Ethnic Inequalities in Improving Access to Psychological Therapies (IAPT)

Full report

NATIONAL COLLABORATING CENTRE FOR **MENTAL HEALTH**

NHS
RACE & HEALTH
OBSERVATORY

Ethnic Inequalities in Improving Access to Psychological Therapies (IAPT)

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Executive summary

For many years, there have been concerns that people from minoritised ethnic groups[a] have poorer access to, experience of and outcomes from mental health services, including talking therapies compared with people from White British groups.

This review of ethnic inequalities in the Improving Access to Psychological Therapies (IAPT) programme in England tells a story of some progress and improved outcomes for minoritised ethnic groups, but with continued inequalities including between different minoritised ethnic groups.

The review also found intersectional differences (for example, when other demographic characteristics, such as gender, socioeconomic status and age were taken into account).

Key findings were:

In comparison with White British people, with the exception of Chinese people, people from minoritised ethnic groups (including non-British White people):

- **experienced worse outcomes, although this has narrowed in recent years**

- **waited longer for assessment**

- **were less likely to receive a course of treatment following assessment.**

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[a] See Terminology section, on language used in this report around ethnicity.

2 There were differences between minoritised ethnic groups. Of note:

- 'Bangladeshi', 'Pakistani' and 'Other Asian' (not including 'Indian' and 'Chinese') ethnic groups, as well as people from 'Mixed White' and 'Black Caribbean' ethnic groups, and 'Other Ethnic Group', have worse outcomes than other minoritised ethnic groups.

3 Inequalities in outcome for people from minoritised ethnic groups are associated with:

- increased symptom severity at initial assessment

- living in areas with higher levels of deprivation, and higher unemployment

- waiting longer for assessment, waiting longer between treatment.

4 The IAPT Black, Asian and Minority Ethnic Service User Positive Practice Guide (PPG), published in 2019 was well received by services, but:

- does not appear to be used consistently across services

- commissioners did not report good knowledge of the PPG's recommendations when compared with IAPT staff and leads.

Note: The most recent aggregated IAPT data from NHS Digital, for which we could not access individual patient data, appears to show further improvements for a number of minoritised ethnic groups (especially for the 'Black: African', 'Black: Caribbean', 'Asian: Indian' and 'Other: Chinese' groups, as well as 'White: Other White Background'). This highlights some positive action taken by IAPT services in narrowing the gap for minoritised ethnic groups, and it is hoped these positive findings will continue in the coming year(s).

Recommendations

The recommendations have been developed for NHS Talking Therapies, for anxiety and depression, services, but the principles that underpin them are also relevant to other healthcare settings and should be applied to service delivery across the mental health care pathway.

Influencing system leaders

1 Integrated care boards (ICBs)[b] and those in leadership roles in mental health services, should:

   a. respond to the inequalities highlighted in this report, and

   b. use local data to understand the needs of minoritised ethnic communities in their local area, and

   c. identify the resources and funding that can be used to implement these recommendations and address those inequalities. This includes monitoring the population and reporting specifically on outcomes.

2 ICBs and other system leaders should undergo training to improve their understanding of mental health inequalities, with regard to the needs of people from minoritised ethnic backgrounds. The training should include:

   a. an overview of wider societal ethnic inequalities, and

   b. how ethnic discrimination impacts experiences of healthcare, and

   c. how person-centred care that takes people's experiences of inequality into account can improve engagement and outcomes.

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[b] And organisations providing NHS Talking Therapies services.

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

3 NHS Talking Therapies, for anxiety and depression services should fully implement the Positive Practice Guide. All ICBs should take full account of the recommendations of the Positive Practice Guide when commissioning services, including budgeting for the additional resources needed.

Meeting the aims of the Patient and Carer Race Equality Framework (PCREF), through:

Community engagement

4 Designated staff should support services to engage with communities, to:

   a. co-produce culturally informed pathways into care, and

   b. engage with and gain understanding of local communities to promote the benefits of psychological therapy, the types of support available and how treatment can be accessed, to facilitate referral.

