool for IAPT from a service perspective.

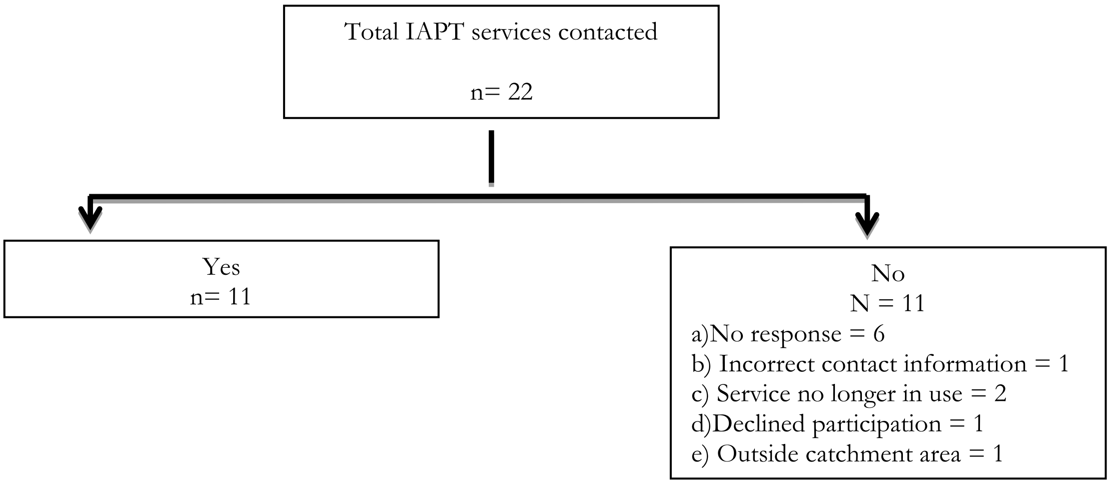
3.5.2 TULIP: Cultural sensitivity audit tool guidelines

We developed guidelines to using the cultural sensitivity audit tool by enhancing the original audit questions with detailed explanations of each question supplemented with examples.

Study 4.0: TULIP: cultural sensitivity audit of IAPT services in the North West of England: Results

Figure 8 below describes the process of service inclusion for the IAPT TULIP audit. The figure describes services initially contacted and the appropriate responses.

***Figure* 8 IAPT service responses for TULIP audit participation**



Audit results *Table 10* Log of IAPT services contacted

Please see *Table 10, Page 151* for the Log of IAPT services contacted.

Table 10 : Log of IAPT services contacted

IAPT service	*Date of first contact*	*Number of contact exchanges*	*Methods of contact (Phone or email)*	*Audit completed or uncompleted*	*Preferred method of completion*	*Date completed*	*Number of IAPT staff present in meeting*	*Request for further involvement*	*Requested feedback*	*(ST) = Same team covers both sites.*
Rossendale & Hyneburn (ST)	22.09.16	6	Both	Completed	Phone	06.10.16	1	Yes	Yes	(ST)
Burnley Mindmatters	22.09.16	6	Both	Completed	On site	29.06.16	2	Yes	Yes	Not applicable
Kirklees & Cumberland IAPT	19.06.16	6	Both	Completed	On site	28.09.16	1	Yes	Yes	(ST)
Access Sefton	13.09.16	6	Both	Completed	On site	28.09.16	2	Yes	Yes	Not applicable
Tameside & Glossop	19.09.16	6	Both	Completed	On site	03.10.16	1	Yes	Yes	(ST)
Oldham	12.09.16	8	Both	Completed	On site	30.09.16	1	Yes	Yes	Not applicable
East Lancashire (Nelson, Burnley, Accrington & Bacup (ST))	15.09.16	10	Both	Completed	Phone	06.10.16	1	Yes	Yes	Same manager
Blackburn	12.09.16	6	Both	Completed	Phone	06.10.16	1	Yes	Yes	Not applicable
Six Degrees Salford	06.08.16	4	Both	Completed	On site	04.10.16	1	Yes	Yes	Not applicable
St Helens	23.09.16	12	Both	Completed	Online	10.10.16	1	Yes	Yes	Not applicable
Flyde & Wyre	29.09.16	6	Both	No response.						
Warrington	13.09.16	6	Both	No response.						
Rochdale	12.06.16	6	Both	No response.						
NYE Bevan House	12.09.16	6	Both	No response						
St Johns Centre	15.09.16	6	Both	No response						
Preston Mindsmatter	20.09.16	6	Both	Completed	Phone	12.10.16	1	Yes	Yes	Not applicable
Healthy Minds Bury	12.09.16	6	Both	No response.						
Buxton	13.09.16	8	Both	Refused participation due to busy schedule.						
The Dales, Calderdale	19.06.16	Excluded due to location in South West Yorkshire, outside of study catchment area.								
Blackpool Centre	13.09.16	Service no longer in operation.								
Talk Liverpool North	13.09.16	Service no longer in operation.								
Pennine Care NHS Trust	19.09.16	Incorrect contact details provided on NHS website. Contact number provided for Pennine care NHS trust central headquarters and not IAPT services.								

3.6.1 Recruiting IAPT services results

The author located contact details for IAPT services from the NHS choices website database. The author contacted IAPT services (n= 22) detailed in table xx using both email and phone calls as a method of recruitment. The author found that the NHS choices website database of IAPT services was often not up to date. Some services that were contacted were no longer running (n = 2) and some had the incorrect phone number (n = 1). Services were contacted multiple times; all services were contacted via both phone and email (Mean = 5.6 attempts, range = 1-12). Over a quarter of services initially contacted did not respond to recruitment attempts (n=6), services who exceeded 6 attempts with no response were not contacted further. Services who agreed to participant were further contacted to arrange a convenient date and time for audit completion (Mean = 12, range = 4-12). On the website it often shows different sites as separate services when in practice the same IAPT team can cover several sites. Participating sites identified if their staff team covered more than one site (n = 3) or one site only (n = 8).

3.6.2 Data collection procedure results

The number of audited IAPT services (n=11) and their demographics are reported in Table 11, Page 154.

Out of the 11 services audited preference for method of audit completion were reflected as, on site (n = 6), phone (n=4) and electronic, self-completion (n = 1). All services had service managerial representation during audit completion. Two services had two representatives present and the others had only the manager (n = 9). All 11 services requested feedback from the audit and further involvement in any research proceedings.

3.6.3 Demographics of included IAPT service catchment areas

The majority South Asian ethnic minority groups within service catchment areas varied between services. The mean densities of South Asians across included service catchment areas were; Indian (mean = 2.8%), Pakistani (mean= 4.25%), Bangladeshi (mean =1.5%) and Other Asian (mean = 1.97%).

Table's 12-15, Pages 155 – 159 present audit responses from IAPT services participating in the TULIP cultural sensitivity audit. Please refer to *page 160* for descriptions of responses.

Table 11 **IAPT services included in TULIP audit**

IAPT Service	*Type of IAPT service*	*Member of staff who completed the audit*	*Method of audit completion*	*Majority South Asian ethnic minority populations within service catchment area*	*Reference*
Access Sefton	NHS	Service manager	On site	Indian (0.2%), Other Asian (0.2%) Bangladeshi (0.1%) & Pakistani (0.0%)	(LCC 2011)
Blackburn IAPT (Accrington)	NHS	Service manager	On site	Indian (13.4%), Pakistani (12.07%) Other Asian (1.1%) & Bangladeshi (1.03%)	(LCC 2011)
Burnley IAPT Nelson	NHS	Service manager	On site	Pakistani (6.8%), Bangladeshi (2.79%), Other Asian (0.8%) & Indian (0.37%)	(LCC 2011)
East Lancashire (Pendle view & Ribble valley)	NHS	Service manager	On site	Pendle Pakistani (17.3%), Bangladeshi (0.43%), Indian (0.26%) & Other Asian (0.7%). Ribble Valley Pakistani (0.52%), Indian (0.36%), Other Asian (0.3%) & Bangladeshi (0.06%)	(LCC 2011)
Hyndburn and Rossendale (Bacup)	NHS	Service manager	Phone	Bangladeshi (2.41%), Pakistani (1.68%), Other Asian (0.3%) &Indian (0.27%)	(LCC 2011)
Kirklees	NHS	Service manager	On site	Indian (2.5%), Pakistani (2.0%), Other Asian (1.5%) & Bangladeshi (0.8%)	(Council 2016a)
Oldham Healthy Minds	NHS	Service manager	On site	Bangladeshi (7.3%), Other Asian (2.9%), Pakistani (10.1%) & Indian (0.7%)	(Council 2016b)
Preston Mind Matters	NHS	Service manager	Phone	Indian (10.27%), Pakistani (3.16%), Other Asian (0.9%) & Bangladeshi (0.27%)	(LCC 2011)
Tameside and Glossop healthy minds	NHS	Service manager	On site	Indian (1.4%), Pakistani (1.2%), Bangladeshi (1.2%) & Other Asian (0.1%)	(Borough 2011)
St Helens	NHS	Service manager	Electronic	Indian (0.3%), Other Asian (0.3%), Pakistani (0.1%) & Bangladeshi (0.1%)	(Council 2011)
Six Degrees Social enterprise, Salford	Community interest company	Service Manager	On site	Indian (1.09%), Other Asian (0.8%), Pakistani (0.78%) & (Bangladeshi (0.25%)	(QPZM 2011)

Table 12 **Audit responses for Introducing and engaging community; Questions; 1.1-1.10**

Service	**Audit responses for Questions; 1.9 & 1.10 see *Table 14***							
	1.1 Are there any written information materials available introducing the local LAPT services?	*1.2 Are written information materials available in any ethnic languages?*	*1.3 Are written information materials only translated or have been culturally adapted as well?*	*1.4 From where were the translated information materials sourced?*	*1.5 Does your LAPT service have a website?*	*1.6 Is the written information on the website available in any ethnic language?*	*1.7 Is the information available on the website only translated or culturally adapted as well?*	*1.8 From where did you source this translated information?*
A	No	NA*	NA*	NA*	Yes	No	NA*	NA*
B	Yes	No	NA*	Neither	Yes	No	Neither	NA*
C	Yes	No	NA*	Neither	Yes	Yes	Translated	External
D	No	No	NA*	Neither	Yes	No	Neither	NA*
E	No	No	NA*	Neither	Yes	No	Neither	NA*
F	Yes	Yes	Both	Internal	No	No	Both	Internal
G	Yes	No	NA*	Neither	Yes	Yes	Translated	External
H	Yes	No	NA*	Neither	No	No	Neither	Neither
I	Yes	No	NA*	Neither	Yes	Yes	Neither	Neither
J	Yes	Yes	Translated	Internal	No	No	Translated	External
K	No	NA*	NA*	NA*	No	No	Neither	Neither

NA* = Not applicable

Table 13 **Audit responses Communication; Questions 2.1 – 2.4, 2.6-2.9, Policy; Question 3.1 and Team Composition; Questions 4.3-4.5.**

Service	**Audit responses for Question; 2.2, 2.5, 4.1 & 4.2 see** ***Table 14***										
	2.1 When a client phones into the service do you have provisions to talk to them in any ethnic language other than English?	*2.3 Do you have provisions to have written correspondence with Clients in ethnic languages (e.g. letters)?*	*2.4 Do you have provisions to verbally communicate with clients who do not speak English during therapy?*	*2.6 Do you have information on mental illness for patients? (e.g. leaflets)*	*2.7 Is the written information available in any ethnic language?*	*2.8 Are the materials only translated or culturally adapted as well?*	*2.9 From where did you source your translated information materials?*	*3.1 Does your IAPT service have a specific policy on how to work with ethnic minority patients?*	*4.3 Has your staff received any specific cultural sensitivity training?*	*4.4 Has your staff received training on how to work with interpreters?*	*4.5 Is there any supervision available for your staff to discuss cultural issues?*
A	Yes	No	Yes	Yes	Yes	Translated	External	No	Mandatory training	No	Yes
B	No	No	Yes	Yes	No	Neither	Neither	No	Mandatory training	No	No
C	Yes	No	Yes	Yes	No	Neither	Neither	No	Mandatory training	Yes	No
D	Yes	Yes	No	Yes	Yes	Translated	External	No	Mandatory training	No	No
E	No	No	Yes	Yes	Yes	Translated	External	No	Mandatory training	Yes	Yes
F	Yes	Yes	Yes	Yes	No	Both	External	No	Mandatory training	No	Yes
G	Yes	Yes	Yes	Yes	No	Neither	Neither	Yes	Mandatory training	Yes	Yes
H	Yes	Yes	Yes	Yes	No	Neither	Neither	No	Mandatory training	No	No
I	Yes	Yes	Yes	Yes	No	Neither	Neither	No	Mandatory training	No	Yes
J	Yes	Yes	Yes	Yes	Yes	NA*	External	Yes	Mandatory training	No	No
K	Yes	No	Yes	Yes	No	Neither	NA*	No	Mandatory training	No	No

NA* = Not applicable

Table 14 **Audit responses for Treatment; Questions 5.1 – 5.14 and Costs; Question 6.1**

Service	**Audit responses for Questions; 5.4, 5. & 5.11 see *Table 14***											
	5.1 Do you offer gender matching of therapist if requested by client?	*5.2 Do you facilitate linguistic matching if requested by client?*	*5.3 Do you provide therapy in any ethnic language?*	*5.5 Are manuals/ workbooks only translated or culturally adapted as well?*	*5.6 From where did you source this translated information?*	*5.8 Are the outcome measures only translated or culturally adapted as well?*	*5.9 From where did you source this translated information?*	*5.10 Is there provision of interpreters in your LAPT service?*	*5.12 Do you have any special considerations made for ethnic minority clients who drop out~? Please describe*	*5.13 Do you provide any sign posting to local ethnic minority specific psychotherapy services or third sector organisations?*	*5.14 Do you make any special considerations to reassure ethnic minority clients about confidentiality?*	*6.1 To meet the needs of ethnic clients does your budget contain ring-fence monitory allocation?*
A	Yes	Yes	Yes	Translated	External provider	Translated	External	Yes	No	Yes	Yes	Yes
B	Yes	Yes	Yes	Neither	NA*	Neither	NA*	Yes	No	No	No	No
C	Yes	Yes	No	Neither	NA*	Translated	External	Yes	No	No	No	No
D	Yes	Yes	No	Neither	NA*	Translated	External	Yes	No	Voluntary Sector	Yes	Yes
E	Yes	No	Yes	Neither	NA*	Translated	Internal	Yes	No	No	Yes	Yes
F	Yes	Yes	Yes	Neither	NA*	Translated	External	Yes	No	Yes	Yes	Yes
G	Yes	Yes	Yes	Translated	External	Neither	NA*	Yes	No	No	Yes	No
H	Yes	Yes	Yes	Neither	NA*	Neither	NA*	No	No	No	Yes	No
I	Yes	Yes	Yes	Neither	NA*	Neither	NA*	No	No	No	Yes	No
J	Yes	No	No	Translated	External	Translated	External	Yes	Yes	Yes	Yes	No
K	Yes	Yes	No	Translated	External	Some translated	External	Yes	No	No	No	Yes

NA* = Not applicable

Table 15 **Audit Qualitative responses for Introducing and engaging community, Communication, Team Composition and Treatment; Questions; 1.9, 1.10, 2.2, 2.5, 4.1, 4.2, 5.4, 5.7 and 5.11**

Service	**Audit Question**								
	1.9 Please provide examples of the translated materials	*1.10 Do you actively make efforts to engage ethnic family or care providers of clients? If yes, Please provide examples;*	*2.2 (2.1 When a client phones into the service do you have provisions to talk to them in any language other than English?) If yes, how?*	*2.5 (2.4 Do you have provisions to verbally communicate with clients who do not speak English during therapy?) If yes, how?*	*4.1 What is the ethnic breakdown of staff members in your team?*	*4.2 What other languages does your staff speak?*	*5.4 (Are therapy manuals/ workbooks available in any ethnic languages?) Which languages?*	*5.7 (Do you use outcome measures in any other ethnic languages?) Which languages?*	*5.11 Does your service make any extra efforts to improve ethnic engagement in therapy?*
A	NA*	Yes, projects and promotion with ethnic minority community	4 members of bilingual staff	Interpreters 5 bilingual clinicians	Indian & Pakistani	Punjabi Urdu Gujarati	Urdu Punjabi	Urdu Punjabi	Food bank vouchers
B	NA*	Linking with projects in the BME community	NA*	Interpreters	White British	None	NA*	NA*	Outreach work with BME community
C	Home Page	No example provided	2 bilingual members of staff. Can facilitate polish and Russian.	Interpreters & Translating service "Global" CWP	Polish & White British	Polish Russian	NA*	NA*	Food bank vouchers and offer double sessions
D	NA*	If required	Language Line If staff is available	Interpreters, Translated outcome measures, Translated self-help materials, Language line	White British	None	NA*	No example provided	
E	NA*	1 specific BME outreach worker, Translated business cards, Patients can bring individuals along, Community engagement events, Papers to advertise, Quality and diversity engagement team & Tasks and finish group looking at access.	Ethnically diverse action admin team.	Interpreters, Bilingual staff	Indian, Sri Lankan & White British	2 Bengali, Gujarati, Tamil	NA*	No example provided	Food bank vouchers and afternoon group sessions

F	Service and project information (Polish)	Translators	Practitioners' skills. Telephone translators, Texts from the deaf community/audiology referrals.	Translator service, available via phone or face-to-face	White British Other Polish	Polish, Hebrew & French	NA*	No example provided	No
G	No example provided	Women's groups, Community engagement for low access groups	Telephone Translation services	Translators, Bilingual therapists	White European, Asian, White British	Punjabi, Urdu, Bengali, Gujarati	No, Can be translated if required.	NA*	Community engagement outreach in the community
H	NA*	Assessments with ethnic staff who can speak with families, Networking with the community to promote and create awareness, Ethnic volunteers on desk.	Ethnic staff and volunteers	Ethnic staff and volunteers	White British	Urdu, Gujarati	NA*	NA*	Food bank vouchers
I	NA*	No example provided	Ethnic volunteers	Ethnic volunteers	White British & Asian	None	NA*	NA*	Food bank vouchers
J	IAPT outcome measures & Patient information materials	Will liaise with care providers connected to clients	Translation service can be booked. Encourage face-to-face appointments	Translation service	White British	NA*	National IAPT materials	Bengali, Gujarati, Hindi, Punjabi, Urdu, GAD 7 (Arabic and Polish), PHQ 9 (Polish) and WSAS (Work and social adjustment scale) (Polish)	'champion' roles for staff specifically responsible for improving engagement
K	NA*	NA*	Interpreters	Interpreters	Polish, Afro Caribbean & White British	Polish	No example provided	No example provided	Transport provisions and locating team members in difference GP surgeries to become more accessible.

*NA = Not applicable

3.6.4 Cultural sensitivity audit of IAPT services

i. Audit results: Introduction and engaging the community: Questions 1.1-1.10

1.1 – 1.8

Please refer to Table 12, Page 155 for Audit responses for Introduction and engaging the community: Questions 1.1-1.8

From the services audited the majority had access to written information materials to introduce their service (64%). Although 64% of services had access to written information materials only 18% had access to languages other than English, furthermore only 9% had both translated and cultural adapted materials. The 64%that had access to translated materials had translated them internally. Services reflected whether they had a service website accessible to the public, out of the included services, 64% reflected they had this facility. From the services who had a website, more than half reflected that the website was not available in ethnic languages (57%). Where ethnic languages were available they were only translated (43%).

1.9 & 1.10

Please refer to Table 15 Pages 158-159 for Audit Qualitative responses for Introduction and engaging community; Questions; 1.9 & 1.10

Less than half the included services had provisions for translated materials (36%). Examples were provided by 27% of services, which included; Service website homepage (9%), Service and project information (9%) and Patient information sheets (9%).

The majority of services highlighted that they made extra efforts to engage the family or care providers of patients (82%), of which 78% provided examples. Some services facilitated this need through ethnic/low access community specific engagement, promotion and networking projects (45%), others linked specifically with care providers and family members (9%). Whereas 27% of services had ethnic volunteers, specific ethnic or BME outreach staff that had linguistic matching skills used to liaise with patients, families and carers. Translators were used to help facilitate by 9% of services. Furthermore, translated business cards had been specifically developed and used by 9%, to aid in the promotion of their service within the ethnic minority community.

ii. Audit results : Communication; Questions 2-1 – 2.9

2.1, 2.3, 2.4, 2-6 – 2.9

Please refer to Table 13, Page 156 for audit responses Communication; Questions 2-1 - 2.4, 2.6 – 2.9, 3.1 & 4.3 – 4.5

The majority of services audited had provisions for communicating in languages other than English over the phone (82%). Over half the services could facilitate written correspondence in other ethnic languages (55%). Out of the 11 services audited, 9% were not able to facilitate a language other than English during therapy. All services had written information materials about mental illnesses for patients, however over half the services were not able to facilitate other languages (66%). Out of the services able to facilitate translated information materials about mental illness (36%), only one service had access to translated and culturally adaptation, all were sourced externally.

2.2 & 2.5

Please refer to Table 15, Page 158-159 for Audit Qualitative responses for Communication; Questions; 2.2 & 2.5

Out of the 11 services included over half had provisions for staff on site to facilitate for clients requiring other ethnic languages when phoning in (55%). Some services also used language line or telephone translators to facilitate this need (45%). Only one service was not able to facilitate ethnic languages over the phone when clients ring in to their service. All of the services were able to facilitate ethnic languages during therapy, of which some used interpreters or translating services (82%). Some services were able to facilitate this demand through the availability of bilingual staff on site (36%) or ethnic volunteers (18%).

iii. Audit results : *Policy; Question 3.1*

3.1

Please refer to Table 13, Page 156 for audit responses for Policy Question; 3. 1

In regards to having a specific policy on working with ethnic minority patients within IAPT services, only 18% of services had a specific policy.

iv. Audit results : *Team Composition; Question 4.1-4.5*

4.3 - 4.5

Please refer to Table 13, Page 156 for audit responses for Team Composition; Questions; 4.3-4.5

Services were asked whether their staff members had received any specific training on cultural sensitivity, all services reflected that only IAPT mandatory diversity training had been completed. Services with staff members who had received training for working with interpreters represented less than half the sample (27%). Out of the total sample, some had access to specific supervision to discuss cultural issues (45%).

4.1 & 4.2

Please refer to Table 15, Page 158-159 for Audit Qualitative responses for Team Composition; Questions; 4.1 & 4.5

Over half of the services had staff from ethnicities other than White British (64%). Of services with ethnically diverse staff members, ethnicities represented included; Asian staff members (36%), Polish (27%), White European (9%), Afro Caribbean (9%), other white British (9%) and other (9%).

Over half the services had a linguistically diverse team with staff members speaking at least one language other than English (64%). The most common languages spoken by teams were; Gujarati (36%), Polish (27%), Urdu (27%), Bengali (27%), Punjabi (18%), Russian (9%), Tamil (9%), Hebrew (9%), French (9%).

v. Audit results: Treatment; Questions 5.1 – 5.14

5.1 – 5.3, 5.5, 5.6, 5.8-5.10, 5.12-5.14

Please refer to Table 14, Page 157 for audit responses for treatment; Questions 5.1 – 5.3, 5.5,5.6, 5.8-5.10, 5.12-5.14

All services were able to facilitate gender matching if requested by a patient. Most services were able to facilitate linguistic matching if requested by a client (82%). If a patient requested this preference some services were able to facilitate therapy in an ethnic language (64%).

Less than half the services were able to provide workbooks/manuals that were translated (36%), no services had access to culturally adapted manuals or workbooks. Services who had these materials translated, used external providers. Provisions for all translated outcome measures were facilitated by 55% of services, with 9% of services having access to some translated and other services not having provisions for any translated (36%). All services except 2 had provisions for interpreters (82%).

Only one service (9%) made special considerations for ethnic minorities who dropped out. Less than half the services included in the audit would facilitate the signposting of patients to local ethnic minority specific psychological therapy services (36%), out of which three sign posted to other NHS services and one to the voluntary sector. Over half the services included in the audit made special considerations to reassure ethnic patients about confidentiality (73%).

5.4, 5.7 & 5.11

Please refer to Table 15 Page 158-159 for Audit Qualitative responses for Treatment; Questions; 5.4, 5.7 &5.11

Only 27% of services had access to therapy manuals and workshops translated into ethnic languages. From these services 9% would have them translated upon request, 9% would access them via the National IAPT materials and 9% was limited to translations of only Urdu and Punjabi. Over half the services audited could facilitate outcome measures translated into ethnic languages (55%), examples were not provided for all

(36%). The services that could facilitate this need identified that languages available were Urdu (18%), Punjabi (18%), Gujarati (9%), Hindi (18%), and Bengali (18%) for all outcome measures. Only GAD-7 was available in Arabic and Polish at one service, PHQ-9 in Polish (9%) and WSAS (Work and social adjustment scale) in Polish at 9% of services.

Out of the included services most made extra efforts to improve engagement from ethnic minorities in therapy (91%). Extra efforts included; Food bank vouchers (45%), Community outreach and engagement workers (27%), Double therapy sessions (9%), afternoon sessions (9%), Transport provisions (9%) and Locating staff in GP surgeries to increase ease of access (9%).

vi. Audit results: Cost; Question 6.1

6.1

Please refer to Table 14, Page 157 for audit responses for Cost; Question 6.1

Less than half the services included in this audit (45%) had a ring fence monitory allocation of their budget to meet the needs of ethnic patients within their service.

Study 4.1: TULIP: Cultural sensitivity audit feedback from service managers: Results

Documenting of feedback from service managers who completed the TULIP audit at each service

Table 16 IAPT service preference for audit feedback and further involvement

Service	*Provided feedback about the audit tool and guidelines*	*Highlighted areas for further development of the audit tool or guidelines*
1	Yes	Yes
2	Yes	Yes
3	Yes	Yes
4	Yes	Yes
5	Yes	Yes
6	Yes	Yes
7	Yes	Yes
8	Yes	Yes
9	No	No
10	No	No
11	No	No

3.7.1 Types of feedback received from IAPT services included in the TULIP audit

Feedback from the completed audit was requested by 100% of participating services. Further participation in progressive stages of TULIP project development was requested by all participating services. Out of the included services 73% provided qualitative feedback about the audit tool and guidelines and recommendations for further developments.

3.7.2 Qualitative themes of feedback from audited services

a) <u>Positive reinforcement of the TULIP and TULIP: Guidelines</u>

A consistent theme reflected by service managers during feedback was positive reinforcement of TULIP and TULIP: Guidelines. Services commented that;

> *"It's a good start that's needed" (S1).*

Service managers commented that the tool and guidelines were,

> *"Comprehensive" (S7), "helpful in highlighting areas* of improvement"
> (S2) and "*gaps in cultural sensitivity"* (S1).

The attribute of the audit being,

> *"Very straight forward"* (S5) and *"not difficult to complete" (S7)…*

…was reflected as being aided by how the,

> *"Guidelines reduce fears of being questioned on performance" (S7)* …

…from the results of the cultural sensitivity audit at their service.

Service managers also reflected that, within the guidelines the inclusion of,

> *"Examples are helpful for people to fill in audit" (S7)*

The barriers that may be experienced by ethnic minorities accessing each service highlighted by the audit were reflected on by service managers, who commented,

> *"Essential to capture the breakdown of ethnicities" (S7),*
>
> *"Going through the process of considering things, the process of referral to delivery is useful" "going through things you would normally assume, how would I know if something is culturally sensitive or not"* … *"it is thought provoking, not long, with scope expand where needed" (S4)*
>
> *"Captured a lot of different areas struggled with as a team" (S5)*
>
> *"Got me thinking about what facilities we have and don't have" (S6)*
>
> *"It makes you think" (S8)*

Service manager comments supported the possible positive impact of TULIP within IAPT. One service manager commented that it was,

> *"Reassuring to know it's being done" (S1).*

The consistent positive feedback within comments from service managers reinforces that TULIP encouraged service managers to reassess their current facilitation of the needs of ethnic minorities within their service. Further to this the audit captured areas that services were currently aware of as being problematic for their team.

b) Highlighting of areas for further development of TULIP

Service managers discussed the possibilities for further use of TULIP in the future, commenting that currently,

> *"Mechanisms for feedback from groups… there's no way of doing that at the moment" (S4).*

Feedback about the tool and guidelines further extended to how they,

> *"Would definitely use* (them) *internally" (S2).*

Managers commented on the multi-faceted possibilities for TULIP and TULIP: Guidelines and how they,

> *"Could be used widely by secondary care services" (S4).*

Comments from service managers also included suggestions to,

> *"Add translator requests figures" (S7) and to,*
>
> *"Add GP session, as they are key to referral process" (S4).*

A service manager suggested that it,

> *"May be better to focus on translators" (S8).*

This feedback was taken into consideration and concluded upon that the audit has the adequate number of items specific to facilitating translators within IAPT.

A service manager that completed the audit on site suggested that,

> *"It could be conducted over the phone" (S8).*

Over the phone completion, electronic self-completion and on site (facilitated by a researcher) were initially presented to service managers as options for preference of audit completion.

c) Future development of TULIP and previous initiative employed by IAPT services to improve cultural sensitivity

Concerns associated with lack of culturally appropriate facilities were reflected upon reflection of the audit by service managers, one manager commented that,

> *"It worries me that there are people whose needs are not met" (S8).*

Service managers commented upon previous initiatives that they has employed to tackle cultural issues within their services, these included,

> *"Cultural competence training previously received by Dr Waheed" (S2).*

Another service manager mentioned how their service,

> *"had a previous initiative 2 years ago where therapists would translate materials however due to numbers of dialects present and materials rapidly changing it was difficult to keep up with demands and it was dropped" (S6).*

This problem was emphasised within IAPT due to it being,

> *"Difficult to get consistent translators for all sessions" (S8).*

Where services were able to use translators and interpreters they found that,

> *"Interpreter training* (is) *needed (S2)…* a resource that is available is *"The Manchester council training" (S2)* …. However it was commented upon that it *"is not fit for our practice" (S2)*

The impact of lack of ethnic facilitation with IAPT services and its impact were commented upon, specifically how it can make it,

> *"Difficult to engage minority community as we don't have literature materials" (S3),*

However service managers provided feedback that,

> *"Having a central source that is checked would be good" (S4),*

Furthermore for the future development of TULIP an,

> *"Online resource would be key" (S4).*

The feedback from IAPT service managers reflected that previous efforts had been employed by services however that these had upon reflection not been as effective as initially intended. Managers supported the need for cultural sensitivity improvement within IAPT and identified the impact on patient engagement that had occurred due to lack of facilitation of this need.

CHAPTER IV

DISCUSSION

4.0 *Discussion: Key findings*

I would like to discuss the key findings from the studies conducted in this MPhil project, highlighting the strengths and weaknesses that arose. Further to this I would like to make recommendations for future research developments based upon these key findings.

a) *Barriers to accessing psychological therapy for ethnic minorities residing in western countries: systematic review: Key findings*

The focus of this review was to investigate barriers to accessing psychological therapies (excluding psychodynamic therapy) for ethnic minorities residing in western countries. The results of this review highlight areas within an ethnic minority patients' journey of accessing to engaging in psychological therapy which may cause hindrance to receiving appropriate treatment, captured in a broad set of 5 over-arching barrier themes and 21 subthemes from the 8 selected papers.

Patient related barriers include: 1. Trust (Mistrust from patients and families towards mental health services), 2.Language (Barrier extending from patient: practitioner communication difficulties to difficulties working with interpreters and using written materials), 3.Patient confidentiality (Patient fears about breach of confidentiality from practitioners leading to reluctance to access and disclose information), 4.Reluctance to disclose (Resulting from the importance of keeping information within the family, and lack of consistent therapist), 5.Stereotype(Stereotyping of patient characteristics from staff and stereotypes around mental health from within communities), 6.Mental health literacy(Patient lack of understanding of mental health problems and eligibility for mental health service support), 7.Patients view of therapists(Patients expectations of therapists having a lack of cultural or religious knowledge appropriate to their needs), 8.Religion(Provisions required to facilitate religious requirements, difference between therapist biological and patients' religious interpretation experiences), 9.Stigma(Stigma around mental health from patient, family and community perspective), 10.Past experiences about treatment(Negative experiences of mental health treatment from patient, family and friends), 11.Presenting symptoms (cultural and religious differences in the interpretations of presenting symptoms).

Community related barriers include: 12.Cultural expectations from the community (Prejudice towards paying for and accessing mental health from community), 13.Lack of community support (Lack of support from community for patients accessing psychological support).

Family related barriers include: 14.Lack of family support (families being unaware or unsupportive of patient needs), 15.Family influence (requirement of spousal approval prior to access or refusal to inform family about accessing services).

Health service related barriers include; 16.Preference for alternate treatment (Patients preference for seeking help from religious healers or family and friends), 17.Appropriateness of service (Patient misconceptions about nature of services, services being too rule bound), 18.Lack of understanding of referring service (Lack of understanding of patient needs from practitioners), 19.Patients' preference for therapist to hold certain characteristics (Patients preference for therapist to having a culturally sensitive approach to psychotherapy), 20.Patients expectations of therapists(patients expectations that the therapist will encourage them to act against the teachings of their religion).

The theme of Practical issues barriers included: 21. Cost (Patient's lack of understanding of the financial burden of seeking psychological support).

b) Development of TULIP: cultural sensitivity audit tool staff perspective: Key findings

The success of the development of this project in on multi-method steps used to develop TULIP, and test the first cultural sensitivity audit tool within IAPT services. I developed the TULIP: cultural sensitivity audit tool in a concise and clear format questionnaire style format. The themes and items discussed in the previous stage of the project were taken in to consideration during development of the audit tool. To facilitate ease of self-completion of the audit tool I developed TULIP: Guidelines to compliment the audit tool. The audit completion procedure was explained in detail and each question was complimented with a detailed explanation and example answers.

c) TULIP: Cultural sensitivity audit of IAPT services in the North West of England: Key findings

I audited 11 IAPT services in the North West of England. There was a 78% preference for onsite completion of TULIP facilitated by a researcher. Upon reflection from service manager feedback, services identified that they would complete the audit over the phone in the future. The main barrier that was apparent across services was the lack of facilitation of languages other than English. This barrier was a present throughout the 4 steps of the IAPT patient pathway. Only 9% of services had translated and culturally adapted materials promoting their service at step 1. At step 1, only 9% of services were able to accommodate other languages on their website for patients when accessing self-referral, IAPT information or patient information sheets. The 27% of services that were able to better engage the ethnic community had specific ethnic volunteers or BME outreach staff in place. This barrier was consistently reflected throughout step 1, with over the phone communication in other languages being limited to the availability of staff or through facilitation of outsourcing an appropriate interpreter or language line. Facilitating language barriers through outsourcing was however not available immediately and required a prior appointment to be made. Furthermore during treatment at step 2 and step 3, outcome measures, mental health literacy materials, handbooks and manuals were limited in translations available for IAPT patients. Only 36% of services were able to facilitate culturally adapted manuals and workbooks. In order to facilitate the needs of ethnic minority patient's services reflected that they would outsource translators, interpreters and materials, these resources are often charged out of the service budget. Less than half the services audited (45%) highlighted that they had a specific budget which is used to facilitate the needs of ethnic minorities. Within IAPT there was no specific policy for working with ethnic minorities used across all services, however 18% of included services reported that their service had an independent policy of how to worth with this patient group.

d) TULIP: Cultural sensitivity audit feedback from service managers: Key findings

Feedback about the TULIP cultural sensitivity audit tool and guidelines from service managers participating in the audit were positive. Managers highlighted that where was a need within IAPT for a way in which to assess barriers experienced by ethnic minorities accessing their services and further to this the need to facilitate an intervention to reduce barriers. The barriers highlighted by the audit were reflected as being consistent with experiences of the managers within their services. Service managers highlighted that the audit made them reconsider efforts being made within IAPT to better engage the ethnic minority community. Managers reflected that the audit was concise and straight forward to complete, furthermore the guidelines helped to settle any fears about audit performance based follow up. Feedback about changes to the items within the audit discussed including further detail about the facilitation of translators. After review of feedback we decided that questions about translators were sufficient and that the inclusion of a question about numbers of translator requests would not aid in highlighting barriers to accessing IAPT for ethnic minorities but may be something for services to consider and assess internally for their own benefit. Services that requested to complete the audit on site reflected that the audit was straight forward and therefore could be completed over the phone in the future. Audit feedback results from service managers reflected that a central source of culturally adapted materials is required within IAPT, as well as cultural sensitivity and working with translators training for staff. Managers highlighted that they would have a preference for a central online resource. Services had previously made efforts to outsource these facilities but had found that translators/interpreters were not consistent or that training was not appropriate for their service.

4.1 Intergroup differences and similarities

Mental health service barriers to accessing therapy compared to barriers to accessing psychological therapy for ethnic minorities.

Table 17 Barriers in Mental health services vs Psychological therapy services

Mental Health services	*Psychological therapy services*
Major severity of mental health disorders	Minor severity of mental health disorders
More stigma	Less stigma
Mental health in patients/ out patients	Community based / primary care services
Less time consuming practitioner contact	More time consuming practitioner contact
Accepted and recognised mental health disorders	Less recognition of mental health disorders
Medication focused treatment	Primarily talking based treatment interventions

The majority of previous literature is primarily focused on barriers to accessing mental health services as opposed to accessing psychological therapy services. There a many commonalities between the two types of services and the barriers patients experience during access. Commonalities in barriers are within; lack of patient awareness about mental illnesses as well as the nature of mental health series (Sue et al. 1994). This barrier was evident from our extracted barrier themes in the systematic review of barriers to accessing psychological therapy for ethnic minorities residing in western countries (mental health literacy, presenting symptoms). Other patient related barrier commonalities include; cultural barriers (Leong and Kalibatseva 2011), this barrier was also captured within our systematic review. From the perspective of this project a psychological therapy services we extracted the following barrier themes; Patient related barriers (stereotype, religion and stigma), Expectations of the community (Cultural expectations of the community). These barriers were often reflected as having a cultural underpinning which differed from the western approach practices within IAPT services. Literature about mental health service barriers also discusses the barrier of lack of cultural sensitive services which include language barriers and poor cultural understanding from a service perspective (Chen and Rizzo 2010;Sentell et al. 2007). The research within this project also reflected these barriers within the following themes; Patient related barriers (Language and reluctance to disclose), Health service related barriers (Appropriateness of service, Lack of understanding of the referring service, Patients preference for therapist to hold certain characteristics, Patients expectations of therapist and Preference for alternate treatment). These barriers were evident throughout the IAPT patient pathway with differences arising between patient and practitioner understanding of cultural expectations as well the ability of a service to facilitate the needs of this community. Barriers differed slightly in the specificity of barriers appropriate to psychological therapy services. Patients reflected that they had misconceptions about the nature of psychological therapy and often associated it with the provision of medication such as antidepressants. Treatments using medication are more relative to mental health services as opposed to psychological therapy which is centred on talking and behavioural therapy within the IAPT services. Practical barriers were also captured within mental health service barriers literature, literature reflected that lack of child care or transport provisions may hinder access from ethnic minorities (Leong and Kalibatseva 2011). The barrier theme of Practical issues was also captured in psychological therapy literature, in the theme; Practical issues barriers (Cost). Due to psychological therapy being either face to face or over the phone, with regular sessions over a 6 month period within IAPT, practical issue barriers are limited sessions. The need may not require facilitation within an IAPT service as a permanent measure but more so when the need requires facilitating during a treatment session. In a mental health inpatient service this need may need permanent or more long-term facilitation which would have greater financial impact on a service budget.

Language barriers were reflected within both mental health services (Hatfield et al. 1996) and also psychological therapy services in the form of the barrier theme; Patient related barriers (Language). The barrier of language would be consistent across psychological therapy and mental health services, where practitioners may not be linguistically matched to patients accessing treatment. Within inpatient mental health facilities it may be more financially viable to have permanent staff linguistically matched to the majority ethnic minority population due to more immediate need for this facilitation on a day to day basis. In regards to psychological therapy services, they are often paper heavy, with service promotion, self-referral, correspondence materials, and outcome measures and mental health literacy materials all being paper heavy. Furthermore within IAPT, whether a patient accesses step 2 low intensity talking therapy or step 2 high intensity CBT therapies, the patient and practitioner are reliant on linguistic matching. This need is often facilitated by bilingual staff or outsourcing of translators. Due to need of linguistic facilitation being depended on the need of a patient during a pre-organised appointment, IAPT's method of facilitating language barriers may differ from mental health service facilitation.

Severity of mental health disorders seen in mental health services differ from the lower intensity mental illness seen within IAPT services, which have a primary focus on depressive and anxiety disorders. For this reason intervention pathways for patients differ between services. Furthermore the role of the therapist differs between the two services, for example mental health services may deal with more severe mood disorders such as Bi-polar disorder, a patient differing from Bi-polar would be excluded and onward referred from IAPT to a specialist service. Disorders dealt with in mental health service may often include patients requiring both psychotherapeutic, psychiatric support complimented by medicinal treatments. This patient group requires a support different to IAPT, and thus staff training would also differ. A staff member within a mental health service may not only require cultural sensitivity training of how to work in a psychotherapeutic setting but also a psychiatric setting working with patients prescribed medications.

4.2 *Strengths and limitations of studies*

a) Barriers to accessing psychological therapy for ethnic minorities residing in western countries: systematic review: Strengths and limitations (Study 1)

The major strength of this review is that it is the first of its kind to investigate the barriers to accessing psychological therapies for ethnic minorities in western countries. Research conducted area primarily focuses barriers to accessing psychiatric services as opposed to psychological therapy services where patients accessing the service have mild to moderate severity of mental health problems. Previous research in this area is scarce, however the previously published review by WW on barriers to recruiting ethnic minorities to mental health research created an underlying insight into the area and barriers that may be apparent (Brown et al. 2014;Waheed et al. 2015). Statistics highlight the need for psychological support for ethnic minorities, with prevalence in particular for anxiety and depression significantly high in this population.

The findings of this review suggest that reducing only patient related barriers may not be sufficient in resolving the broader problem of cultural sensitivity. Due to the multifaceted nature of the barriers associated with ethnic minorities accessing psychological therapy, it may be essential to take a multifaceted approach to creating a solution that simultaneously resolves patient and service related barriers to have the more efficient and effective outcome. Evident from the 6 papers included, research in this area is limited which resulted in ethnic minority groups included in this review being limited to; 'African American', 'Latino', Urdu community', 'Euro American', 'Orthodox Jewish', 'Somali Community', 'Tamil Community', 'Bengali Community', 'Hispanic', 'Muslim Arab American' and 'American Indian' groups, the need for further research to be conducted in this field is emphasised in order to create more representative literature. In most developed countries there are ethnic minority groups, however the ethnic origin of these groups differs between countries, for example in the United Kingdom the largest ethnic minority group is the South Asian population, whereas in the United States ethnic minorities often come from an African-Caribbean or Hispanic background. Out of the 6 published papers included in this review 5 of the studies were conducted in the US, and only 1 was conducted in the UK, further research requires a more culturally sensitive approach in order to capture the barriers experienced by ethnic minorities accessing psychological therapies in a variety of different countries. Although barriers have overlap and may be common between ethnic minority patients in the UK and the US, it may be beneficial to better understand the differences and similarities between experiences of this population group across different locations. Further research is required to gain a better understanding of each barrier and its applicability to different ethnic backgrounds. It is essential to further understand how each barrier affects different cultures, different ethnic groups and religious backgrounds in order to appropriately facilitate change in the psychological therapy system and improve access for ethnic minorities.

b) Understanding the IAPT patient pathway Strengths and limitations (Studies 2.0-2.2)

The strengths of study 2 were that I conducted a thorough search of available IAPT literature published from the development to initiation and delivery of IAPT services. IAPT services use these handbooks for their recommended care pathway; this allowed me to gain an understanding of the background behind IAPT's initiation from a government perspective. It also allowed me to understand what the recommended IAPT patient pathway for care was to reflect upon when conducting site visits in study 2.1.

The strength of study 2.1 was that I recruited two IAPT services located in high ethnic density catchment area. This was beneficial as the barriers experienced within these services were reflective of the South Asian minority ethnic patients accessing IAPT. The limitation of this study was that not all steps of the IAPT patient pathway were represented by staff members at each site. Although this was a limitation, due to IAPT's standardised patient pathway, the role of staff members at each step does not allow for much deviance.

Study 2.1 the second aim of study 2.1 facilitated the capturing of an IAPT Training Commissioner for the North West of England's perspectives about,

a) The accuracy of our further detailed IAPT patient pathway.
b) The need for our research project within IAPT.
c) The recruitment of IAPT staff members for our focus group.

This ensured that the additional detail I had made to the pathway was reflective of IAPT's intervention procedure. A limitation of this study was that out of the three, only 1 Training Commissioner from the North West of England was present during the meeting. Although only one Training Commissioner was present, she was representative of the services in the North West of England and was able to facilitate the recruitment of IAPT staff members for study 2.2 IAPT staff focus groups.

c) ***Barriers to accessing IAPT services for ethnic minorities from a staff perspective: Strengths and Limitations (Study 2.2)***

A major strength of study 2.2 was that we were able to capture qualitative data directly from IAPT staff members across the North West of England. The staff members were able to provide their experiences and opinions of barriers experienced by ethnic minority patients accessing their service at each stage of the IAPT patient pathway. A limitation of this study was that no participants attended the second focus group and thus our final represented participant numbers for IAPT staff members was limited to the perspective of 4 services.

d) ***Development of TULIP: cultural sensitivity audit tool staff perspective: Strengths and limitations (Study 3 & 3.1)***

The strength of studies 3 & 3.1 was that it included experts from a variety of academic backgrounds, with extensive but varied areas of IAPT expertise. Further to experts having worked with IAPT, they had backgrounds in developing and implementing culturally sensitive treatment interventions, this complimented the development of the TULIP. The TULIP: cultural sensitivity audit tool is the first of its kind developed specifically for a psychological therapy service. The tool captures the barriers experiences by ethnic minorities accessing psychological therapy captured throughout the previous 6 studies. This allowed for the development of a well-informed, thorough yet concise audit tool. The development of TULIP: Guidelines facilitated the clarification of any apprehensions service managers may have prior to and during audit completion. The provision of item by item explanations of questions and examples created a straight forward audit tool that could be independently completed. A limitation of study 8 was that due to limited resources the audit tool was limited to electronic paper, or in person paper completion. With greater resources the tool may be further refined, an electronic version which automatically collects data could be developed.

e) TULIP: Cultural sensitivity audit of IAPT services in the North West of England: Strengths and limitations (Studies 4.1)

A major strength of studies 4.1 was that this was the first cultural sensitivity audit of IAPT services. The results of this audit allowed the capturing of levels of cultural sensitivity within services in the North West of England, while capturing major barrier themes that where highlighted during analysis. The capturing of barriers across the included services enabled greater insight into areas of IAPT that may require further cultural sensitivity development. A limitation of this study was that we recruited 11 services out of the 22 initially contacted. Furthermore the number of initially conducted services did capture contact details for services which were no longer in service or incorrect details, this highlighted that the central resource for locating IAPT services may require updating and may be creating hindrance to service access.