Providing culturally sensitive care

5 Services should ensure that all interventions are provided in a culturally sensitive way, including:

   a. an awareness that some people from minoritised ethnic communities may need extra sessions, to ensure that they and their therapist can develop a full understanding of the sociocultural and discriminatory factors that may impact their experience of mental health problems

   b. working jointly with providers of interpreter services to ensure that the same interpreter can be available over the course of treatment, for therapeutic consistency

   c. training for all staff in the most effective ways to work with interpreters so that the best treatment can be provided to people for whom the English language is a barrier

d. the provision of extra time for service staff, therapists and service users, to enable the additional work associated with the use of interpreters and the locations of care

e. cultural sensitivity should be embedded in the training, supervision and daily practice of the service, and

f. ensuring that staff and people using services[c] have access to co-produced materials and resources across a range of media (for example, face-to-face and online).

Advancing equality

6

Services should use their own data, alongside nationally available reporting to develop and evaluate programmes of work with communities and other stakeholders to address access and outcome inequalities (such as those that persist for certain minoritised ethnic communities, for example the Bangladeshi community), ideally:

a. local data could identify communities for whom inequalities exist, and the impact of service-led initiatives could then be monitored over time, and

b. publicly available national data could be used to benchmark against outcomes for individual minoritised ethnic communities, and identify services who demonstrate reduced inequalities, which might inform the sharing of service models.

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[c] See Terminology section, on language used in this report around people using IAPT services.

Workforce: training and competence

7 Education providers and services, in co-production with people with lived experience who belong to minoritised ethnic communities, should design and deliver ongoing continuing professional development (CPD) for all NHS Talking Therapies for anxiety and depression staff to provide a therapeutic environment that is culturally safe for the communities that clinicians are working with; the training should include a focus on understanding the impact of institutional racism on the experiences of people from minoritised ethnic groups.

Workforce: recruitment and retention

8 Services should recruit, train and retain a diverse staff workforce that is reflective of and able to respond to the needs of the local community.

9 National efforts should be made to increase the sociodemographic (sex, ethnicity, age) representation of the workforce (for example, recruiting more men may help to increase engagement and uptake of NHS Talking Therapies for anxiety and depression by men from some minoritised ethnic backgrounds)

10 Services should take ongoing action to address inequalities in opportunities for minoritised staff to progress into senior leadership roles, including positive action to reduce systemic barriers to promotion.

1.   Introduction

1.1.   Background

The NHS Race and Health Observatory commissioned the National Collaborating Centre for Mental Health (NCCMH) to carry out a review of ethnic inequalities in access, experience and outcomes for people who engage or try to engage with IAPT services (renamed 'NHS Talking Therapies, for anxiety and depression').

There have been different referral rates by ethnicity since the IAPT programme was launched.[1, 2] A 2021 report into mental health statistics for England explored referrals into IAPT services and outcomes of treatment using the national NHS Digital dataset.[3] Data since 2019/20 show some improvements in access and recovery rates across minoritised ethnic groups. However, at that time, only people from 'White' and 'Chinese' ethnic groups had a recovery rate of over 50%.

A policy guide, the IAPT Black, Asian and Minority Ethnic Service User Positive Practice Guide[4] (referred to in this report as 'the PPG'), was developed to help improve service design and delivery in order to improve IAPT service access, experience and outcomes for people from Black, Asian and minoritised ethnic backgrounds.

By 2020/21, people from Black and Black British groups had a recovery rate of over 50%, demonstrating that the gap has narrowed for some but not all minoritised ethnic groups.

In their equalities strategy, NHS England[5] acknowledges its duty to advance equalities in NHS services. This duty involves considering the needs of groups of people experiencing or at risk of inequalities, and working to find ways to reduce inequalities, such as providing culturally sensitive care.[6] The strategy acknowledges that people from some minoritised ethnic groups have 'poorer recovery rates in talking therapy services (IAPT) than 'White British' groups'.