Study 9 focused on staff feedback about TULIP and whether services wished to have further involvement in future developments. The strengths of service manager feedback allowed me to capture the reflections of managers who had completed the audit and used the guidelines. These reflections facilitated the capturing of recommendations for further tool development of the tool and progression of TULIP in the future. The feedback was also highly beneficial in capturing reinforcement about the need for TULIP and potential positive impact this project could have from a service perspective. The limitation was that not all service managers provided thorough feedback about the tool, however all service managers requested further involvement in the progression of the TULIP and feedback from their audit.

4.3 Suggested facilitation of change through a cultural sensitivity intervention

Applying the AMP model to develop a cultural sensitivity intervention

The AMP model describes the three areas essential to improvement of mental health support in primary care; community engagement, quality of primary care and psychosocial interventions (Dowrick et al. 2016) . Using the AMP model as a template, the essential areas of intervention delivery supported by the findings in this project are; educating the community, making psychological therapies culturally sensitive and enabling psychological therapy services to become culturally sensitive. The accumulation of these three areas of intervention may not only improve access to psychological therapies for ethnic minority patients but may impact the wider field of research with ethnic minority individuals.

4.4 Future implications

In order to effectively and efficiently assess levels of cultural sensitivity within services and to highlight both strengths and flaws within, it may be suggested that a cultural sensitivity audit tool be created. The cultural sensitivity audit tool may be used to assess levels of cultural sensitivity within a specific psychological therapy service. Due to the nature of psychological therapy services differing from service to service it may be of greater benefit to develop service specific tools, this will allow for the capturing of cultural sensitivity in accordance with the procedures of the service in question alongside the opportunity for the development of service specific solutions.

Through educating ethnic minorities on a community level, we may be able to create a greater awareness of the importance of research and the availability of mental health support. Post intervention ethnic minority patients may be less inclined to fear confidentiality issues through the use of education in the community. Furthermore the impact of educating service providers may increase cultural sensitivity within services, enabling service providers and clinicians to better understand cultural backgrounds and needs of patients from ethnic minority backgrounds.

We suggest that education on both practitioner and patient levels is required in order to create awareness and reduce barriers created due to ethnic or religious background. We suggest that through creating awareness on a patient and practitioner level, patients will have a greater understanding of the nature of psychological therapy services and practitioners will have a greater awareness of patients' cultural or religious barriers that may be presented. Further to this the complicated nature of barriers associated with and experienced by ethnic minorities accessing psychological treatment, reinforces the need for further research to be conducted in this area. Evident from the results of this broad review of published literature, ethnic minority groups in this field are underrepresented with only 12 ethnic minority groups being represented, further highlighting the need to conduct broader randomised control trials to create more representative participant

Table 18 Suggested barrier theme solutions

Table 18 describes barrier themes categorised under suggested solutions

Community engagement (a)	***Increasing cultural sensitivity within psychological therapy services (b)***	***Making psychological therapies more culturally sensitive (c)***
1.Trust 3. Patient Confidentiality 12. Cultural expectations from the community 13. Lack of community support 15..Family Influence 16.Preference for Alternate Treatment 19.Patients preference for therapists to hold certain characteristics 20.Patients expectations of therapist 4. Reluctance to disclose 6. Mental health literacy 7. Patients view of therapist 8. Religion 9.Stigma 10.Past experiences about treatment 11.Presenting symptoms	2. Language 3. Patient Confidentiality 4. Reluctance to disclose 5. Stereotype 17. Appropriateness of service 18. Lack of understanding of referring health service 19. Patients preference for therapists to hold certain characteristics 21.Cost	2. Language 19. Patients preference for therapists to hold certain characteristics 21.Cost

a) Discussion of barrier solution themes and suggested facilitation of change through a cultural sensitivity intervention

Implementing an intervention to improve cultural sensitivity in psychological therapy services encompasses three key areas; a) Community engagement, b) increasing cultural within psychological therapy services, and c) making psychological therapies more culturally sensitive. Each barrier theme was categorised into a, b, &/or c in accordance with recommended solutions through intervention. Referring to *figure 17*, the 21 barrier subthemes are categorised into intervention through (a) community engagement. This paper suggests that through education on a community engagement level one may be able to increase ethnic minority patient mental health literacy about psychological disorders and awareness about psychological therapy support available to dispel any pre-existing stigma towards psychological therapy services and service providers. The provision of translated materials and the delivery of workshops or talks in the native tongue of ethnic minority dense areas, one may be able to bridge patient and community related barriers which create hindrance prior to and during a patient's journey in gaining psychological therapy. A recurrent barrier theme was cultural or religious background and the misconception that practitioners are unaware of and/or under-facilitating the needs of patients. In order to dissipate such beliefs patients may gain reassurance through talks and workshops provided as part of an intervention to create greater cultural sensitivity from a patient perspective. Talks and workshops would further emphasise the need and benefit of family and community support when loved ones are suffering from psychological problems. Further to this any concerns about confidentiality could be explained and reassured by reiterating and emphasising the importance of confidentiality from a practitioner and service provider standpoint. This may be achieved by discussing the negative implications for service providers if they breached confidentiality (Abrams et al. 2009;Loewenthal et al. 2012;Smith 2012;Westermeyer et al. 2002;Loewenthal and Rogers 2004;Carpenter-Song et al. 2010;D'Alessandro 2007;Haque-Khan 1997).

Barrier themes categorised into (b) 'Increasing cultural sensitivity within psychological therapy services' focuses on the service provider approach to making psychological therapy services more accessible for ethnic minorities. Through facilitating an intervention within psychological therapy services one may tackle barriers the following barriers; language, appropriateness of service, lack of understanding of referring health service, patient confidentiality, stereotype, reluctance to disclose, cost and patients preference for therapists to hold certain characteristics. The intervention on a service level is multifaceted; education alone will not increase cultural sensitivity to an acceptable level but may help to dispel some barriers to an extent. Educating service providers about different cultures and religions of ethnic minority patients may aid in bridging lack of understanding of referring health services. Our systematic review found that patients reflected stereotype from service providers, this may come from a practitioner's lack of understanding of a patient's religion or cultural background. We suggest that through talks, workshops and the provision of brief literature to explain cultural and religious backgrounds of ethnic minority patients, the likelihood of stereotype may be reduced. This community reflected a preference for service providers to hold similar ethnic backgrounds to themselves, gender matching or linguistic matching or required a translator. These barriers may be accommodated by employing multicultural and multilingual staff within psychological therapy services. With more multicultural and gender diverse staff available services may be able to better accommodate the ethnic minority community needs by simultaneously reducing language barriers and decrease reluctance to disclose. This community often experience an additional waiting time due to limited availability of translators, as well as this, service providers often incur extra costs of hiring translators, through facilitation of multilingual staff waiting times and costs may be reduced (Carpenter-Song et al. 2010;Westermeyer et al. 2002;Loewenthal and Rogers 2004;Abrams et al. 2009;Loewenthal et al. 2012;Smith 2012;Haque-Khan 1997;D'Alessandro 2007).

The final intervention category (c) 'Making psychological therapies more culturally sensitive' tackles the following barriers; patients preference for therapists to hold certain characteristics, cost and language. Reflecting upon the barriers extracted in this review, in order to make psychological therapies more culturally sensitive one must facilitate for language barriers, this may be achieved by employing multilingual therapists. Often the use of translators with no therapeutic background can distort the translation of treatment between patient and practitioner leaving patients feeling frustrated and fearing breach of confidentiality from the translator. Through employing multilingual therapists, additional costs of external interpreters will also be reduced. Simultaneously if therapists are both multilingual and from a variety of ethnic and cultural backgrounds they may also facilitate the reduction of the barrier; patients preference for therapists to hold certain characteristics (Abrams et al. 2009;Westermeyer et al. 2002;Loewenthal et al. 2012).

Through the facilitation of these three suggested interventions one may anticipate more accessible and culturally sensitive psychological therapies for ethnic minorities, the repetition throughout emphasises the multifaceted nature of both the cultural sensitivity problem and solution.

The intervention strategies suggested above include the following procedures; production of relevant materials, (educational, translations and adaptations), the addition of multicultural and multilingual staff. These solutions may be necessary to creating more culturally sensitive psychological therapy services for ethnic minorities; however they incur further funding to be accommodated. Previous research reports the need for these strategies for ethnic minority engagement in mental health research, due to the same target population being investigated this paper suggests that similar strategies may be necessary for the ethnic minority populations accessing psychological therapy. There is a lack of documented support for the success of such strategies, therefore through the implementation and assessment of the suggested intervention strategies researchers will gain a better understanding of the feasibility and level of success in improving cultural sensitivity through application of further research. To assess the success of cultural sensitivity interventions the optimum approach way to do so is to intertwine interventions into randomised control trials and assess them in a quasi-experimental or experimental manner, with participant groups accessing psychological therapy services which are either implementing cultural sensitivity improving measures or psychological therapy services which are not implementing cultural sensitivity measures. This however raises ethical questions of whether it is ethical to give greater cultural sensitivity provision to one patient group and not another. Barriers often encountered are related to specific services due to differences in procedure, this highlights the need to tailor interventions to individual services as each service procedures are similar but contain disparities.

i. Development of a toolkit to improve cultural sensitivity within IAPT services (TULIP: Toolkit).

We propose the development of a cultural sensitivity toolkit to improve British South Asian access to IAPT services. The toolkit should reflect the cultural sensitivity improvement needs of IAPT services captured in cultural sensitivity audits TULIP: Service and TULIP: User.

ii. Developing toolkit materials for introducing and engaging the British South Asian community in accessing the IAPT services.

We recommend the following;

a) Translation and cultural adaptation of IAPT promotional materials (flyers, posters and leaflets) into the main British South Asian languages in the UK, Urdu, Hindi, Gujarati, and Bangla reflecting the needs of the Pakistani, Indian and Bangladeshi population.

b) Translation and cultural adaptation of the following IAPT educational materials into the main British South Asian languages in the UK, Urdu, Hindi, Gujarati and Bangla reflecting the needs of the Pakistani, Indian and Bangladeshi population: pamphlets, flyers/posters, referral procedure, stepped care model - step1/step2 step3/step4, role of psychological wellbeing practitioners, role of cognitive behavioural therapist, role of high intensity therapist, role of senior CBT therapist, role of counsellor, role of psychologist and role of eye movement desensitisation and reprocessing(EMDR) therapy, discharge procedure.

c) Provisions for training of IAPT staff to improve engagement with the British South Asian community to improve access to psychological therapy.

d) Provisions of training of IAPT staff for working with family or care givers of British South Asian patients accessing psychological therapy.

iii. Developing toolkit materials for improving communication with the British South Asian community to improve access to IAPT services.

We recommend the following;

a) Development of the following translated and culturally adapted IAPT patient communication materials into the main British South Asian languages in the UK, Urdu, Hindi, Gujarati and Bangla reflecting the needs of the Pakistani, Indian and Bangladeshi population: referral form, recruitment template letter, and appointment reminder template letter, follow up and discharge template letters.

b) Translated and culturally adapted mental health literature into the main British South Asian languages in the UK, Urdu, Hindi, Gujarati and Bangla reflecting the needs of the Pakistani, Indian and Bangladeshi population: pamphlets, flyers and posters about; minimal symptoms of anxiety and/or low mood, mild to moderate depression, mild to moderate anxiety disorders, sleep problems, social anxiety, generalised anxiety, panic disorder, moderate to severe depression/anxiety disorders, social anxiety, generalised anxiety, severe and recurrent depression and anxiety disorders.

iv. *Developing a specific cultural sensitivity policy for IAPT on how to work with ethnic minority patients to improve access from British South Asians.*

We recommend the development of a specific policy which to capture the following procedures to consider when working with ethnic minority patients in IAPT:

a) Development of a policy for essential supervision for IAPT staff to discuss cultural issues that may arise when working with ethnic minority patients.
b) To develop a specific policy for special considerations to take into account with when working with ethnic minority patients.
c) A specific policy on reassuring ethnic minority patients about confidentiality.
d) A specific policy for every IAPT service to have a budget for ring-fence monitory allocation.

v. *Providing the relevant training for IAPT service providers to improve cultural sensitivity and improve access from British South Asian clients (team composition).*

We recommend the following;

a) Provisions for training of IAPT staff members in working with translators.
b) Training for IAPT staff members for how to engage the family and care-givers of ethnic minority clients.
c) IAPT staff specific training in being culturally sensitivity when working with ethnic minority patients in a psychotherapeutic setting.

vi. *Developing translated and culturally sensitive materials to be used to improve treatment of British South Asian clients when accessing IAPT to improve access to psychological therapy services.*

We recommend the following;

a) Translating and culturally adapting the following materials into the main British South Asian languages in the UK, Urdu, Hindi, Gujarati and Bangla reflecting the needs of the Pakistani, Indian and Bangladeshi population: outcome measures PHQ9 and GAD7 translated and culturally.
b) Developing a database containing ethnic specific voluntary sector psychological therapy organisations and NHS services for signposting.

c) Developing a database of translated and culturally adapted psychotherapeutic terms into the main British South Asian languages in the UK, Urdu, Hindi, Gujarati and Bangla reflecting the needs of the Pakistani, Indian and Bangladeshi population. Psychotherapeutic terms will be translated and culturally adapted with descriptions to describe psychotherapeutic terms where necessary.

b) Potential future implications of proposed research

i. Community level

Through the development and implementation of the TULIP: Toolkit this study holds the possibility of improving awareness within the British South Asian community. Translated and culturally adapted materials will provide IAPT services nationally to promote their services to the lowest access ethnic minority population in the UK. Through delivery of IAPT literature and promotional materials the British Asian minority population may have improved access to IAPT services. Translated and culturally adapted materials about mental illness supported within IAPT services may help to engage the under-served population by creating awareness around mental health and reducing stigma within the British South Asian population.

ii. Service level

Through the delivery of cultural sensitivity training to IAPT service providers, the initial barriers experienced by British South Asian patients when accessing IAPT services will be reduced. Service providers will have a greater understanding of barriers experienced by British South Asian patients when accessing psychological therapy and how to incorporate the facilitation of barriers into the delivery of psychotherapeutic support during the IAPT patient pathway. With the increased level of awareness of cultural sensitivity in IAPT service providers increased provisions for ethnic minority patients accessing will be inherent within IAPT services for when British South Asian patients access IAPT.

Furthermore through training of working with family and care givers of British South Asian patients IAPT service providers will have an inherent understanding of how to accommodate the needs of patients when accessing IAPT services, which may facilitate better access and engagement of British South Asian patients in psychological therapy.

Training of IAPT service providers in working with translators in a culturally sensitive approach to psychotherapeutic support will help to improve access of British South Asian patients. Working with translators in a psychotherapeutic setting will provide IAPT service providers with the knowledge of adapting their delivery of therapy when working with British South Asian patients in a culturally sensitive manner while supporting the effective delivery of psychotherapeutic support.

iii. Nationally

Through greater promotion and delivery of psychological therapy to British South Asian patients nationally access from British South Asian patients to IAPT may improve. Through IAPT promoting the psychotherapeutic support provided by their service in a culturally adapted and appropriately translated manner outreach to the British South Asian community will improve. The increase of national awareness of mental health disorders in the British South Asian population through the accessibility of translated and culturally adapted materials may lead reduced stigma and a national increase in access to IAPT services from the British South Asian community.

The collection of levels of cultural sensitivity in IAPT services in the UK will create an awareness of barriers experienced by the ethnic minority population when accessing IAPT services. This will allow IAPT services to implement the TULIP: Toolkit where appropriate to improve levels of cultural sensitivity and thus access to their IAPT service. Implementation of the TULIP: Toolkit within IAPT services nationally holds the potential for IAPT services to become more accessible for British South Asians nationally.

iv. Internationally

The potential outcomes of this research hold global implications. Barriers highlighted previously are representative of global research into barriers to accessing psychological therapy for ethnic minorities. The TULIP cultural sensitivity audit tools hold the potential of being developed for mental health services, health care services across the globe. With further development future research can develop the TULIP tool to accommodate the patient pathway of other health care and mental health care services when assessing levels of cultural sensitivity. The future of this research holds the possibility of assessing levels of cultural sensitivity within mental health services and health care services worldwide.

The TULIP toolkit may be adapted to reflect the relevant materials required by other mental health care and health care services globally relevant to the ethnic minority population in their catchment area. The development and implementation of the TULIP toolkit within other mental health services may be multidisciplinary with the overlap of mental health problems treated across services globally. Where a service may have a majority British South Asian ethnic minority population requiring treatment for anxiety and depression items from the TULIP toolkit developed in this research project may be applicable and used. Service provider training, literature, communication and educational materials may be of multidisciplinary use across mental health/health care services globally. This provides the potential for a global improvement in the delivery of culturally sensitivity psychotherapeutic support for South Asian ethnic minority populations and thus improved access.

4.5 Conclusion

Access to psychological therapies for ethnic minorities has its challenges from patient and practitioner stand points. To combat barriers from one side alone is not adequate to creating a solution in the long term. To appropriately battle cultural sensitivity and combat barriers experienced by ethnic minorities accessing psychological therapy one must resolve patient related barriers and practitioner related barriers. Further to this there is a demand for further research in this field to be conducted in order to create a more culturally sensitive and representative sample of literature in western countries for ethnic minorities accessing psychological therapies. Psychological therapy services differ in their processes and prevalence of minority ethnic group of patients accessing the service and residing locally, thus barriers occur at different points during the patient journey dependent on the service accessed, thus interventions demand tailoring to the needs of individual psychological therapy services and the minority ethnic group in need. This review aims to create awareness about barriers experienced by ethnic minorities in western countries accessing psychological therapy services and furthermore highlight the lack of culturally representative research currently available in the field.

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APPENDICES

Appendix 1 Topic guide for discussions with IAPT staff: Site visits

Topic guide for discussion with IAPT staff members on site visits

1. What is the standard IAPT patient pathway put into practice at your service?

2. Please describe a patient's journey. (Use Figure 3 'IAPT Patient pathway from recommendations' for own reference).

3. What is role within IAPT?

4. Please could you describe your responsibilities?

5. Where in the IAPT pathway does your role take effect?

6. At your service do you ever make any ddeviations from the standard recommended IAPT pathway?

7. How do you and your service facilitate the needs of ethnic minority patient's accessing you service, if at all?

Appendix 2 Topic guide IAPT North West of England Training commissioner

Topic guide for discussion with an IAPT North West Training Commissioner

i. We will present our findings from IAPT site visits and discussions with IAP staff members.

ii. From which we developed a further detailed IAPT patient pathway.

1. **Does the further detailed IAPT patient pathway reflect the standard patient journey through IAPT services?**

2. **Can you provide us with your confirmation that the further detailed IAPT patient pathway that we have developed is representative of procedures used within services?**

iii. We will now present our proposed research project. We aim to conduct focus groups with IAPT staff members in order to capture barriers experienced by ethnic minorities accessing IAPT.

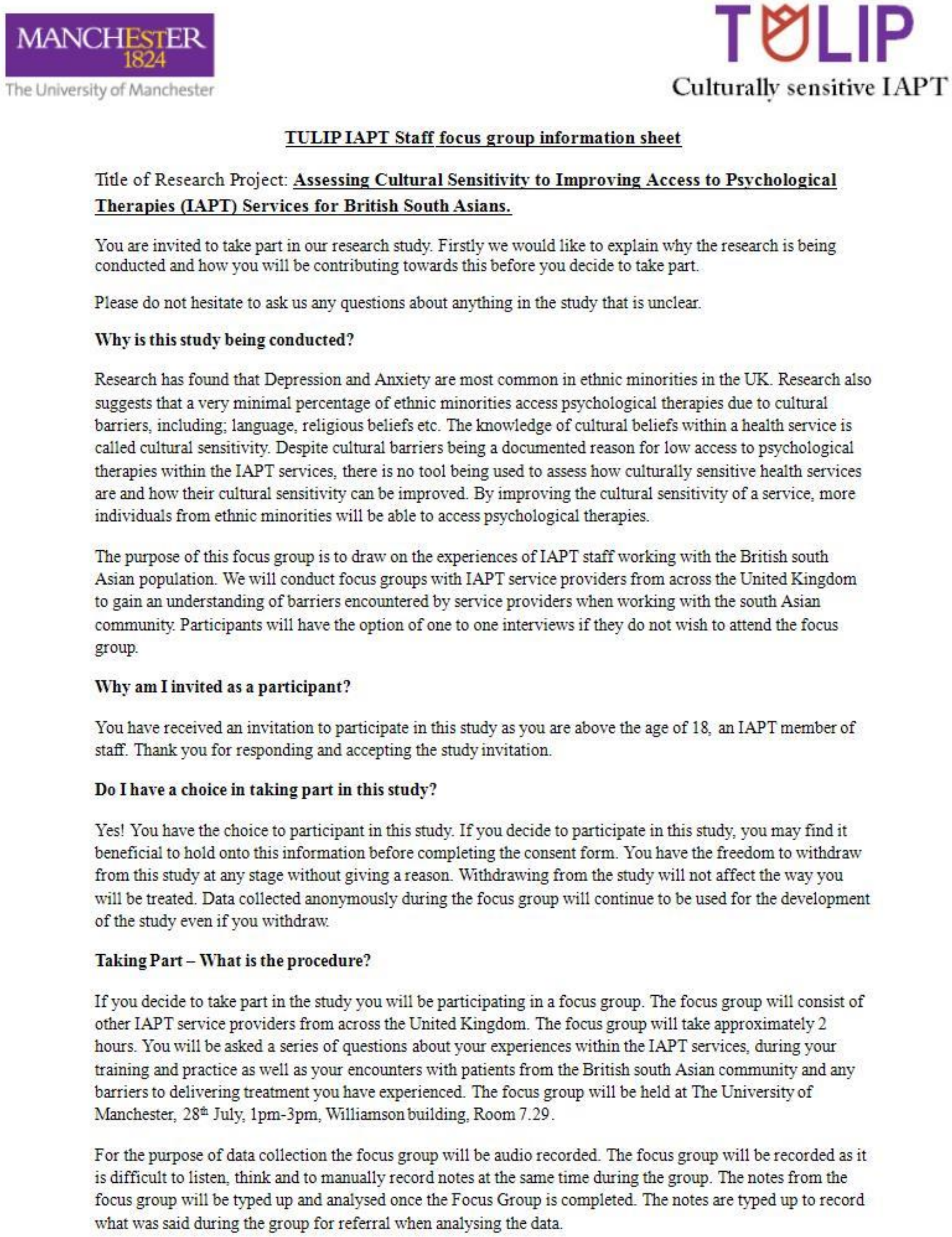
iv. From this feedback we aim to develop a cultural sensitivity audit tool to be used by IAPT services independently, to high light areas of excellence and required improvement for cultural sensitivity.

3. **Please could you provide your approval for recruiting IAPT staff members to participate in our focus group?**

4. **Can you aid in facilitating the IAPT staff member recruitment process?**

5. **What is your opinion on the feasibility of our proposed research and the need for a cultural sensitivity audit tool to be used by IAPT?**

Appendix 3 IAPT Staff focus group participant information sheet



MANCHESTER 1824
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TULIP
Culturally sensitive IAPT

TULIP IAPT Staff focus group information sheet

Title of Research Project: **Assessing Cultural Sensitivity to Improving Access to Psychological Therapies (IAPT) Services for British South Asians.**

You are invited to take part in our research study. Firstly we would like to explain why the research is being conducted and how you will be contributing towards this before you decide to take part.

Please do not hesitate to ask us any questions about anything in the study that is unclear.

Why is this study being conducted?

Research has found that Depression and Anxiety are most common in ethnic minorities in the UK. Research also suggests that a very minimal percentage of ethnic minorities access psychological therapies due to cultural barriers, including; language, religious beliefs etc. The knowledge of cultural beliefs within a health service is called cultural sensitivity. Despite cultural barriers being a documented reason for low access to psychological therapies within the IAPT services, there is no tool being used to assess how culturally sensitive health services are and how their cultural sensitivity can be improved. By improving the cultural sensitivity of a service, more individuals from ethnic minorities will be able to access psychological therapies.

The purpose of this focus group is to draw on the experiences of IAPT staff working with the British south Asian population. We will conduct focus groups with IAPT service providers from across the United Kingdom to gain an understanding of barriers encountered by service providers when working with the south Asian community. Participants will have the option of one to one interviews if they do not wish to attend the focus group.

Why am I invited as a participant?

You have received an invitation to participate in this study as you are above the age of 18, an IAPT member of staff. Thank you for responding and accepting the study invitation.

Do I have a choice in taking part in this study?

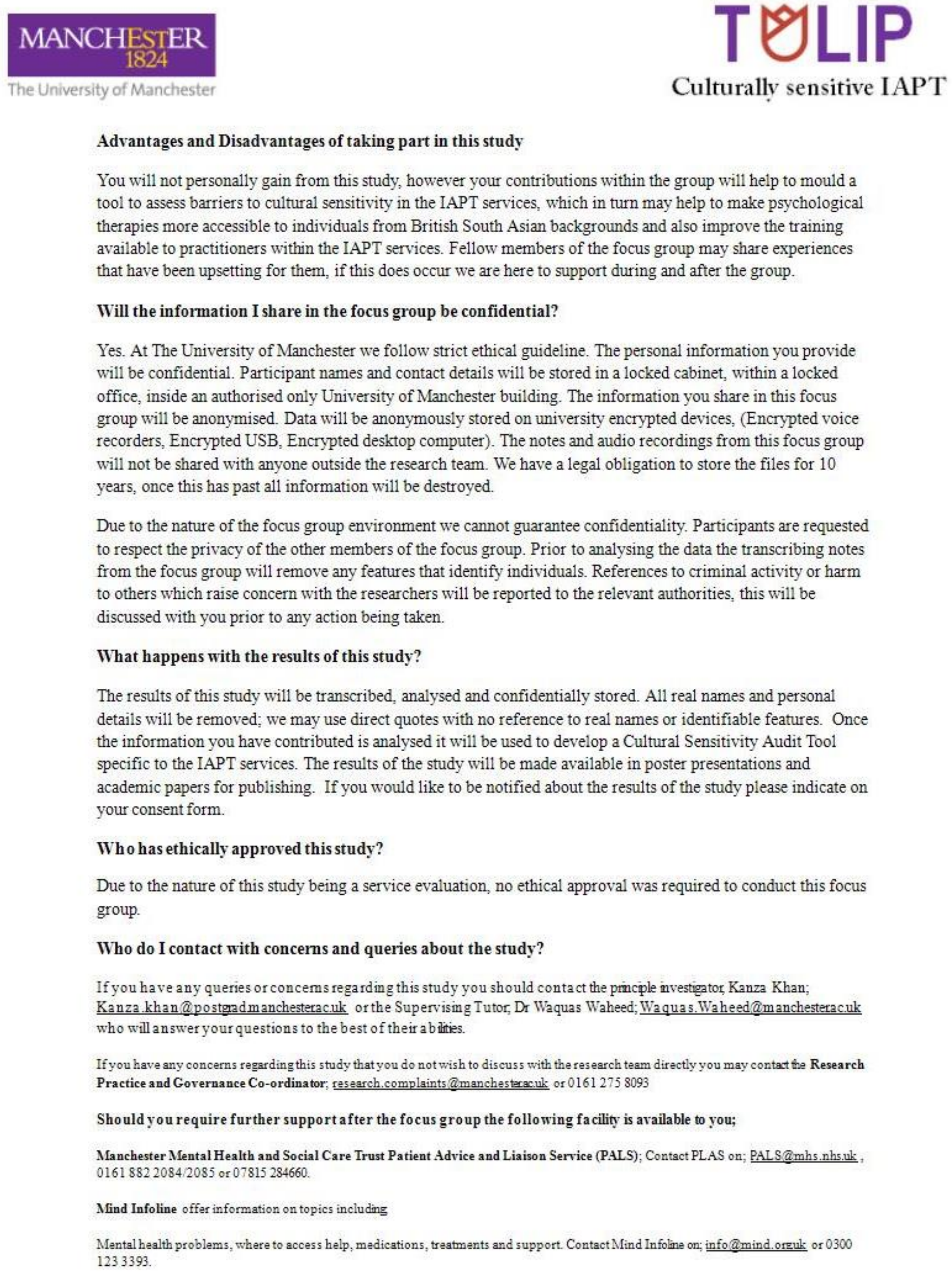
Yes! You have the choice to participant in this study. If you decide to participate in this study, you may find it beneficial to hold onto this information before completing the consent form. You have the freedom to withdraw from this study at any stage without giving a reason. Withdrawing from the study will not affect the way you will be treated. Data collected anonymously during the focus group will continue to be used for the development of the study even if you withdraw.

Taking Part – What is the procedure?

If you decide to take part in the study you will be participating in a focus group. The focus group will consist of other IAPT service providers from across the United Kingdom. The focus group will take approximately 2 hours. You will be asked a series of questions about your experiences within the IAPT services, during your training and practice as well as your encounters with patients from the British south Asian community and any barriers to delivering treatment you have experienced. The focus group will be held at The University of Manchester, 28th July, 1pm-3pm, Williamson building, Room 7.29.

For the purpose of data collection the focus group will be audio recorded. The focus group will be recorded as it is difficult to listen, think and to manually record notes at the same time during the group. The notes from the focus group will be typed up and analysed once the Focus Group is completed. The notes are typed up to record what was said during the group for referral when analysing the data.

Appendix 3 IAPT Staff focus group participant information sheet



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Advantages and Disadvantages of taking part in this study

You will not personally gain from this study, however your contributions within the group will help to mould a tool to assess barriers to cultural sensitivity in the IAPT services, which in turn may help to make psychological therapies more accessible to individuals from British South Asian backgrounds and also improve the training available to practitioners within the IAPT services. Fellow members of the focus group may share experiences that have been upsetting for them, if this does occur we are here to support during and after the group.

Will the information I share in the focus group be confidential?

Yes. At The University of Manchester we follow strict ethical guideline. The personal information you provide will be confidential. Participant names and contact details will be stored in a locked cabinet, within a locked office, inside an authorised only University of Manchester building. The information you share in this focus group will be anonymised. Data will be anonymously stored on university encrypted devices, (Encrypted voice recorders, Encrypted USB, Encrypted desktop computer). The notes and audio recordings from this focus group will not be shared with anyone outside the research team. We have a legal obligation to store the files for 10 years, once this has past all information will be destroyed.

Due to the nature of the focus group environment we cannot guarantee confidentiality. Participants are requested to respect the privacy of the other members of the focus group. Prior to analysing the data the transcribing notes from the focus group will remove any features that identify individuals. References to criminal activity or harm to others which raise concern with the researchers will be reported to the relevant authorities, this will be discussed with you prior to any action being taken.

What happens with the results of this study?

The results of this study will be transcribed, analysed and confidentially stored. All real names and personal details will be removed; we may use direct quotes with no reference to real names or identifiable features. Once the information you have contributed is analysed it will be used to develop a Cultural Sensitivity Audit Tool specific to the IAPT services. The results of the study will be made available in poster presentations and academic papers for publishing. If you would like to be notified about the results of the study please indicate on your consent form.

Who has ethically approved this study?

Due to the nature of this study being a service evaluation, no ethical approval was required to conduct this focus group.

Who do I contact with concerns and queries about the study?

If you have any queries or concerns regarding this study you should contact the principle investigator, Kanza Khan; Kanza.khan@postgradmanchesteracuk or the Supervising Tutor, Dr Waquas Waheed; Waquas.Waheed@manchesteracuk who will answer your questions to the best of their abilities.

If you have any concerns regarding this study that you do not wish to discuss with the research team directly you may contact the **Research Practice and Governance Co-ordinator**; research.complaints@manchesteracuk or 0161 275 8093

Should you require further support after the focus group the following facility is available to you;

Manchester Mental Health and Social Care Trust Patient Advice and Liaison Service (PALS); Contact PLAS on; PALS@mhs.nhs.uk , 0161 882 2084/2085 or 07815 284660.

Mind Infoline offer information on topics including

Mental health problems, where to access help, medications, treatments and support. Contact Mind Infoline on; info@mind.orguk or 0300 123 3393.

Appendix 3 IAPT Staff focus group participant information sheet

Who is the organiser for this research?

The organisers for this study are;

Principal Investigator - **Kanza Khan**

MPhil Medicine Student, The University of Manchester, Centre for Primary Care, Institute of Population Health.

Contact details; Kanza.khan@postgrad.manchester.ac.uk

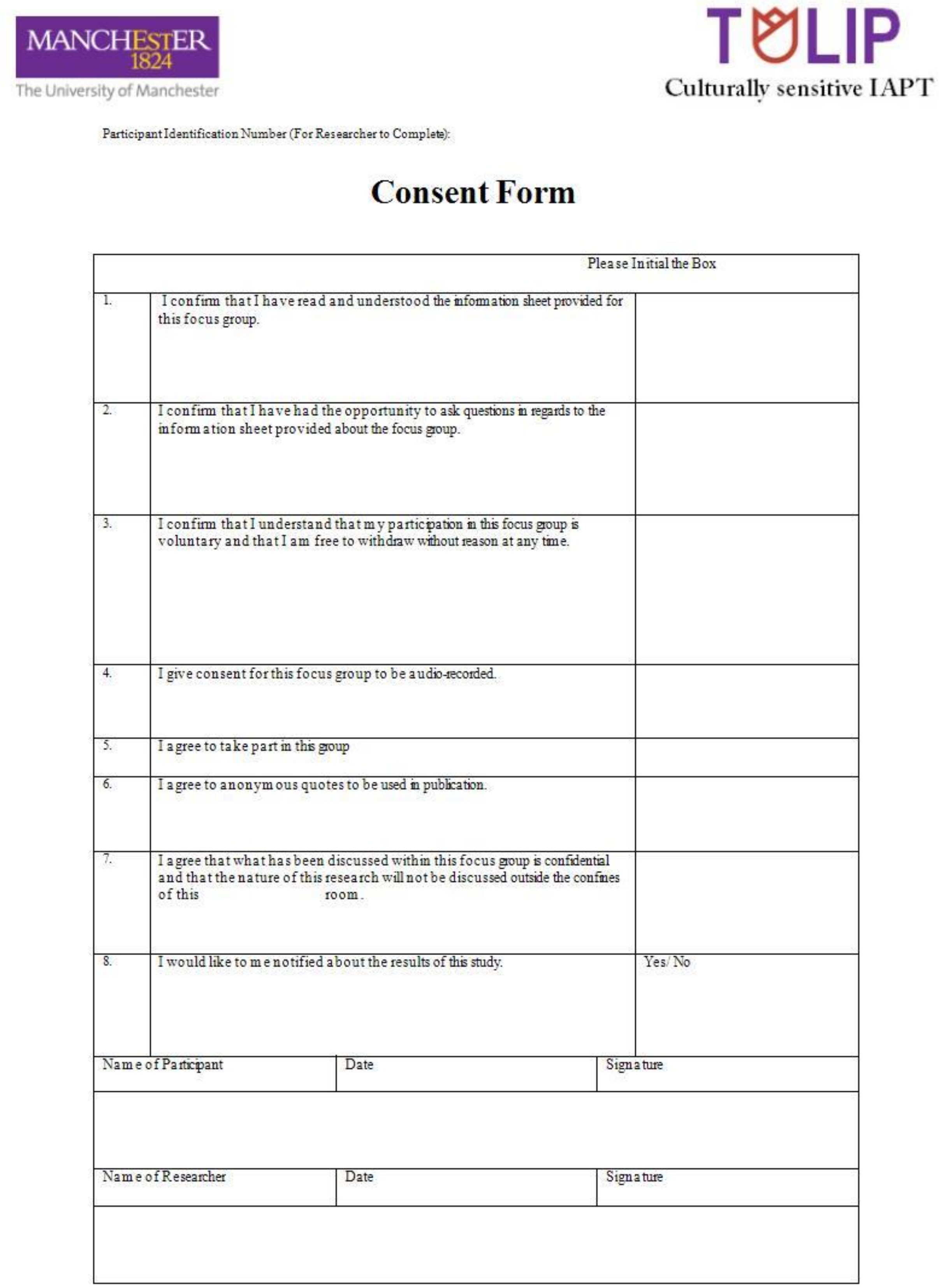
Supervisor **– Dr Waquas Waheed**

Reader in Psychiatry and Honorary Consultant Psychiatrist, Centre for Primary care, Institute of Population Health.

Contact details; Waquas.Waheed@manchester.ac.uk

Thank you for taking the time to read the participant information sheet. Please continue to complete the participant consent Form and demographic sheet.

Appendix 4 IAPT Staff focus group consent form



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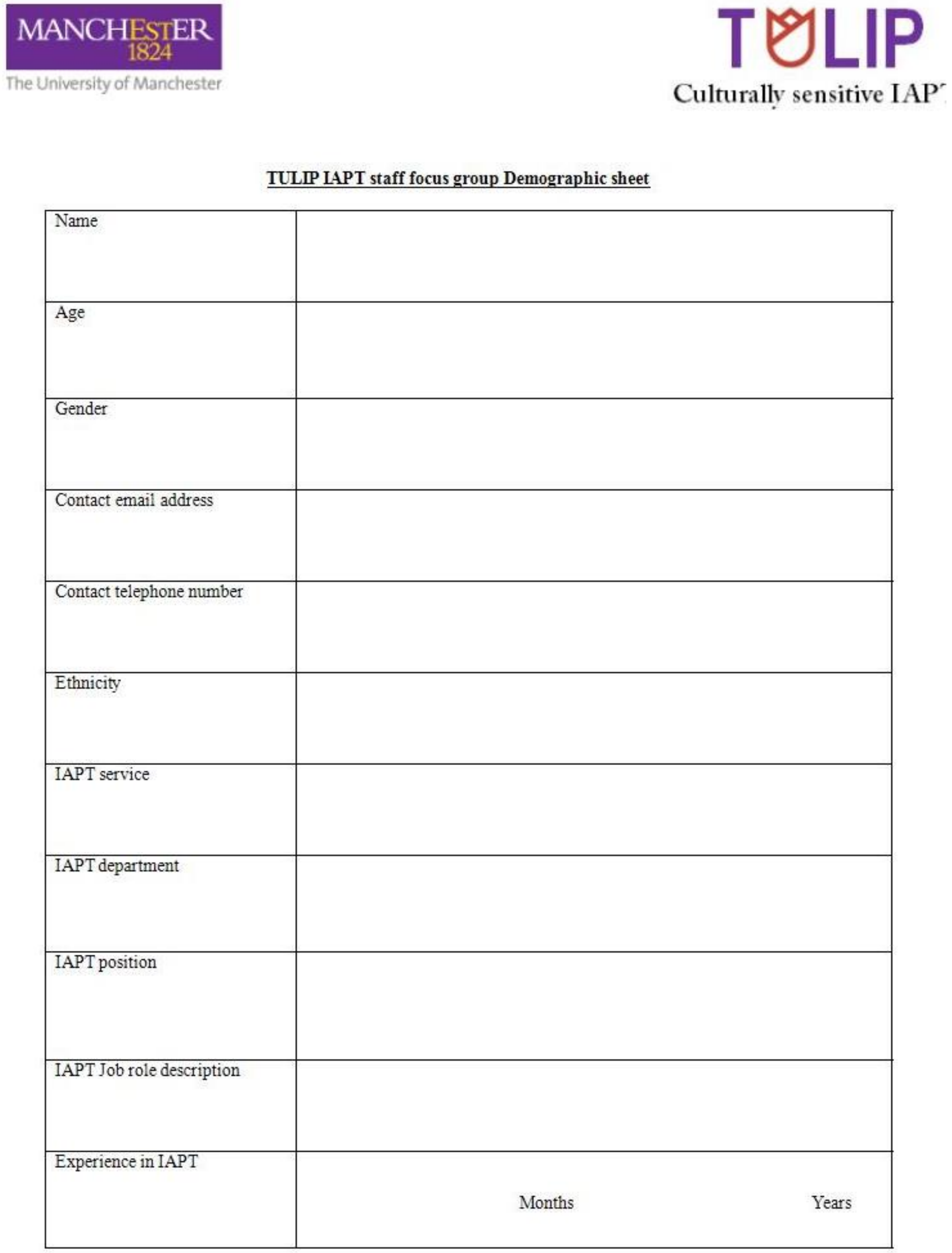
Participant Identification Number (For Researcher to Complete):

Consent Form

		Please Initial the Box
1.	I confirm that I have read and understood the information sheet provided for this focus group.	
2.	I confirm that I have had the opportunity to ask questions in regards to the information sheet provided about the focus group.	
3.	I confirm that I understand that my participation in this focus group is voluntary and that I am free to withdraw without reason at any time.	
4.	I give consent for this focus group to be audio-recorded.	
5.	I agree to take part in this group	
6.	I agree to anonymous quotes to be used in publication.	
7.	I agree that what has been discussed within this focus group is confidential and that the nature of this research will not be discussed outside the confines of this room.	
8.	I would like to me notified about the results of this study.	Yes/ No

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Appendix 5 IAPT Staff focus group participant demographic sheet



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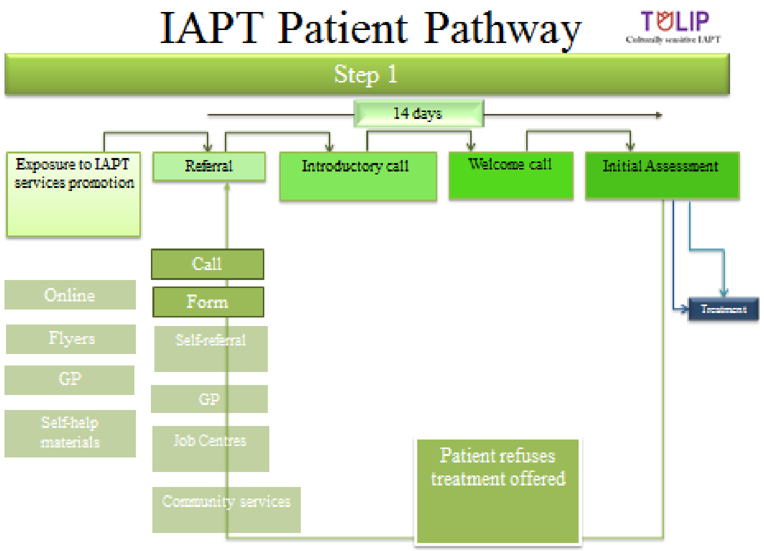
TULIP IAPT staff focus group Demographic sheet

Name	
Age	
Gender	
Contact email address	
Contact telephone number	
Ethnicity	
IAPT service	
IAPT department	
IAPT position	
IAPT Job role description	
Experience in IAPT	Months Years

Appendix 6 Microsoft PowerPoint IAPT patient pathway



IAPT Patient Pathway

TULIP Culturally sensitive IAPT

Step 1

14 days

Exposure to IAPT services promotion

Referral

Introductory call

Welcome call

Initial Assessment

Call

Form

Self-referral

GP

Job Centres

Community services

Online

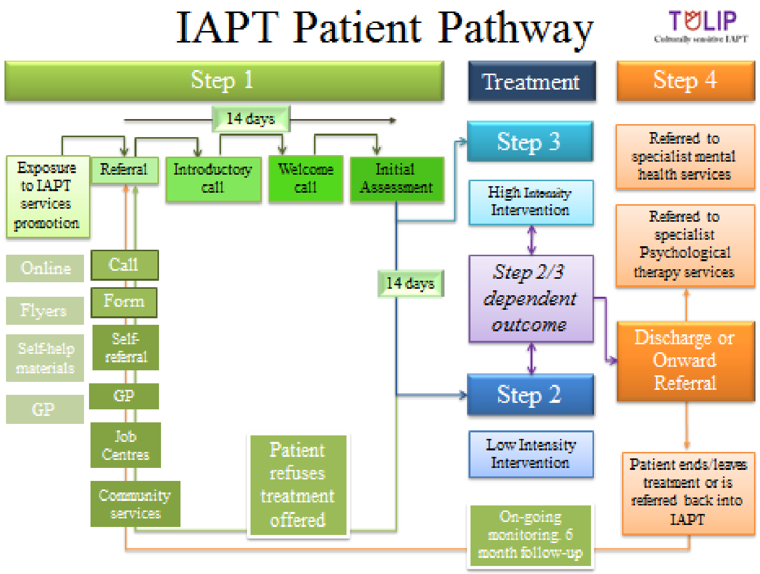
Flyers

GP

Self-help materials

Treatment

Patient refuses treatment offered



IAPT Patient Pathway

TULIP Culturally sensitive IAPT

Step 1

Treatment

Step 4

14 days

Exposure to IAPT services promotion

Referral

Introductory call

Welcome call

Initial Assessment

Online

Flyers

Self-help materials

GP

Call

Form

Self-referral

GP

Job Centres

Community services

Patient refuses treatment offered

14 days

Step 3

High Intensity Intervention

Step 2/3 dependent outcome

Step 2

Low Intensity Intervention

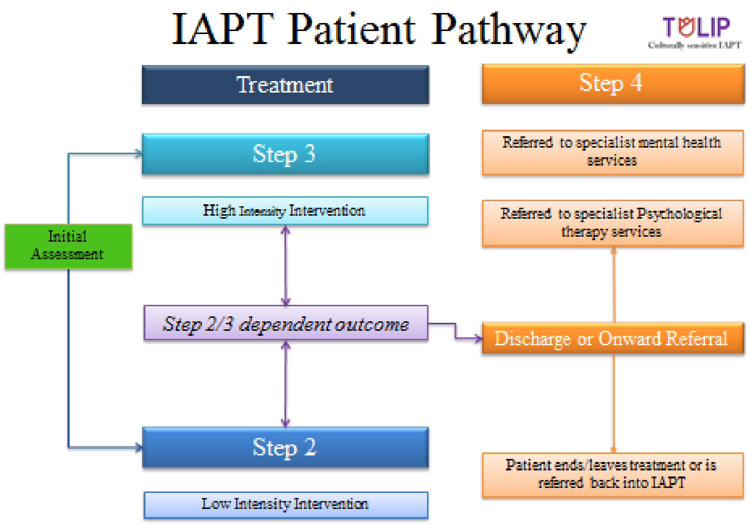
On-going monitoring, 6 month follow-up

Referred to specialist mental health services

Referred to specialist Psychological therapy services

Discharge or Onward Referral

Patient ends/leaves treatment or is referred back into IAPT



IAPT Patient Pathway

TULIP Culturally sensitive IAPT

Treatment

Step 4

Initial Assessment

Step 3

High Intensity Intervention

Step 2/3 dependent outcome

Step 2

Low Intensity Intervention

Referred to specialist mental health services

Referred to specialist Psychological therapy services

Discharge or Onward Referral

Patient ends/leaves treatment or is referred back into IAPT

Appendix 7 Distress protocol

TULIP
Culturally sensitive IAPT

PARTICIPANT DISTRESS PROTOCOL

The researcher in this instance is Kanza Khan and the principal investigator is Dr.Waquas Waheed.