In this report we explore these inequalities further, looking at ethnic differences in access, experience and outcomes for people who use IAPT services.[d]

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[d] See Terminology section, on language used in this report around people who use IAPT services.

1.3.   Aims and objectives

This review aimed to develop an understanding of the nature and extent of ethnic inequalities in IAPT services and, informed by that understanding, develop recommendations on how services can reduce ethnic inequalities in IAPT services. The objectives of the review were to identify:

- what inequalities exist in IAPT services in terms of access, engagement and treatment outcomes
- how people from minoritised ethnic communities experience IAPT pathways, and how they may vary by ethnicity, and
- how services might better embed the recommendations and guidance contained in the PPG.

1.4.   What this report covers

The report provides an overview of IAPT services and the workforce in Section 2, followed by an analysis of nationally available data from IAPT services on service utilisation and outcomes in Section 3 (see also *Appendix 1* for further detail on the analysis of the national IAPT dataset).

Qualitative findings from focus groups with people from minoritised ethnic communities who use IAPT services and with IAPT therapists are provided in Section 4 (see also *Appendix 2* for further detail on the focus groups).

Findings from surveys of IAPT clinical leads and service commissioners are presented in Section 5 (see also *Appendix 3* for further detail on the surveys).

The evidence gathered from a rapid literature review is summarised in Section 6 (see also *Appendix 4* for further detail on the literature review).

Section 7 presents a summary of the services that five voluntary, community and social enterprise (VCSE) sector organisations provide including examples of current positive practice (see also *Appendix 5* for further detail from VCSE organisations on what they do). This section describes how services engage with minoritised communities and support people to access IAPT treatment.

The Terminology section explains this report's use of language around: ethnicity; people who use IAPT services; sex and gender; and cultural sensitivity, safety and competence.

1.6. The Patient and Carer Race Equality Framework

The recommendations in this report can be implemented within the context of the NHS England Patient and Carer Race Equality Framework (PCREF), which provides a systematic and transparent participatory anti-racism framework to drive service improvements for racialised communities.

The PCREF seeks to hold mental health trusts, and mental health service provisions, accountable to evidence, mental health statistical data (Part 1), pertaining to racialised communities, co-develop measurable and practical improvement plans to deliver the six national organisational competencies (Part 2), and using the evidence of patient and carer feedback (Part 3), to ensure services are improving and equitable.

The PCREF parts work together to inform policy and practice development within all mental health services and includes the development of innovative service models to respond to the needs of racialised communities across the mental health pathways and system.

2. IAPT services in England

The information in this section draws from the Health Education England Adult IAPT Workforce Census 2021[7] and the Health Education England NHS Talking Therapies for Anxiety and Depression Workforce Census 2023[7]

2.1. Staffing levels

The IAPT programme started in October 2008. By 2018, the NHS had trained over 10,500 therapists to work in psychological therapies services across the country. Despite turnover, the total number of high-intensity and low-intensity therapists working in IAPT services was 10,315 in 2022, an increase of 5% since 2021.

The size of IAPT services varies significantly. In 2021, the median workforce size in an IAPT service was 49 WTE staff, with the largest IAPT services reporting over 200 WTE staff. IAPT has a lower average vacancy (12% versus 13.8%) and sickness absence (12% versus 13.8%) compared to the average in NHS mental health services, with very low use of agency and bank staff.

2.2. Workforce demographics of ethnicity and gender

The ethnicity of the IAPT workforce is broadly consistent with population demographics across England, with 80% of IAPT staff reporting their ethnicity as 'White or White British' compared with 83% of the wider England adult population.

Table 1 presents a breakdown of the ethnicity of the IAPT workforce.

Table 1: IAPT workforce ethnic demographics[7]

Ethnicity	%
White or White British	80
Asian or Asian British	9
Black or Black British	5
Mixed	3
Chinese/Other	2

Most of the IAPT workforce (80%) report their gender as female (Table 2), similar to wider NHS Benchmarking Network data on psychological therapies. This is in line with the NHS overall, where 77% of staff report as female, though not with the population of England, which was reported as 51% female in the 2021 census.