- After the consensus meeting is conducted and participants have discussed barriers they believe participants experience when accessing the Improving Access to Psychological Therapies (IAPT) service, as well as recommendations for tool development, participants will be asked if they have experienced any distress.

  (If distress is experienced before or during the focus the protocol still applies).

- If participants express that they have not experiences any distress they will be asked if they have any questions, any questions will be addressed by the researcher.

- If participants are satisfied with these answers they will be thanked for their participation and informed that if they need any further information or have any more questions they may contact the researcher.

- We will provide the participant with appropriate contact details for psychological support services internal and external to the University of Manchester.

- Participants will be given the option to have a letter sent to their GP explaining the situation and arranging for them to be seen to discuss the matter.

- If the participants agree to this the principal investigator will post the letter within 3 working days.

- Participants will also be asked if they would like any additional information on the progress of the TULIP research project.

- Finally, if participants are still experiencing distress a prearranged call will be made to the principal investigator to analyse the situation and speak to the participants if necessary to alleviate their distress.

Appendix 8 Expert discussion meeting discussion guide

Expert discussion guide

i. We will present our findings from our systematic review of 'Barriers to accessing psychological therapy for ethnic minorities residing in western countries' in the form of barrier themes and subthemes.

1. **Present Barrier themes and Sub-themes table.**

ii. We will present our further detailed IAPT patient pathway, this was informed by IAPT site visits and discussions with IAPT staff member. The pathway was confirmed by an IAPT North West of England Training commissioner.

iii. We have also provided you with an A3 copy the pathway for your attention.

2. **Present IAPT patient pathway using Microsoft PowerPoint.**

3. **Ask participants if they have any questions relevant to the pathway.**

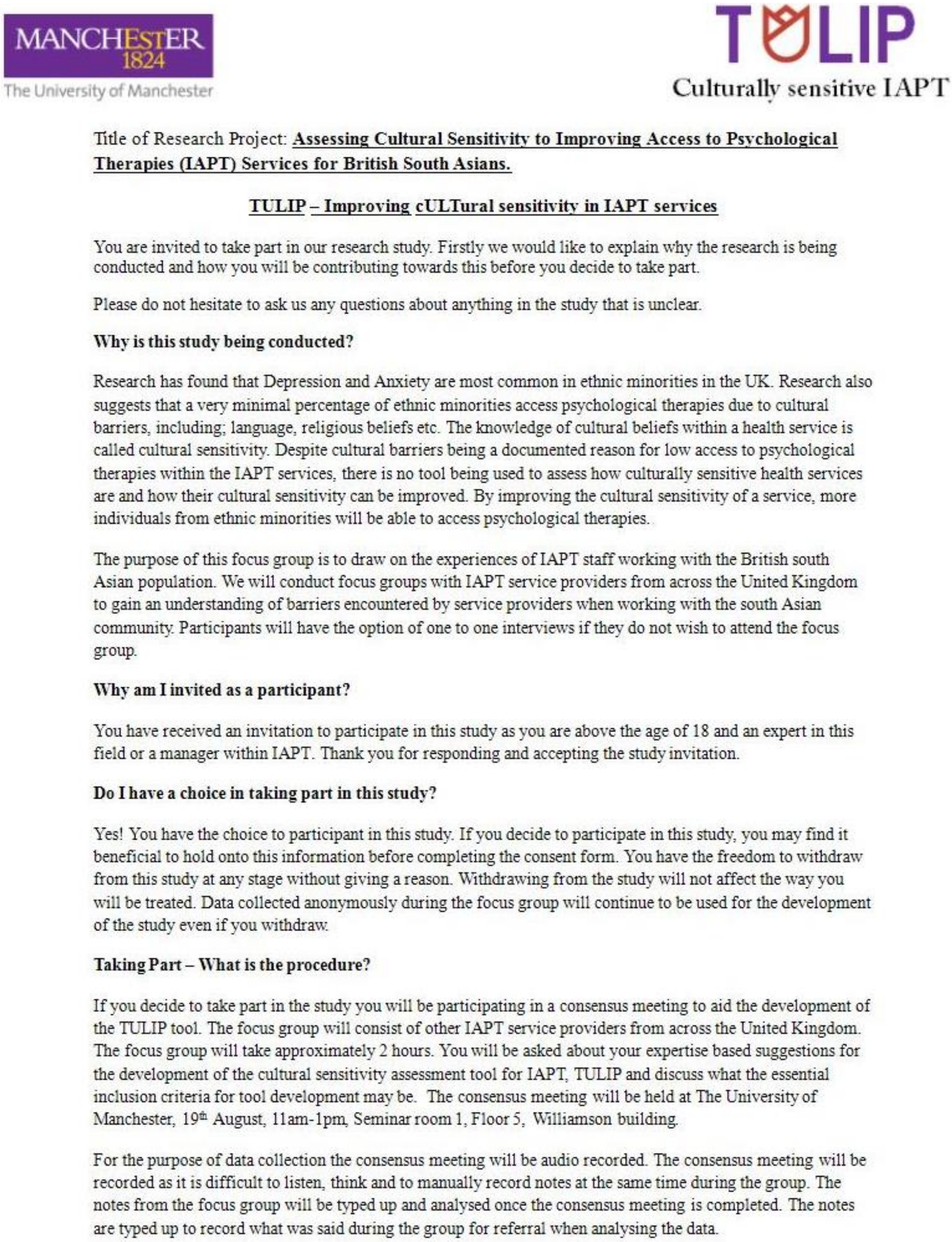
iv. We will now briefly discuss our findings from IAPT staff focus groups. The IAPT staff focus group aimed to capture barriers to accessing IAPT for ethnic minority patients. Results were consistent with our barrier themes and Sub-themes from the systematic review.

v. We will now discuss each step of the IAPT patient pathway alongside the barrier themes and sub-themes. The aim of this step is to discuss and confirm questions that will best capture barriers to cultural sensitivity within IAPT for ethnic minority patients. The questions will combined to develop TULIP, a cultural sensitivity audit tool for IAPT services.

4. **Systematically open discussions to each step of the IAPT patient pathway with potential barriers.**

5. **ASK: How can we phrase questions to best capture barriers that may be present within IAPT services?**

Appendix 9 Expert discussion meeting participant information sheet



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TULIP
Culturally sensitive IAPT

Title of Research Project: **Assessing Cultural Sensitivity to Improving Access to Psychological Therapies (IAPT) Services for British South Asians.**

TULIP – Improving cULTural sensitivity in IAPT services

You are invited to take part in our research study. Firstly we would like to explain why the research is being conducted and how you will be contributing towards this before you decide to take part.

Please do not hesitate to ask us any questions about anything in the study that is unclear.

Why is this study being conducted?

Research has found that Depression and Anxiety are most common in ethnic minorities in the UK. Research also suggests that a very minimal percentage of ethnic minorities access psychological therapies due to cultural barriers, including; language, religious beliefs etc. The knowledge of cultural beliefs within a health service is called cultural sensitivity. Despite cultural barriers being a documented reason for low access to psychological therapies within the IAPT services, there is no tool being used to assess how culturally sensitive health services are and how their cultural sensitivity can be improved. By improving the cultural sensitivity of a service, more individuals from ethnic minorities will be able to access psychological therapies.

The purpose of this focus group is to draw on the experiences of IAPT staff working with the British south Asian population. We will conduct focus groups with IAPT service providers from across the United Kingdom to gain an understanding of barriers encountered by service providers when working with the south Asian community. Participants will have the option of one to one interviews if they do not wish to attend the focus group.

Why am I invited as a participant?

You have received an invitation to participate in this study as you are above the age of 18 and an expert in this field or a manager within IAPT. Thank you for responding and accepting the study invitation.

Do I have a choice in taking part in this study?

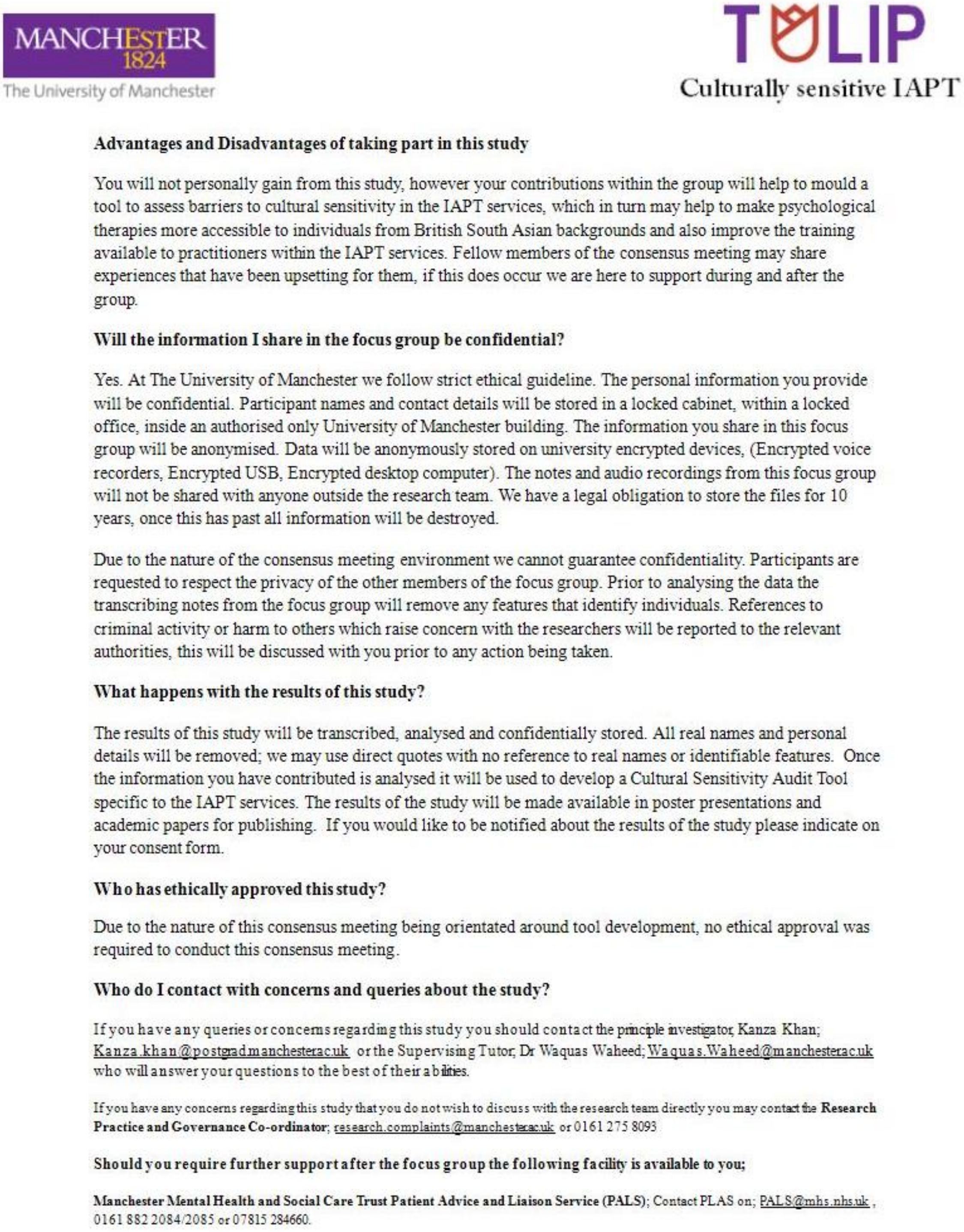
Yes! You have the choice to participant in this study. If you decide to participate in this study, you may find it beneficial to hold onto this information before completing the consent form. You have the freedom to withdraw from this study at any stage without giving a reason. Withdrawing from the study will not affect the way you will be treated. Data collected anonymously during the focus group will continue to be used for the development of the study even if you withdraw.

Taking Part – What is the procedure?

If you decide to take part in the study you will be participating in a consensus meeting to aid the development of the TULIP tool. The focus group will consist of other IAPT service providers from across the United Kingdom. The focus group will take approximately 2 hours. You will be asked about your expertise based suggestions for the development of the cultural sensitivity assessment tool for IAPT, TULIP and discuss what the essential inclusion criteria for tool development may be. The consensus meeting will be held at The University of Manchester, 19th August, 11am-1pm, Seminar room 1, Floor 5, Williamson building.

For the purpose of data collection the consensus meeting will be audio recorded. The consensus meeting will be recorded as it is difficult to listen, think and to manually record notes at the same time during the group. The notes from the focus group will be typed up and analysed once the consensus meeting is completed. The notes are typed up to record what was said during the group for referral when analysing the data.

Appendix 9 Expert discussion meeting participant information sheet



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Advantages and Disadvantages of taking part in this study

You will not personally gain from this study, however your contributions within the group will help to mould a tool to assess barriers to cultural sensitivity in the IAPT services, which in turn may help to make psychological therapies more accessible to individuals from British South Asian backgrounds and also improve the training available to practitioners within the IAPT services. Fellow members of the consensus meeting may share experiences that have been upsetting for them, if this does occur we are here to support during and after the group.

Will the information I share in the focus group be confidential?

Yes. At The University of Manchester we follow strict ethical guideline. The personal information you provide will be confidential. Participant names and contact details will be stored in a locked cabinet, within a locked office, inside an authorised only University of Manchester building. The information you share in this focus group will be anonymised. Data will be anonymously stored on university encrypted devices, (Encrypted voice recorders, Encrypted USB, Encrypted desktop computer). The notes and audio recordings from this focus group will not be shared with anyone outside the research team. We have a legal obligation to store the files for 10 years, once this has past all information will be destroyed.

Due to the nature of the consensus meeting environment we cannot guarantee confidentiality. Participants are requested to respect the privacy of the other members of the focus group. Prior to analysing the data the transcribing notes from the focus group will remove any features that identify individuals. References to criminal activity or harm to others which raise concern with the researchers will be reported to the relevant authorities, this will be discussed with you prior to any action being taken.

What happens with the results of this study?

The results of this study will be transcribed, analysed and confidentially stored. All real names and personal details will be removed; we may use direct quotes with no reference to real names or identifiable features. Once the information you have contributed is analysed it will be used to develop a Cultural Sensitivity Audit Tool specific to the IAPT services. The results of the study will be made available in poster presentations and academic papers for publishing. If you would like to be notified about the results of the study please indicate on your consent form.

Who has ethically approved this study?

Due to the nature of this consensus meeting being orientated around tool development, no ethical approval was required to conduct this consensus meeting.

Who do I contact with concerns and queries about the study?

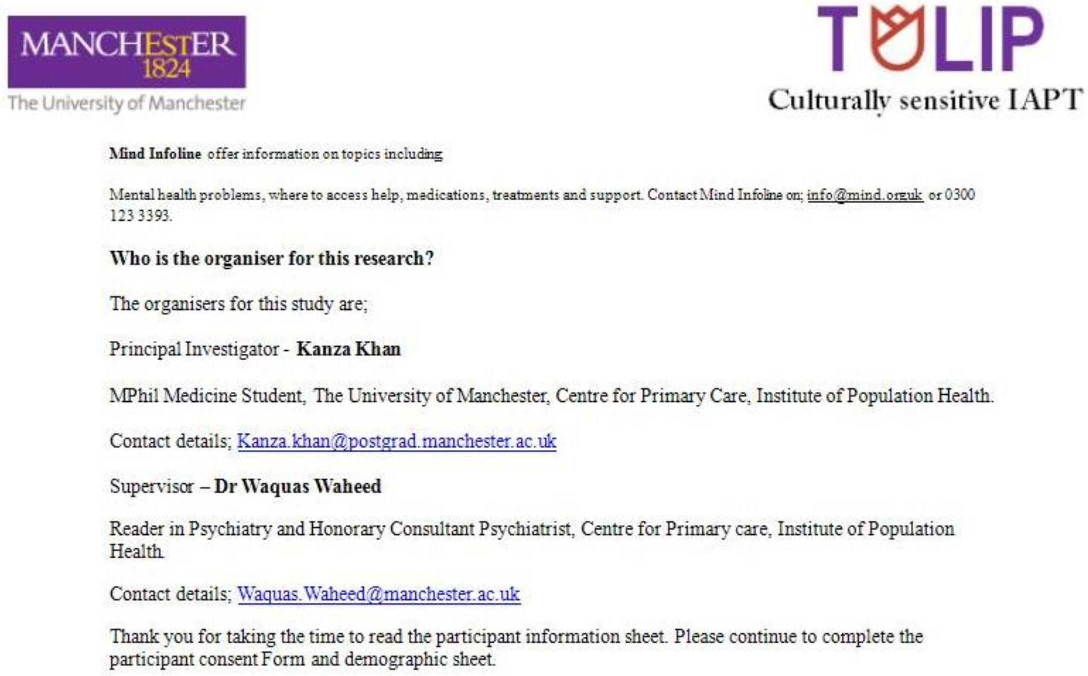
If you have any queries or concerns regarding this study you should contact the principle investigator, Kanza Khan; Kanza.khan@postgradmanchesterac.uk or the Supervising Tutor, Dr Waquas Waheed; Waquas.Waheed@manchesterac.uk who will answer your questions to the best of their abilities.

If you have any concerns regarding this study that you do not wish to discuss with the research team directly you may contact the **Research Practice and Governance Co-ordinator**; research.complaints@manchesterac.uk or 0161 275 8093

Should you require further support after the focus group the following facility is available to you;

Manchester Mental Health and Social Care Trust Patient Advice and Liaison Service (PALS); Contact PLAS on; PALS@mhs.nhs.uk , 0161 882 2084/2085 or 07815 284660.

Appendix 9 Expert discussion meeting participant information sheet



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Mind Infoline offer information on topics including

Mental health problems, where to access help, medications, treatments and support. Contact Mind Infoline on; info@mind.orguk or 0300 123 3393.

Who is the organiser for this research?

The organisers for this study are;

Principal Investigator - **Kanza Khan**

MPhil Medicine Student, The University of Manchester, Centre for Primary Care, Institute of Population Health.

Contact details; Kanza.khan@postgrad.manchester.ac.uk

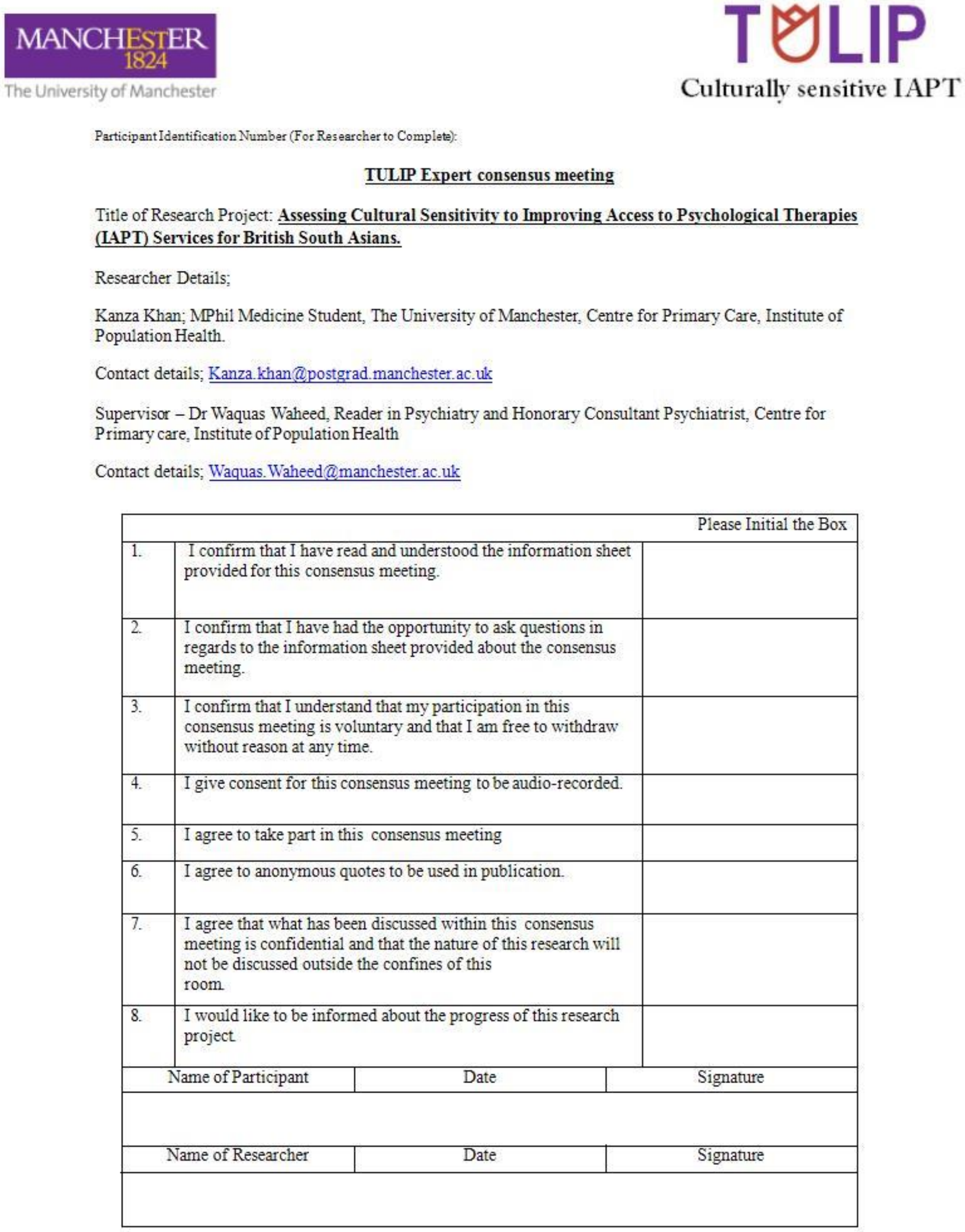
Supervisor – **Dr Waquas Waheed**

Reader in Psychiatry and Honorary Consultant Psychiatrist, Centre for Primary care, Institute of Population Health.

Contact details; Waquas.Waheed@manchester.ac.uk

Thank you for taking the time to read the participant information sheet. Please continue to complete the participant consent Form and demographic sheet.

Appendix 10 Expert discussion meeting participant consent from



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TULIP
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Participant Identification Number (For Researcher to Complete):

TULIP Expert consensus meeting

Title of Research Project: **Assessing Cultural Sensitivity to Improving Access to Psychological Therapies (IAPT) Services for British South Asians.**

Researcher Details;

Kanza Khan; MPhil Medicine Student, The University of Manchester, Centre for Primary Care, Institute of Population Health.

Contact details; Kanza.khan@postgrad.manchester.ac.uk

Supervisor – Dr Waquas Waheed, Reader in Psychiatry and Honorary Consultant Psychiatrist, Centre for Primary care, Institute of Population Health

Contact details; Waquas.Waheed@manchester.ac.uk

		Please Initial the Box
1.	I confirm that I have read and understood the information sheet provided for this consensus meeting.	
2.	I confirm that I have had the opportunity to ask questions in regards to the information sheet provided about the consensus meeting.	
3.	I confirm that I understand that my participation in this consensus meeting is voluntary and that I am free to withdraw without reason at any time.	
4.	I give consent for this consensus meeting to be audio-recorded.	
5.	I agree to take part in this consensus meeting	
6.	I agree to anonymous quotes to be used in publication.	
7.	I agree that what has been discussed within this consensus meeting is confidential and that the nature of this research will not be discussed outside the confines of this room.	
8.	I would like to be informed about the progress of this research project.	

Name of Participant	Date	Signature

Name of Researcher	Date	Signature

Appendix 11 Expert discussion meeting participant demographics sheet

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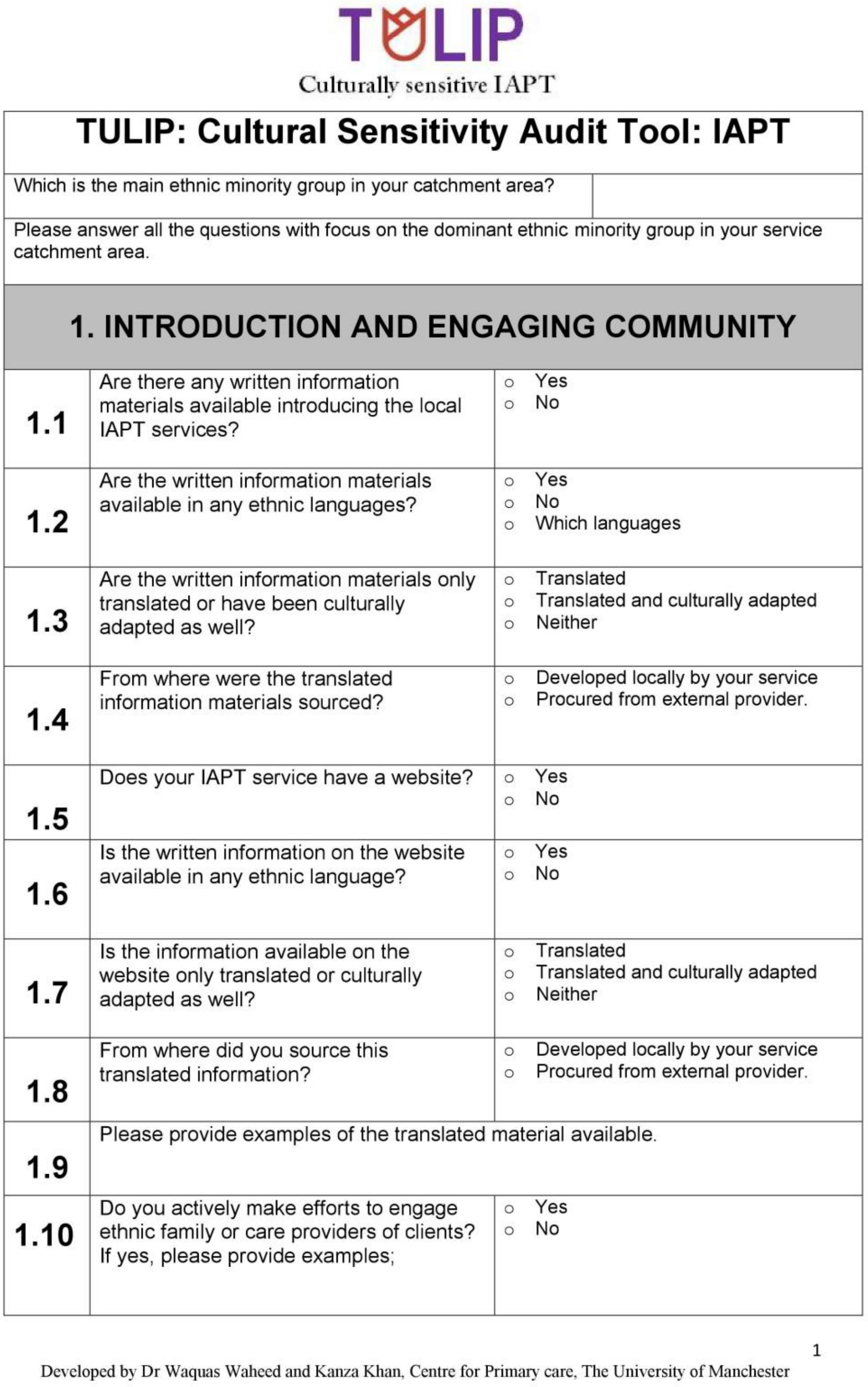
TULIP
Culturally sensitive IAPT

Participant Identification Number (For Researcher to Complete):

TULIP Consensus meeting

Name	
Age	
Gender	
Contact email address	
Contact telephone number	
Ethnicity	
Profession	
Job Role	
Academic experience & interests	
Research experience & interests	
Experience in IAPT	Years Months

Appendix 12 TULIP: Cultural Sensitivity Audit Tool IAPT: IAPT



TULIP
Culturally sensitive IAPT

TULIP: Cultural Sensitivity Audit Tool: IAPT

Which is the main ethnic minority group in your catchment area?		
Please answer all the questions with focus on the dominant ethnic minority group in your service catchment area.		

1. INTRODUCTION AND ENGAGING COMMUNITY

1.1	Are there any written information materials available introducing the local IAPT services?	○ Yes ○ No
1.2	Are the written information materials available in any ethnic languages?	○ Yes ○ No ○ Which languages
1.3	Are the written information materials only translated or have been culturally adapted as well?	○ Translated ○ Translated and culturally adapted ○ Neither
1.4	From where were the translated information materials sourced?	○ Developed locally by your service ○ Procured from external provider.
1.5	Does your IAPT service have a website?	○ Yes ○ No
1.6	Is the written information on the website available in any ethnic language?	○ Yes ○ No
1.7	Is the information available on the website only translated or culturally adapted as well?	○ Translated ○ Translated and culturally adapted ○ Neither
1.8	From where did you source this translated information?	○ Developed locally by your service ○ Procured from external provider.
1.9	Please provide examples of the translated material available.	
1.10	Do you actively make efforts to engage ethnic family or care providers of clients? If yes, please provide examples;	○ Yes ○ No

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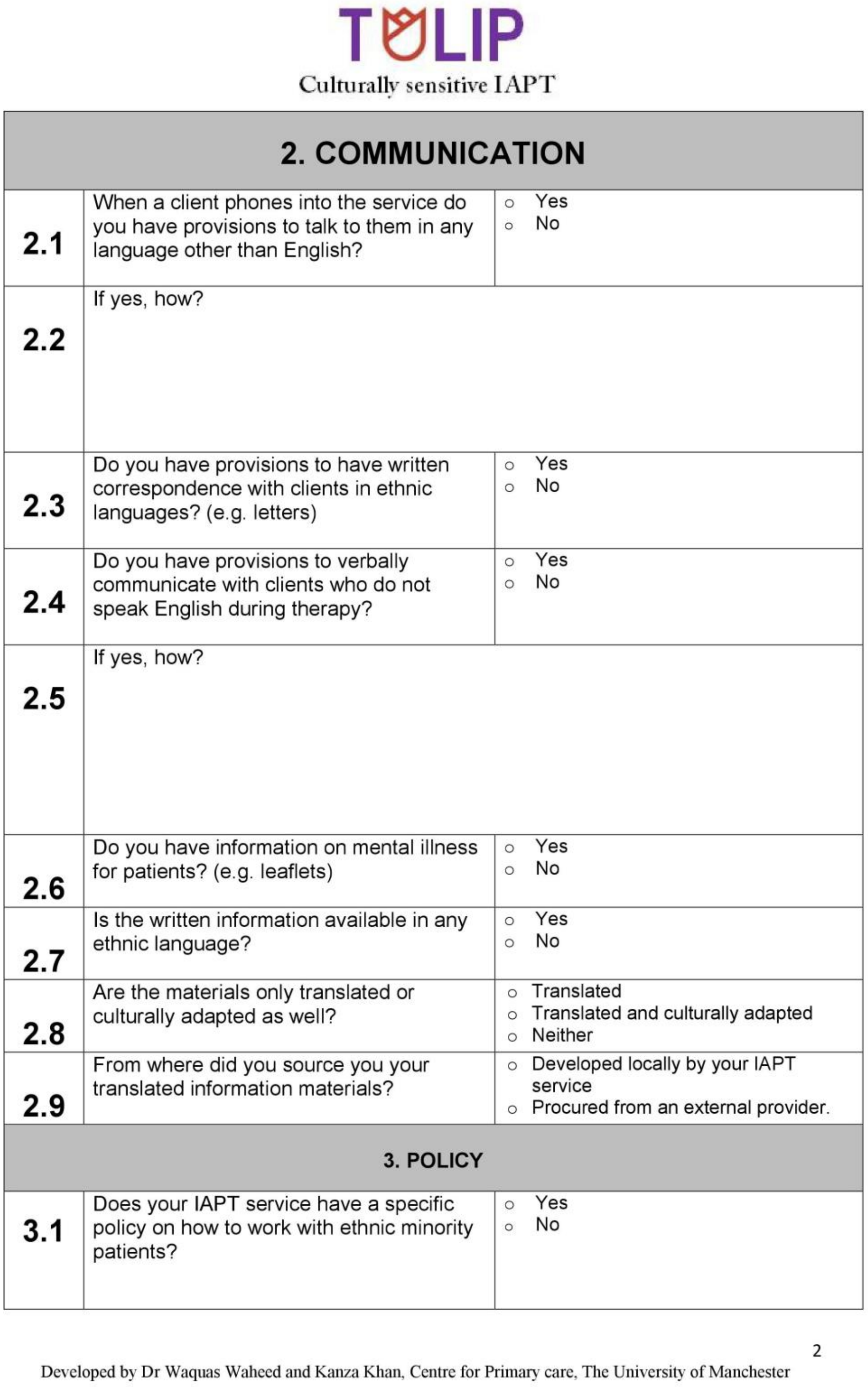
Appendix 12 TULIP: Cultural Sensitivity Audit Tool IAPT: IAPT



TULIP
Culturally sensitive IAPT

2. COMMUNICATION		
2.1	When a client phones into the service do you have provisions to talk to them in any language other than English?	○ Yes ○ No
2.2	If yes, how?	
2.3	Do you have provisions to have written correspondence with clients in ethnic languages? (e.g. letters)	○ Yes ○ No
2.4	Do you have provisions to verbally communicate with clients who do not speak English during therapy?	○ Yes ○ No
2.5	If yes, how?	
2.6	Do you have information on mental illness for patients? (e.g. leaflets)	○ Yes ○ No
2.7	Is the written information available in any ethnic language?	○ Yes ○ No
2.8	Are the materials only translated or culturally adapted as well?	○ Translated ○ Translated and culturally adapted ○ Neither
2.9	From where did you source you your translated information materials?	○ Developed locally by your IAPT service ○ Procured from an external provider.
3. POLICY		
3.1	Does your IAPT service have a specific policy on how to work with ethnic minority patients?	○ Yes ○ No

2

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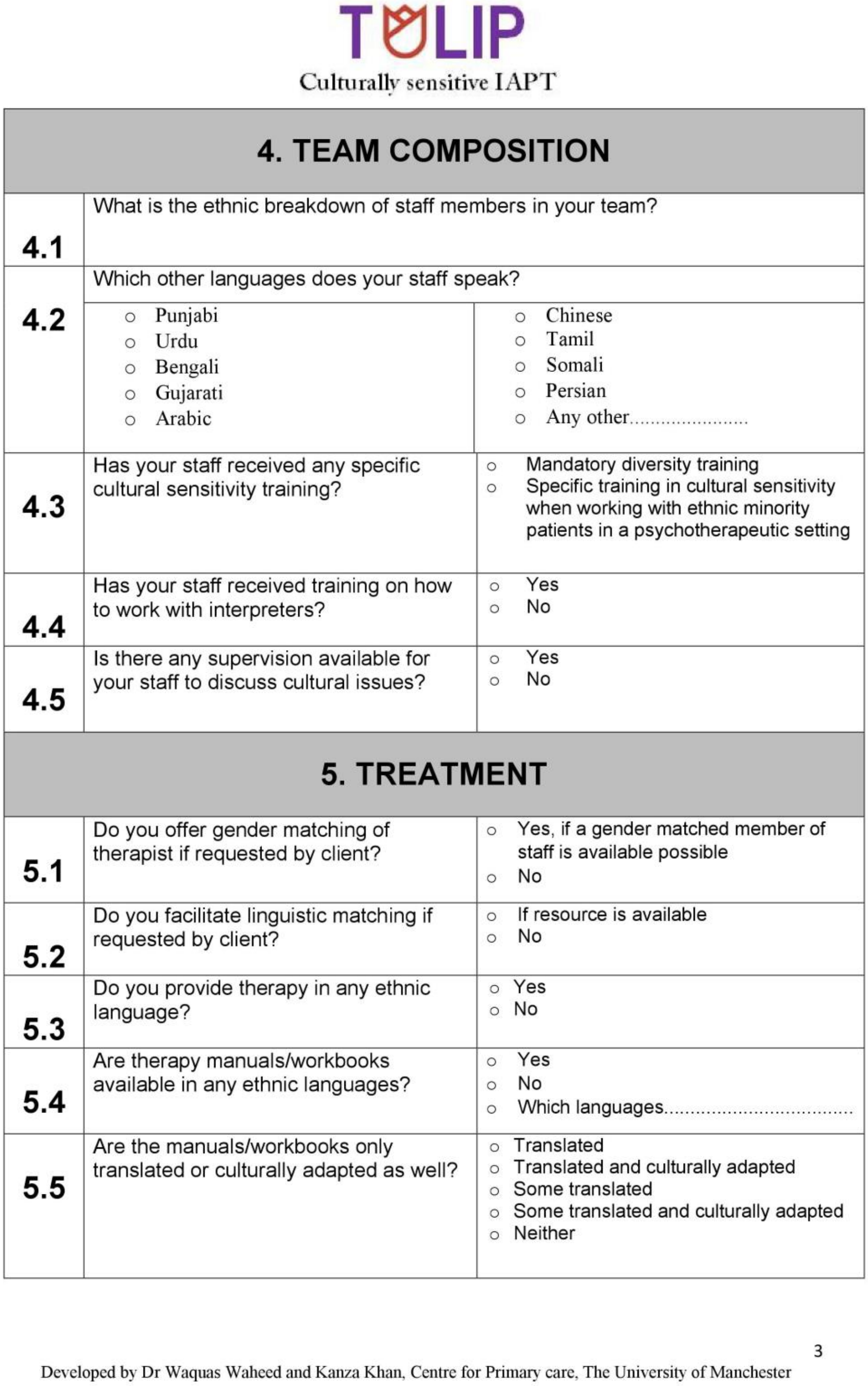
Appendix 12 TULIP: Cultural Sensitivity Audit Tool IAPT: IAPT



TULIP
Culturally sensitive IAPT

4. TEAM COMPOSITION

4.1	What is the ethnic breakdown of staff members in your team?	
4.2	Which other languages does your staff speak? ○ Punjabi ○ Urdu ○ Bengali ○ Gujarati ○ Arabic	○ Chinese ○ Tamil ○ Somali ○ Persian ○ Any other......................
4.3	Has your staff received any specific cultural sensitivity training?	○ Mandatory diversity training ○ Specific training in cultural sensitivity when working with ethnic minority patients in a psychotherapeutic setting
4.4	Has your staff received training on how to work with interpreters?	○ Yes ○ No
4.5	Is there any supervision available for your staff to discuss cultural issues?	○ Yes ○ No

5. TREATMENT

5.1	Do you offer gender matching of therapist if requested by client?	○ Yes, if a gender matched member of staff is available possible ○ No
5.2	Do you facilitate linguistic matching if requested by client?	○ If resource is available ○ No
5.3	Do you provide therapy in any ethnic language?	○ Yes ○ No
5.4	Are therapy manuals/workbooks available in any ethnic languages?	○ Yes ○ No ○ Which languages...................................
5.5	Are the manuals/workbooks only translated or culturally adapted as well?	○ Translated ○ Translated and culturally adapted ○ Some translated ○ Some translated and culturally adapted ○ Neither

3

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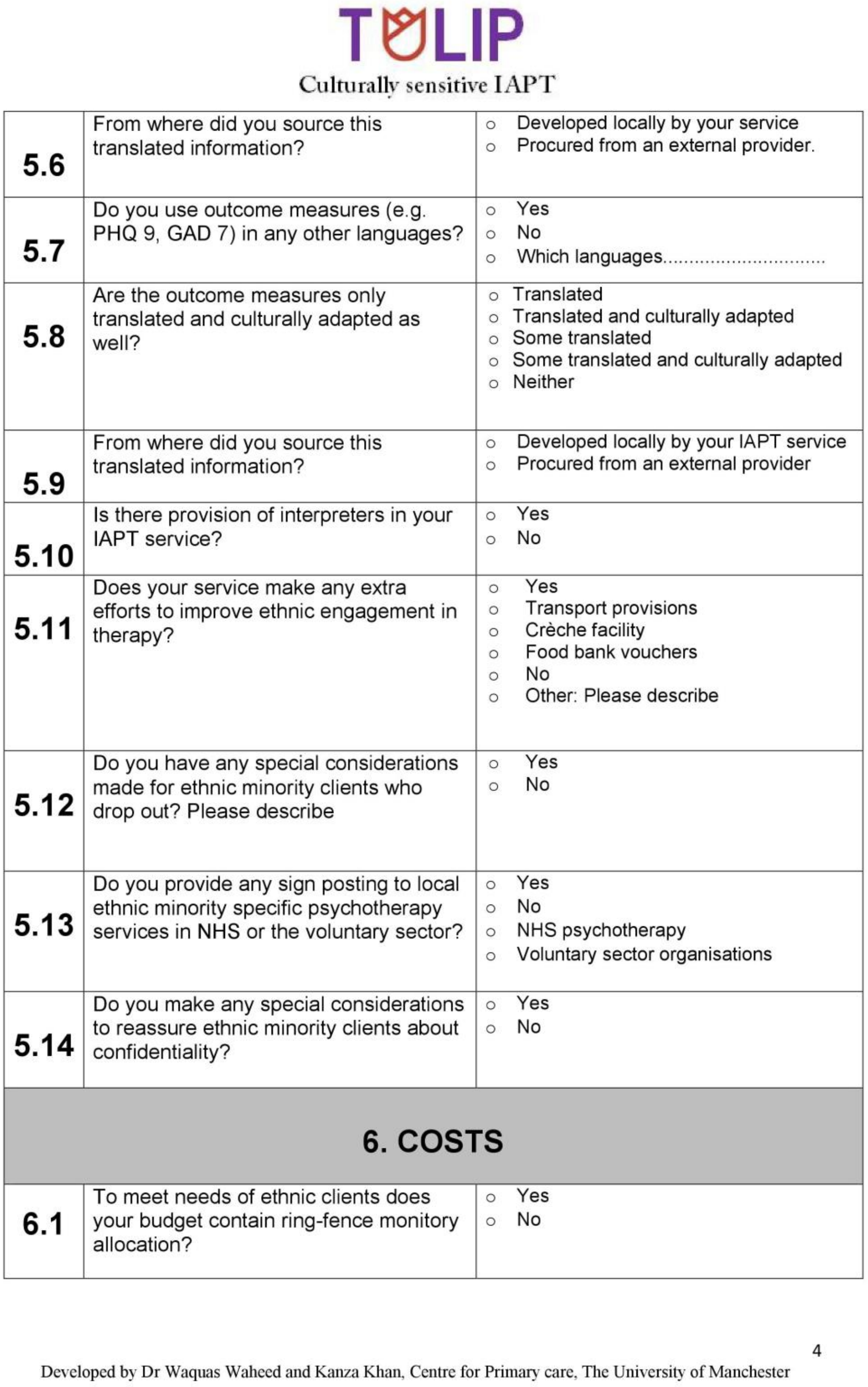
Appendix 12 TULIP: Cultural Sensitivity Audit Tool IAPT: IAPT