Table 2: IAPT workforce gender demographics[7]

Gender	%
Female	80
Male	17
Unknown	2.5
Non-binary	0.1

2.3. How IAPT services provide accessible care

IAPT services are flexible in how treatment is provided. As well as face-to-face options, all IAPT services provide a method of remote care, such as video consultations and treatment sessions over the phone. Most IAPT services provide information and therapies in different languages, co-location of physical and mental health services, and provision of services for people with long-term conditions. Some IAPT services also provide specialised services for specific age groups.[7]

The IAPT-LTC (long-term conditions) pathway also exists to provide interventions for people with long-term health conditions or medically unexplained symptoms. Such interventions may need to be adapted to meet the needs of people with LTCs and there are also specific psychological therapies available in IAPT services for the treatment of specific conditions (for example, irritable bowel or chronic fatigue syndrome).

2.3.1. Therapy offered in non-English languages

70% of IAPT services have staff who can deliver therapy in languages other than English (including Polish 22%, Urdu 19% and Punjabi 14%). Therapy can also be delivered in other languages through the use of interpreters.

3. Analysis of the national IAPT dataset

This section presents analyses of the IAPT national dataset (now named 'NHS Talking Therapies for anxiety and depression data set reports'), which is an aggregated patient dataset of all referrals to IAPT services.

The data are at the level of each referral through to episode of treatment, for each person using IAPT services. This allows for more detailed analyses than would be possible if using only the aggregated data tables that are published alongside the NHS Digital annual IAPT reports. Further information can be found in *Appendix 1*.

3.1. Research questions

The research questions we sought to answer when analysing the data address this report's objectives, and are:

1. How do access and outcomes vary by ethnicity in IAPT services?
2. What factors might contribute to any ethnic inequalities in IAPT access and outcomes?
3. What service, organisation and demographic characteristics are associated with variations in access and outcomes for people from different minoritised ethnic communities?

3.2. Datasets

IAPT services in England are required to collect the same information on every referral, initial assessment and contact with each person using the service. This constitutes the IAPT minimum data set (MDS). This includes sociodemographic information collected at referral, clinical information collected at each contact (for example, at each session), and data on the types of treatments delivered at each session. Pre- and post-treatment outcome data are available for around 98.5% of people who receive a course of IAPT treatment.

To answer the research questions of this review, we have used two datasets: the publicly available aggregate data published by NHS Digital and the annual IAPT national reports (covering the 2015/6 to 2021/22 financial years).[8,e]

The second data set, chosen to answer complex statistical questions is of individual patient data (as opposed to aggregated) on all people using IAPT services who were referred to services nationally for the 2015/16 to 2018/19 financial years. This dataset was provided by NHS Digital to the ADAPT[f] Lab at

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[e] Analyses were performed on the latest data made available by NHS Digital during the development of this report (2015/16 to 2021/22 financial years). However, the NCCMH have been made aware that more recent data shows that waiting times and waits have reduced across many ethnicity groups in the most recent reporting periods, which we could not access for this report.
[f] Ageing, Dementia and Psychological Therapies.

University College London (UCL) for the MODIFY project.[g] The MODIFY dataset has been re-purposed by UCL staff to explore inequalities in access and outcomes for different patient groups using individual level data not available in the aggregated data sets, and the presented analyses are included in this re-purposing. Further information about the datasets can be found in *Appendix 1.1*.

3.3. Recording of ethnicity

Information on ethnicity is collected as part of the IAPT MDS from the NHS Data Model and Dictionary. It is collected using the 16 categories defined in the 2001 UK census, which is 'the national mandatory standard for the collection and analysis of ethnicity'.[h] Those categories make up five high-level categories of ethnicity (see Table 3 and in the Terminology section) that were used by the Office for National Statistics (ONS) in the 2001 census. For these analyses, the more detailed categorisation of 16 ethnicities was used, but high-level categories are also presented for comparison.