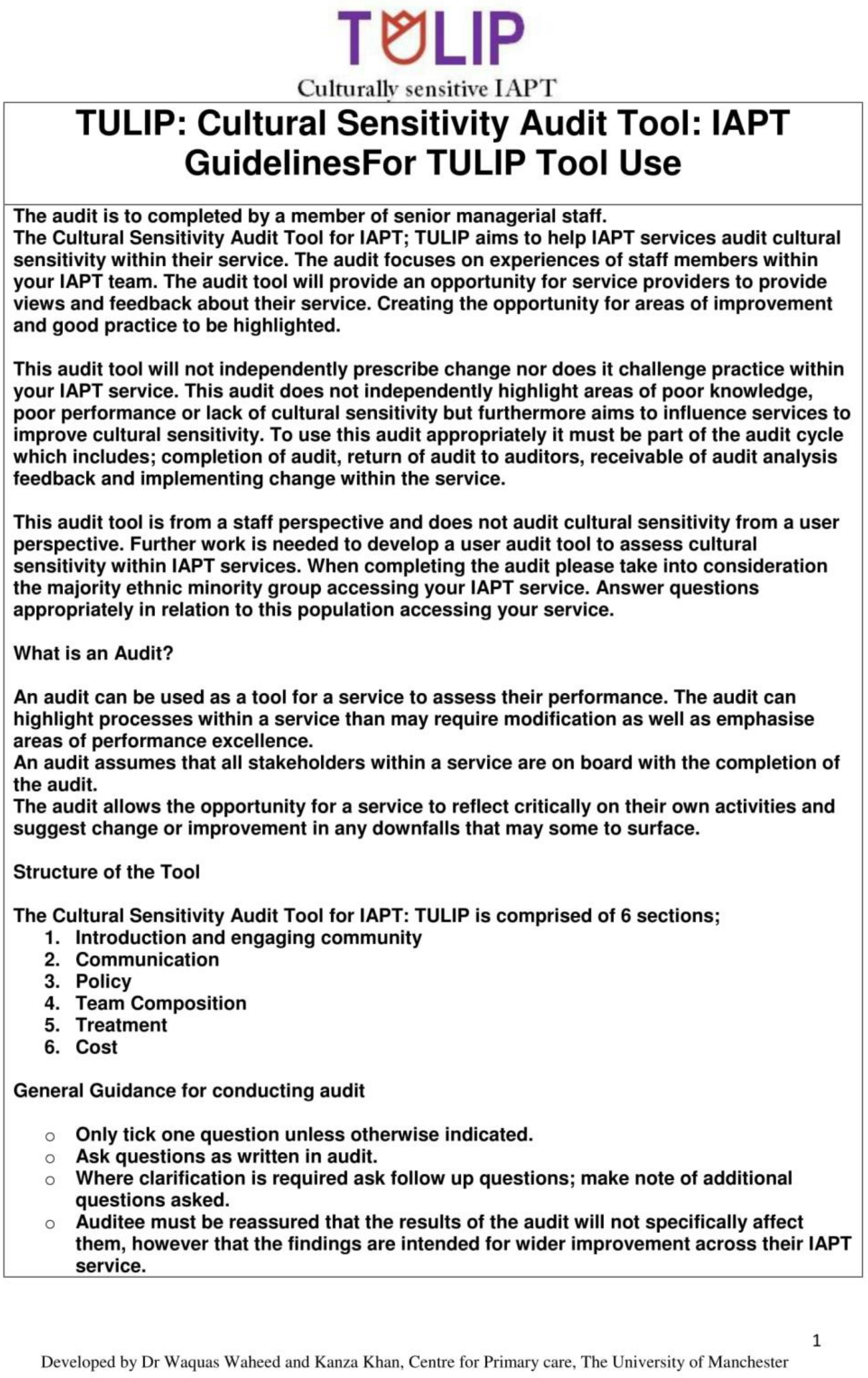


TULIP

Culturally sensitive IAPT

5.6	From where did you source this translated information?	○ Developed locally by your service ○ Procured from an external provider.
5.7	Do you use outcome measures (e.g. PHQ 9, GAD 7) in any other languages?	○ Yes ○ No ○ Which languages..............................
5.8	Are the outcome measures only translated and culturally adapted as well?	○ Translated ○ Translated and culturally adapted ○ Some translated ○ Some translated and culturally adapted ○ Neither
5.9	From where did you source this translated information?	○ Developed locally by your IAPT service ○ Procured from an external provider
5.10	Is there provision of interpreters in your IAPT service?	○ Yes ○ No
5.11	Does your service make any extra efforts to improve ethnic engagement in therapy?	○ Yes ○ Transport provisions ○ Crèche facility ○ Food bank vouchers ○ No ○ Other: Please describe
5.12	Do you have any special considerations made for ethnic minority clients who drop out? Please describe	○ Yes ○ No
5.13	Do you provide any sign posting to local ethnic minority specific psychotherapy services in NHS or the voluntary sector?	○ Yes ○ No ○ NHS psychotherapy ○ Voluntary sector organisations
5.14	Do you make any special considerations to reassure ethnic minority clients about confidentiality?	○ Yes ○ No
	6. COSTS	
6.1	To meet needs of ethnic clients does your budget contain ring-fence monitory allocation?	○ Yes ○ No

Appendix 13 TULIP: Guidelines



TULIP

Culturally sensitive IAPT

TULIP: Cultural Sensitivity Audit Tool: IAPT GuidelinesFor TULIP Tool Use

The audit is to completed by a member of senior managerial staff.
The Cultural Sensitivity Audit Tool for IAPT; TULIP aims to help IAPT services audit cultural sensitivity within their service. The audit focuses on experiences of staff members within your IAPT team. The audit tool will provide an opportunity for service providers to provide views and feedback about their service. Creating the opportunity for areas of improvement and good practice to be highlighted.

This audit tool will not independently prescribe change nor does it challenge practice within your IAPT service. This audit does not independently highlight areas of poor knowledge, poor performance or lack of cultural sensitivity but furthermore aims to influence services to improve cultural sensitivity. To use this audit appropriately it must be part of the audit cycle which includes; completion of audit, return of audit to auditors, receivable of audit analysis feedback and implementing change within the service.

This audit tool is from a staff perspective and does not audit cultural sensitivity from a user perspective. Further work is needed to develop a user audit tool to assess cultural sensitivity within IAPT services. When completing the audit please take into consideration the majority ethnic minority group accessing your IAPT service. Answer questions appropriately in relation to this population accessing your service.

What is an Audit?

An audit can be used as a tool for a service to assess their performance. The audit can highlight processes within a service than may require modification as well as emphasise areas of performance excellence.
An audit assumes that all stakeholders within a service are on board with the completion of the audit.
The audit allows the opportunity for a service to reflect critically on their own activities and suggest change or improvement in any downfalls that may some to surface.

Structure of the Tool

The Cultural Sensitivity Audit Tool for IAPT: TULIP is comprised of 6 sections;

1. **Introduction and engaging community**
2. **Communication**
3. **Policy**
4. **Team Composition**
5. **Treatment**
6. **Cost**

General Guidance for conducting audit

- **Only tick one question unless otherwise indicated.**
- **Ask questions as written in audit.**
- **Where clarification is required ask follow up questions; make note of additional questions asked.**
- **Auditee must be reassured that the results of the audit will not specifically affect them, however that the findings are intended for wider improvement across their IAPT service.**

1

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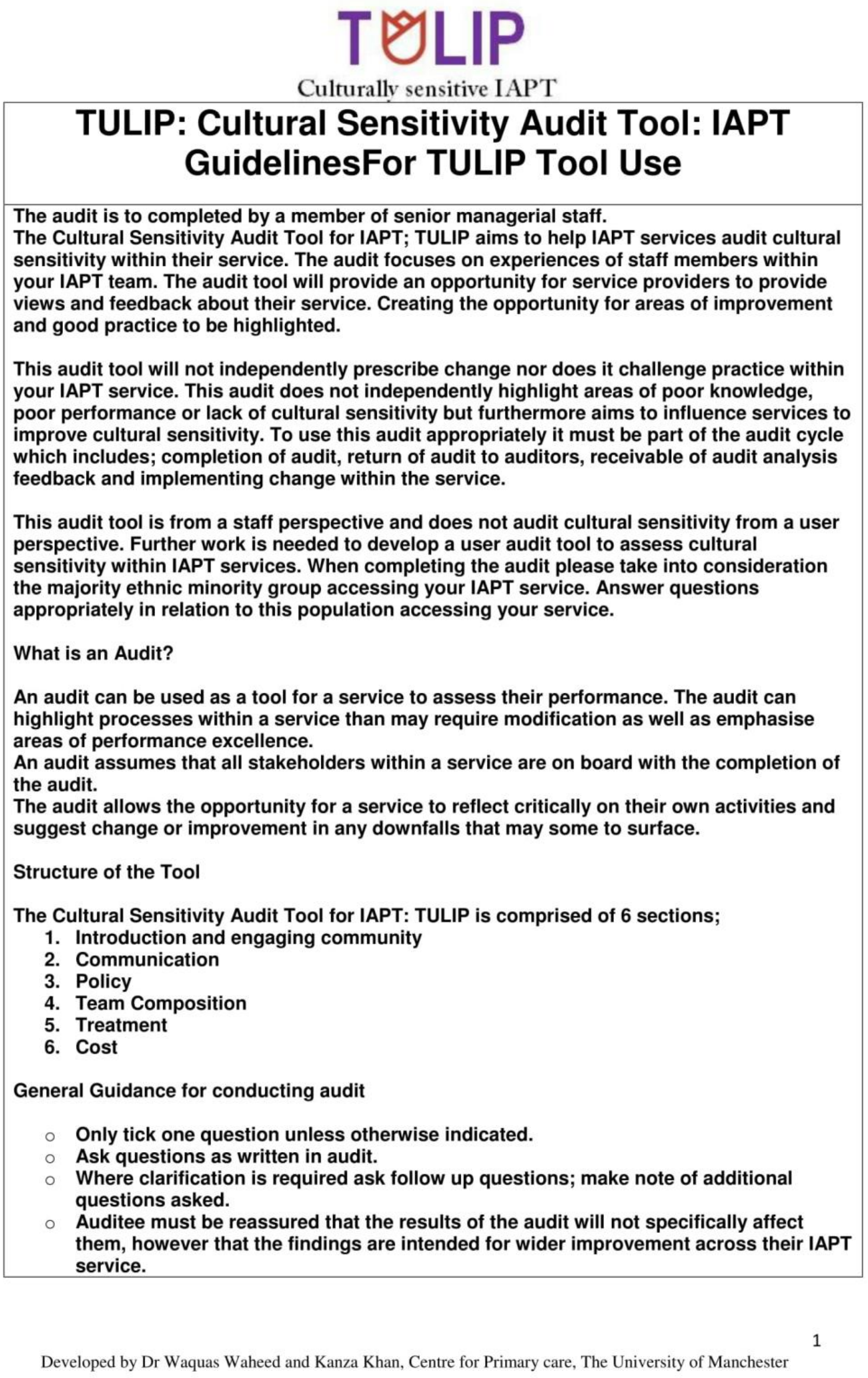
Appendix 13 TULIP: Guidelines



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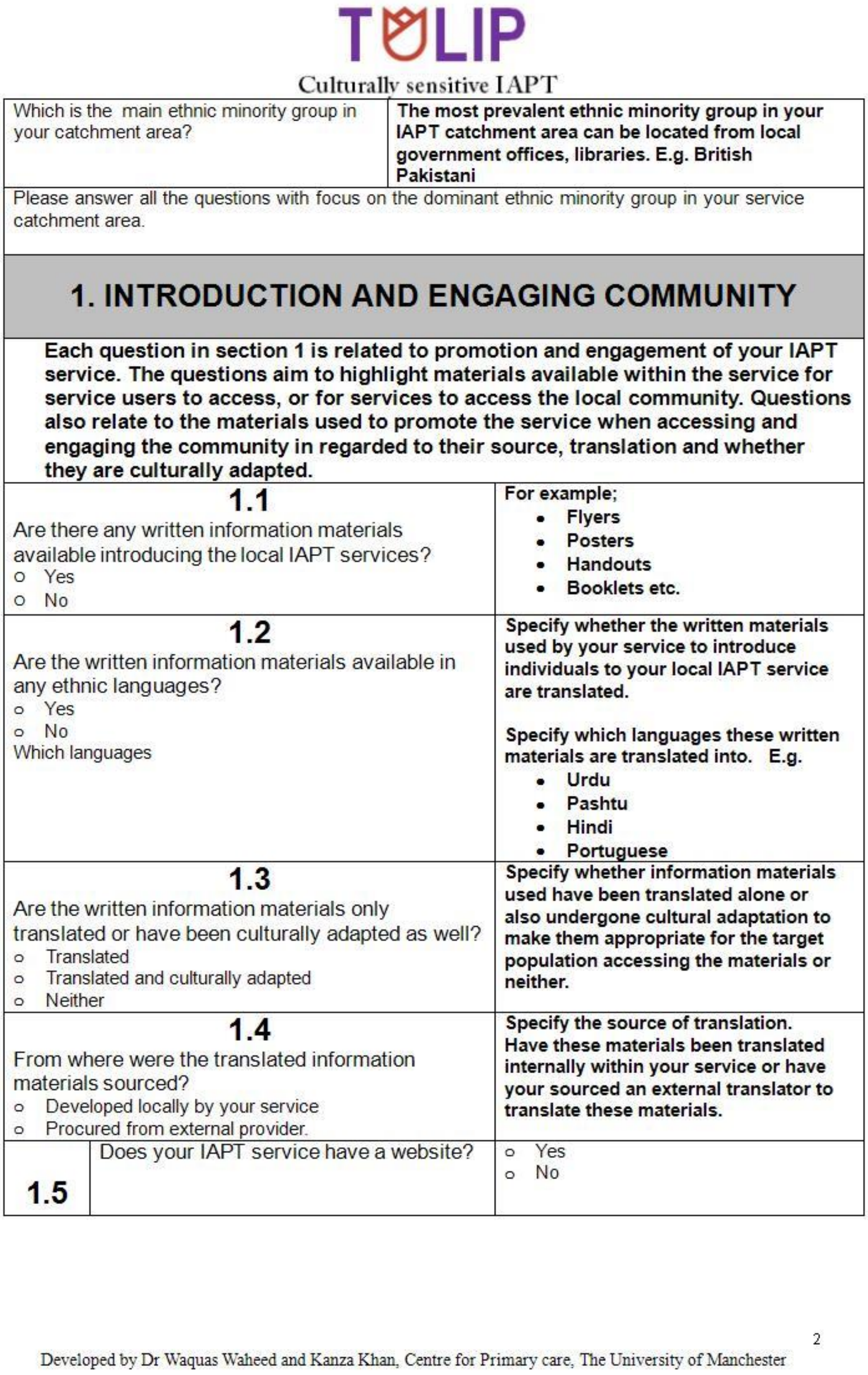
Appendix 13 TULIP: Guidelines



TULIP

Culturally sensitive IAPT

Which is the main ethnic minority group in your catchment area?	**The most prevalent ethnic minority group in your IAPT catchment area can be located from local government offices, libraries. E.g. British Pakistani**
Please answer all the questions with focus on the dominant ethnic minority group in your service catchment area.	

1. INTRODUCTION AND ENGAGING COMMUNITY

Each question in section 1 is related to promotion and engagement of your IAPT service. The questions aim to highlight materials available within the service for service users to access, or for services to access the local community. Questions also relate to the materials used to promote the service when accessing and engaging the community in regarded to their source, translation and whether they are culturally adapted.

1.1 Are there any written information materials available introducing the local IAPT services? ○ Yes ○ No	**For example;** • **Flyers** • **Posters** • **Handouts** • **Booklets etc.**
1.2 Are the written information materials available in any ethnic languages? ○ Yes ○ No Which languages	**Specify whether the written materials used by your service to introduce individuals to your local IAPT service are translated.** **Specify which languages these written materials are translated into. E.g.** • **Urdu** • **Pashtu** • **Hindi** • **Portuguese**
1.3 Are the written information materials only translated or have been culturally adapted as well? ○ Translated ○ Translated and culturally adapted ○ Neither	**Specify whether information materials used have been translated alone or also undergone cultural adaptation to make them appropriate for the target population accessing the materials or neither.**
1.4 From where were the translated information materials sourced? ○ Developed locally by your service ○ Procured from external provider.	**Specify the source of translation. Have these materials been translated internally within your service or have your sourced an external translator to translate these materials.**
1.5 Does your IAPT service have a website?	○ Yes ○ No

2

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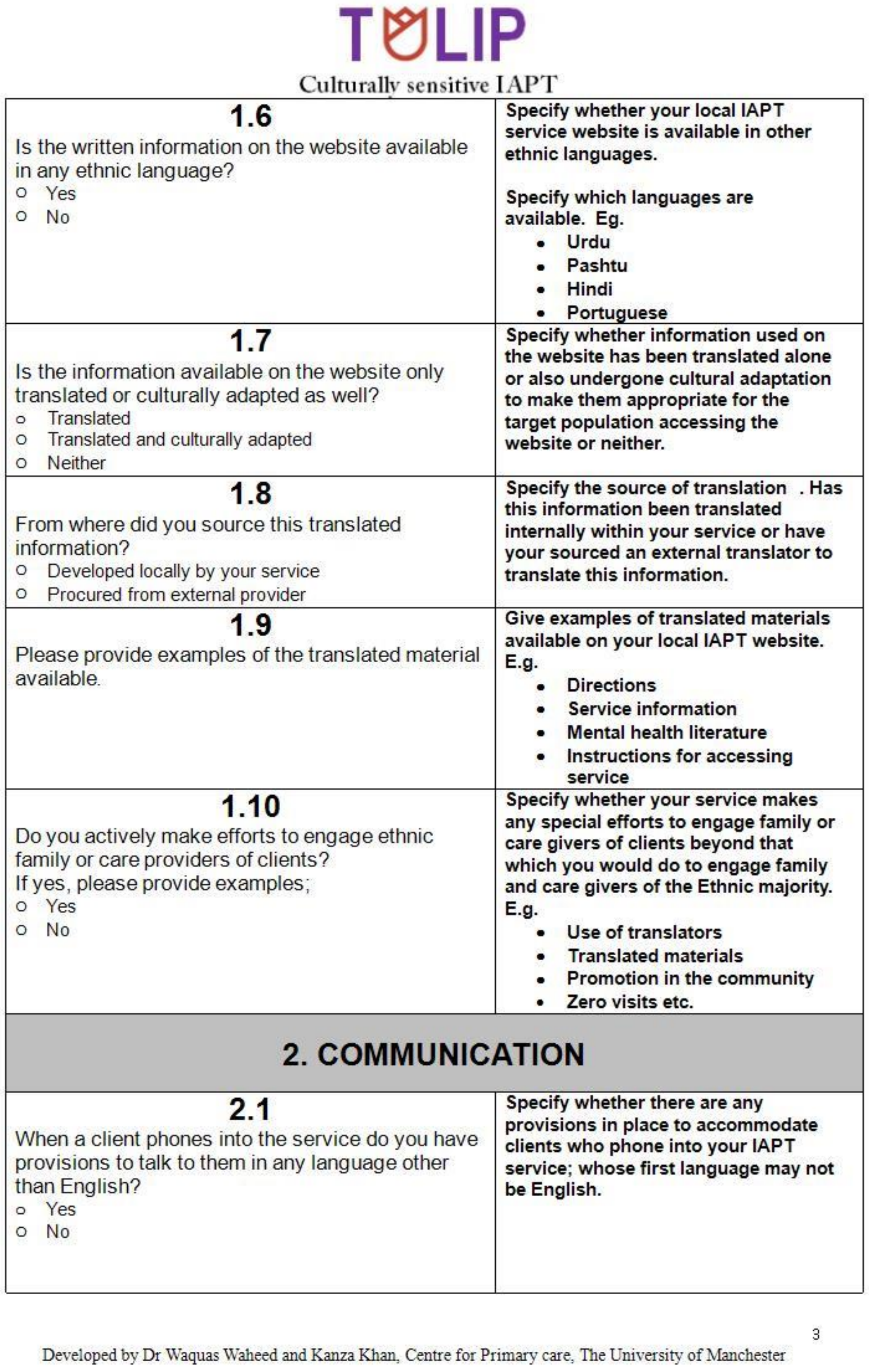
Appendix 13 TULIP: Guidelines



TULIP

Culturally sensitive IAPT

1.6 Is the written information on the website available in any ethnic language? ○ Yes ○ No	**Specify whether your local IAPT service website is available in other ethnic languages.** **Specify which languages are available. Eg.** • **Urdu** • **Pashtu** • **Hindi** • **Portuguese**
1.7 Is the information available on the website only translated or culturally adapted as well? ○ Translated ○ Translated and culturally adapted ○ Neither	**Specify whether information used on the website has been translated alone or also undergone cultural adaptation to make them appropriate for the target population accessing the website or neither.**
1.8 From where did you source this translated information? ○ Developed locally by your service ○ Procured from external provider	**Specify the source of translation . Has this information been translated internally within your service or have your sourced an external translator to translate this information.**
1.9 Please provide examples of the translated material available.	**Give examples of translated materials available on your local IAPT website. E.g.** • **Directions** • **Service information** • **Mental health literature** • **Instructions for accessing service**
1.10 Do you actively make efforts to engage ethnic family or care providers of clients? If yes, please provide examples; ○ Yes ○ No	**Specify whether your service makes any special efforts to engage family or care givers of clients beyond that which you would do to engage family and care givers of the Ethnic majority. E.g.** • **Use of translators** • **Translated materials** • **Promotion in the community** • **Zero visits etc.**
2. COMMUNICATION	
2.1 When a client phones into the service do you have provisions to talk to them in any language other than English? ○ Yes ○ No	**Specify whether there are any provisions in place to accommodate clients who phone into your IAPT service; whose first language may not be English.**

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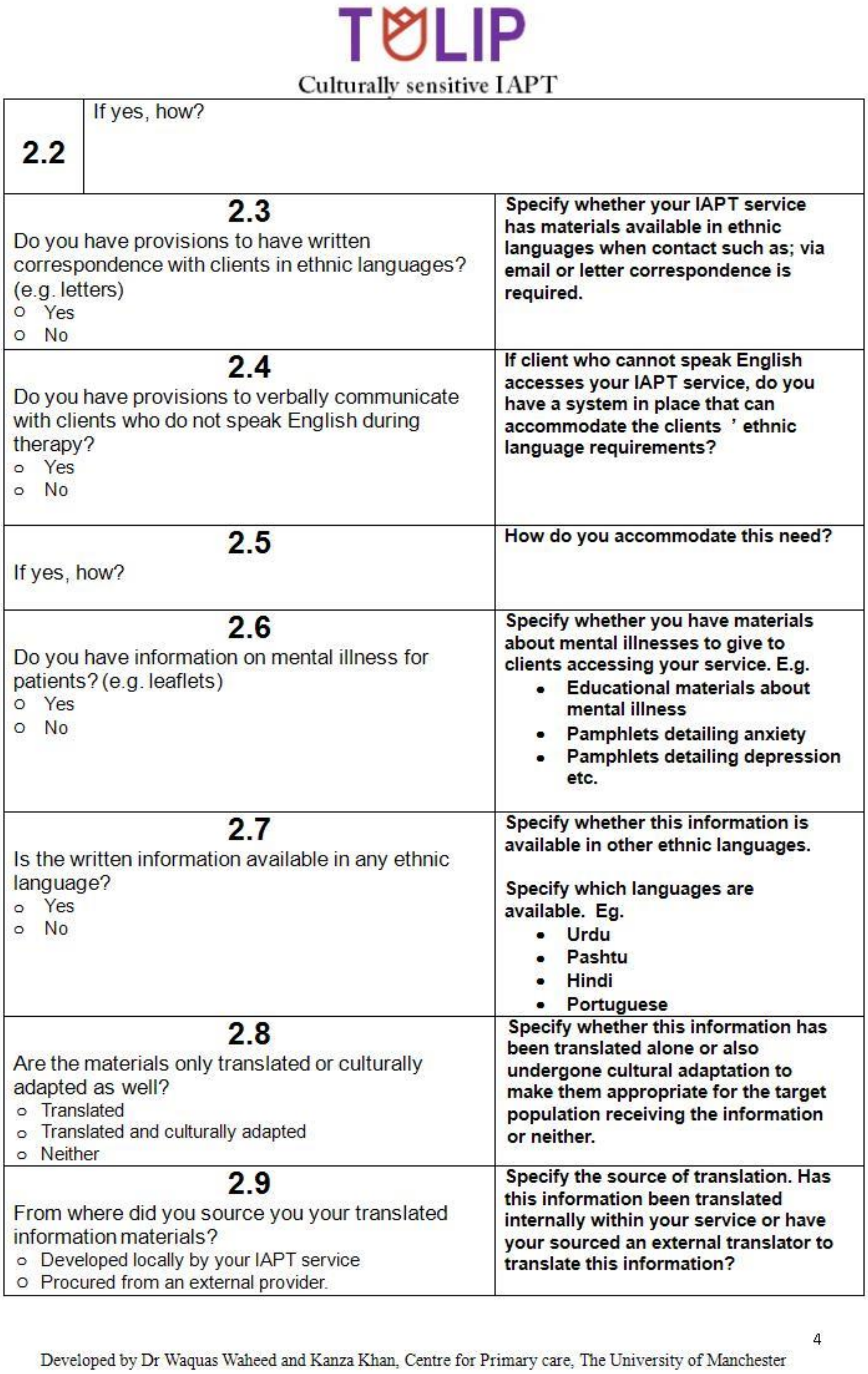
Appendix 13 TULIP: Guidelines



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2.2 If yes, how?	
2.3 Do you have provisions to have written correspondence with clients in ethnic languages? (e.g. letters) ○ Yes ○ No	**Specify whether your IAPT service has materials available in ethnic languages when contact such as; via email or letter correspondence is required.**
2.4 Do you have provisions to verbally communicate with clients who do not speak English during therapy? ○ Yes ○ No	**If client who cannot speak English accesses your IAPT service, do you have a system in place that can accommodate the clients ’ ethnic language requirements?**
2.5 If yes, how?	**How do you accommodate this need?**
2.6 Do you have information on mental illness for patients? (e.g. leaflets) ○ Yes ○ No	**Specify whether you have materials about mental illnesses to give to clients accessing your service. E.g.** • **Educational materials about mental illness** • **Pamphlets detailing anxiety** • **Pamphlets detailing depression etc.**
2.7 Is the written information available in any ethnic language? ○ Yes ○ No	**Specify whether this information is available in other ethnic languages.** **Specify which languages are available. Eg.** • **Urdu** • **Pashtu** • **Hindi** • **Portuguese**
2.8 Are the materials only translated or culturally adapted as well? ○ Translated ○ Translated and culturally adapted ○ Neither	**Specify whether this information has been translated alone or also undergone cultural adaptation to make them appropriate for the target population receiving the information or neither.**
2.9 From where did you source you your translated information materials? ○ Developed locally by your IAPT service ○ Procured from an external provider.	**Specify the source of translation. Has this information been translated internally within your service or have your sourced an external translator to translate this information?**

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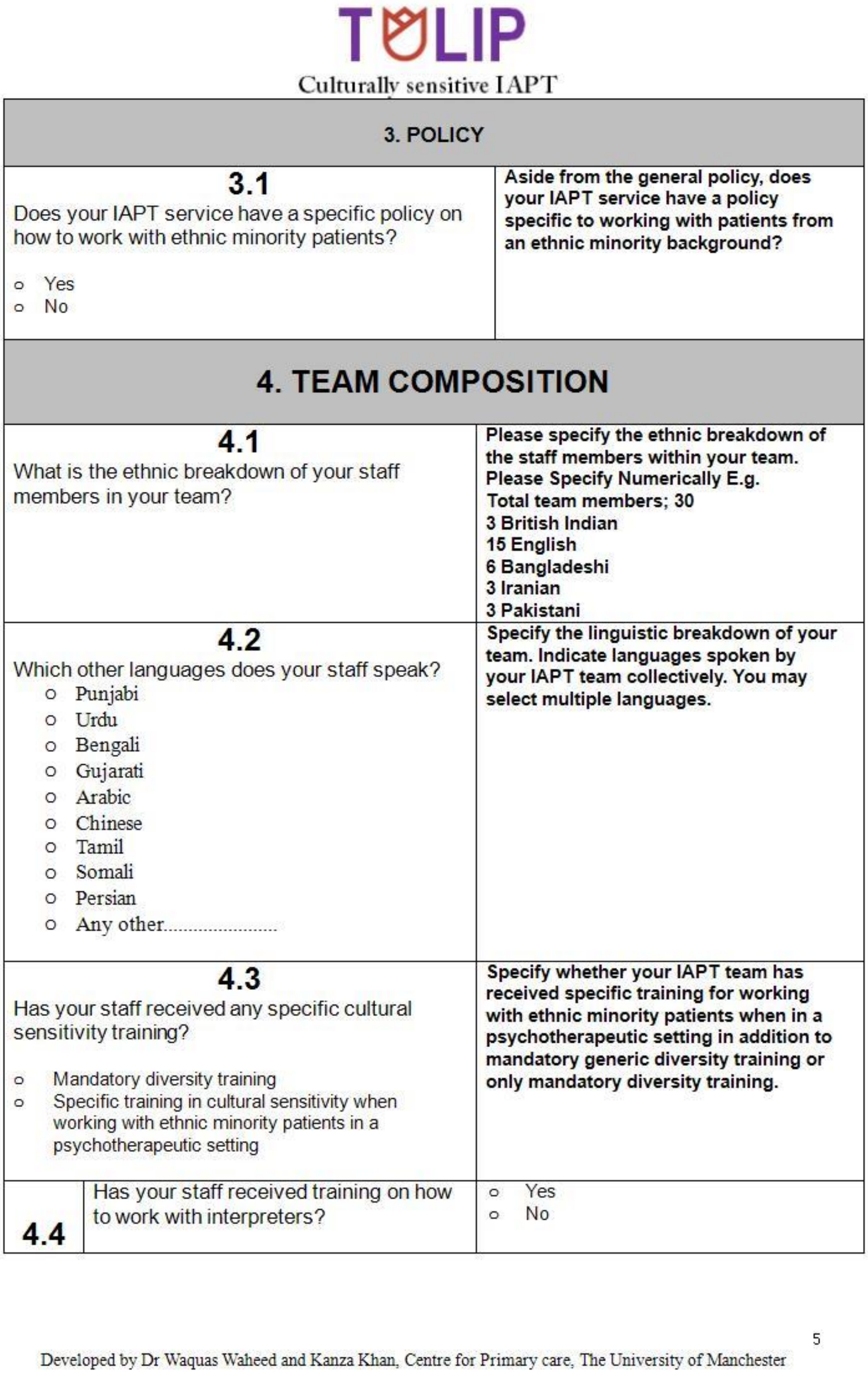

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3. POLICY	
3.1 Does your IAPT service have a specific policy on how to work with ethnic minority patients? ○ Yes ○ No	**Aside from the general policy, does your IAPT service have a policy specific to working with patients from an ethnic minority background?**
4. TEAM COMPOSITION	
4.1 What is the ethnic breakdown of your staff members in your team?	**Please specify the ethnic breakdown of the staff members within your team.** **Please Specify Numerically E.g.** **Total team members; 30** **3 British Indian** **15 English** **6 Bangladeshi** **3 Iranian** **3 Pakistani**
4.2 Which other languages does your staff speak? ○ Punjabi ○ Urdu ○ Bengali ○ Gujarati ○ Arabic ○ Chinese ○ Tamil ○ Somali ○ Persian ○ Any other......................	**Specify the linguistic breakdown of your team. Indicate languages spoken by your IAPT team collectively. You may select multiple languages.**
4.3 Has your staff received any specific cultural sensitivity training? ○ Mandatory diversity training ○ Specific training in cultural sensitivity when working with ethnic minority patients in a psychotherapeutic setting	**Specify whether your IAPT team has received specific training for working with ethnic minority patients when in a psychotherapeutic setting in addition to mandatory generic diversity training or only mandatory diversity training.**
4.4 Has your staff received training on how to work with interpreters?	○ Yes ○ No

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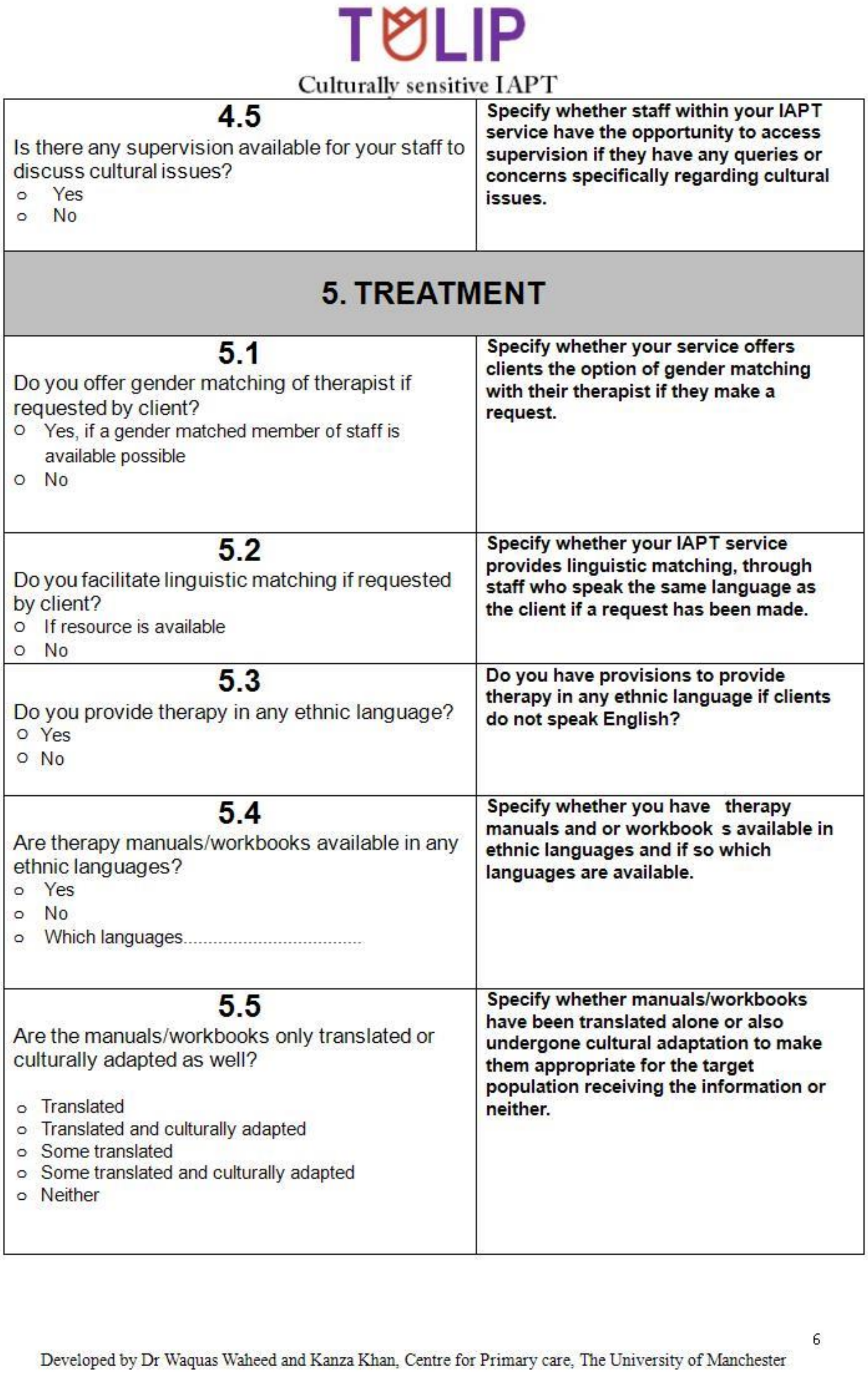

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4.5 Is there any supervision available for your staff to discuss cultural issues? ○ Yes ○ No	**Specify whether staff within your IAPT service have the opportunity to access supervision if they have any queries or concerns specifically regarding cultural issues.**
5. TREATMENT	
5.1 Do you offer gender matching of therapist if requested by client? ○ Yes, if a gender matched member of staff is available possible ○ No	**Specify whether your service offers clients the option of gender matching with their therapist if they make a request.**
5.2 Do you facilitate linguistic matching if requested by client? ○ If resource is available ○ No	**Specify whether your IAPT service provides linguistic matching, through staff who speak the same language as the client if a request has been made.**
5.3 Do you provide therapy in any ethnic language? ○ Yes ○ No	**Do you have provisions to provide therapy in any ethnic language if clients do not speak English?**
5.4 Are therapy manuals/workbooks available in any ethnic languages? ○ Yes ○ No ○ Which languages....................................	**Specify whether you have therapy manuals and or workbook s available in ethnic languages and if so which languages are available.**
5.5 Are the manuals/workbooks only translated or culturally adapted as well? ○ Translated ○ Translated and culturally adapted ○ Some translated ○ Some translated and culturally adapted ○ Neither	**Specify whether manuals/workbooks have been translated alone or also undergone cultural adaptation to make them appropriate for the target population receiving the information or neither.**

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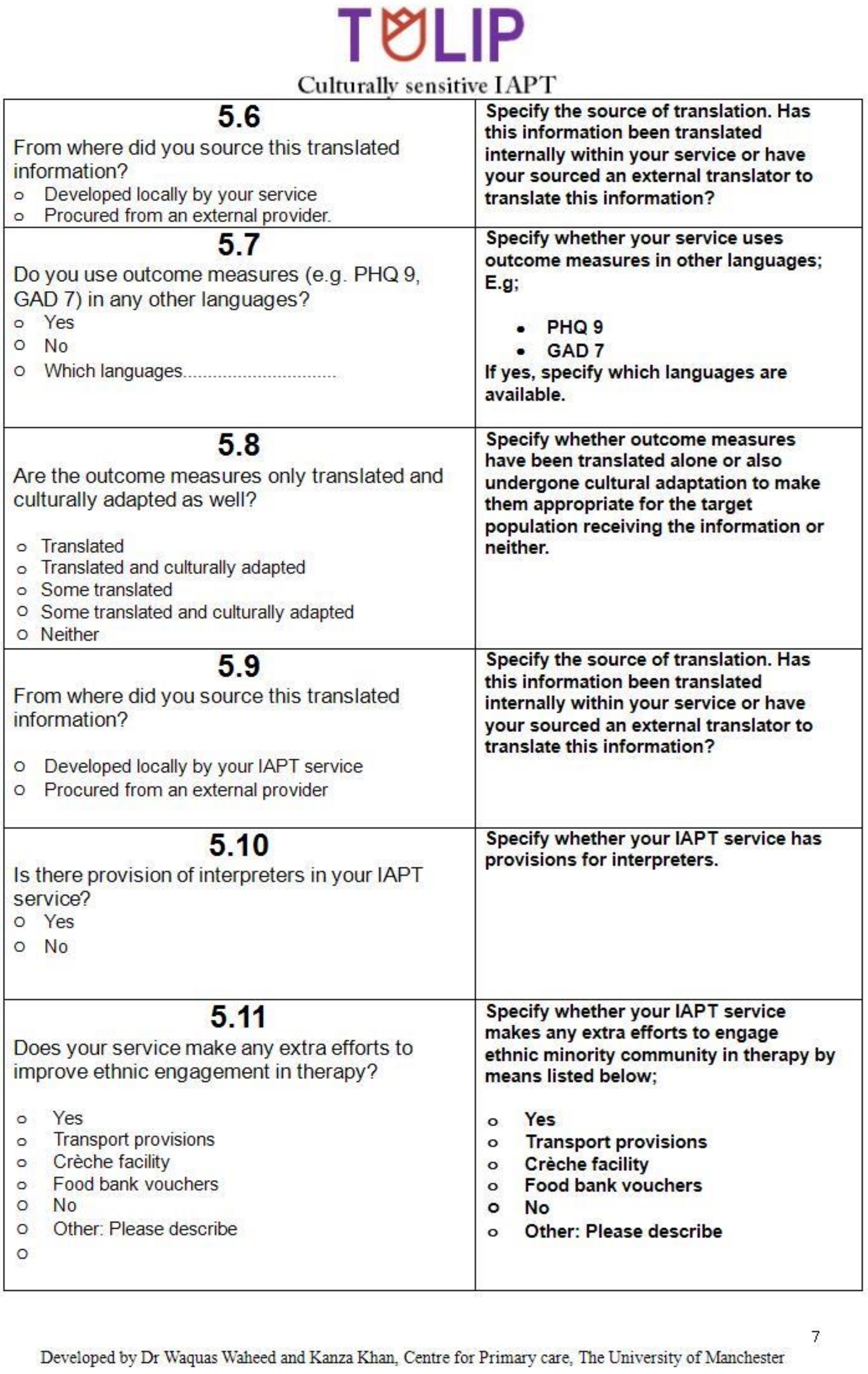

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5.6 From where did you source this translated information? ○ Developed locally by your service ○ Procured from an external provider.	**Specify the source of translation. Has this information been translated internally within your service or have your sourced an external translator to translate this information?**
5.7 Do you use outcome measures (e.g. PHQ 9, GAD 7) in any other languages? ○ Yes ○ No ○ Which languages................................	**Specify whether your service uses outcome measures in other languages; E.g;** • **PHQ 9** • **GAD 7** **If yes, specify which languages are available.**
5.8 Are the outcome measures only translated and culturally adapted as well? ○ Translated ○ Translated and culturally adapted ○ Some translated ○ Some translated and culturally adapted ○ Neither	**Specify whether outcome measures have been translated alone or also undergone cultural adaptation to make them appropriate for the target population receiving the information or neither.**
5.9 From where did you source this translated information? ○ Developed locally by your IAPT service ○ Procured from an external provider	**Specify the source of translation. Has this information been translated internally within your service or have your sourced an external translator to translate this information?**
5.10 Is there provision of interpreters in your IAPT service? ○ Yes ○ No	**Specify whether your IAPT service has provisions for interpreters.**
5.11 Does your service make any extra efforts to improve ethnic engagement in therapy? ○ Yes ○ Transport provisions ○ Crèche facility ○ Food bank vouchers ○ No ○ Other: Please describe ○	**Specify whether your IAPT service makes any extra efforts to engage ethnic minority community in therapy by means listed below;** ○ **Yes** ○ **Transport provisions** ○ **Crèche facility** ○ **Food bank vouchers** ○ **No** ○ **Other: Please describe**

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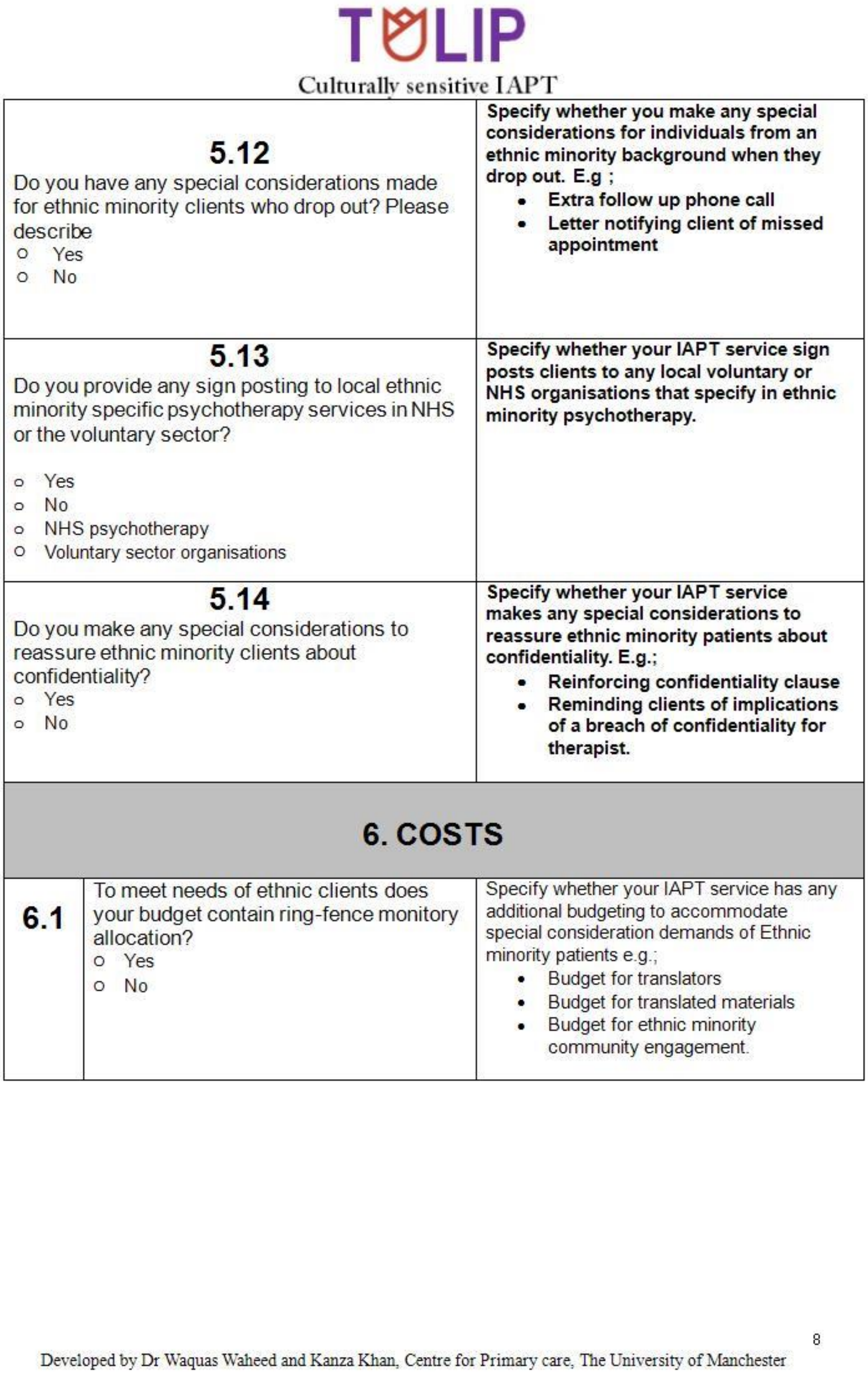

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Culturally sensitive IAPT

5.12	Do you have any special considerations made for ethnic minority clients who drop out? Please describe ○ Yes ○ No	**Specify whether you make any special considerations for individuals from an ethnic minority background when they drop out. E.g ;** • **Extra follow up phone call** • **Letter notifying client of missed appointment**
5.13	Do you provide any sign posting to local ethnic minority specific psychotherapy services in NHS or the voluntary sector? ○ Yes ○ No ○ NHS psychotherapy ○ Voluntary sector organisations	**Specify whether your IAPT service sign posts clients to any local voluntary or NHS organisations that specify in ethnic minority psychotherapy.**
5.14	Do you make any special considerations to reassure ethnic minority clients about confidentiality? ○ Yes ○ No	**Specify whether your IAPT service makes any special considerations to reassure ethnic minority patients about confidentiality. E.g.;** • **Reinforcing confidentiality clause** • **Reminding clients of implications of a breach of confidentiality for therapist.**
	6. COSTS	
6.1	To meet needs of ethnic clients does your budget contain ring-fence monitory allocation? ○ Yes ○ No	Specify whether your IAPT service has any additional budgeting to accommodate special consideration demands of Ethnic minority patients e.g.; • Budget for translators • Budget for translated materials • Budget for ethnic minority community engagement.

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