In this report, comparisons have consistently been made with the 'White' category or the 'White: British' subcategory as the reference group because this was the largest group in most statistical analyses.

Table 3: Ethnic categories in the IAPT MDS (five high-level categories, 16 subcategories)

High-level categorisation	Detailed categorisation
Asian or Asian British ('Asian')	Indian
	Pakistani
	Bangladeshi
	Other Asian Background
Black or Black British ('Black')	Caribbean
	African
	Other Black Background
White	British
	Irish
	Other White Background
Mixed	White and Black Caribbean
	White and Black African
	White and Asian
	Other Mixed Background
Other Ethnic Groups ('Other')	Chinese
	Any Other Ethnic Group

[g] MODIFY = Mental Health and other psychological therapy Outcomes; their relationship to Dementia Incidence in the Following Years (MODIFY): a data linkage and feasibility project.
[h] The UK census ethnicity categories were updated and expanded in the 2011 census, and again in the 2021 census. In the 2001 census 'Chinese' ethnicity was categorised under 'Other', and we have kept this consistent as this this how the categories have been presented to services.

3.4.   Changes in referrals and access to IAPT services over time

3.4.1.   Access to services (NHS Digital reported data)

The number of people referred to IAPT who went on to access services (defined as having at least one treatment session, which may include assessment) and the number of people having a course of treatment (defined as having two or more treatment sessions, allowing pre–post outcomes to be calculated) are available in the nationally aggregated datasets from NHS Digital.

Changes over time in referrals and access for people from different ethnic groups

We present the change over time in the proportion of individuals from each high-level ethnic group category accessing the services in Figure 1 and for completing a course of treatment in Figure 2.

Overall, the proportion of referrals who go on to access IAPT services has decreased over time, from 76% in 2015–16 (849,465 of 1,112,104 referrals with ethnicity data) to 72% in 2021–22 (1,163,467 of 1,625,597 referrals with ethnicity data).

While this may in part be due to the impact of the COVID-19 pandemic, the decreasing trend was observed before the 2020–21 financial year and may be associated with a number of external factors such as high levels of demand and changing referral criteria for secondary care mental health services.

Table 4 presents the access and course of treatment rates in the 2015–16 and the 2021–22 financial years.

*Table 4: Access and course of treatment rates in 2015–16 and 2021–22*

Ethnic category	2015/16 – Access rate	2021/22 – Access rate	2015/16 – Course of treatment rate	2021/22 – Course of treatment rate
White British	76.40%	71.86%	57.99%	55.02%
White Irish	78.24%	69.38%	56.80%	51.27%
Other White background	78.10%	73.92%	57.93%	55.08%
White and Black Caribbean	73.86%	65.68%	50.77%	49.68%
White and Black African	76.99%	67.02%	55.59%	52.00%
White and Asian	76.68%	69.23%	53.68%	52.60%
Other mixed background	72.20%	68.93%	54.70%	51.40%
Indian	76.89%	73.18%	55.20%	53.10%
Pakistani	75.28%	68.49%	50.08%	47.28%
Bangladeshi	77.66%	65.96%	42.07%	47.19%
Other Asian background	76.37%	72.06%	53.15%	49.34%
Caribbean	77.28%	71.10%	53.90%	51.03%
African	76.63%	69.37%	48.66%	49.90%
Other Black background	72.08%	69.43%	50.58%	49.67%
Chinese	80.51%	71.94%	55.03%	49.57%
Other ethnic group	72.85%	68.69%	52.10%	49.94%

The proportions of people with ethnicity data progressing from assessment to treatment also decreased in all five high-level ethnic groups during that period, despite small fluctuations year by year (Figure 1).

In 2015–16, people from the 'White' ethnic group were the least likely to access treatment following assessment. However, by 2021–22 this had reversed and they were more likely to access treatment than any other ethnic group, as the reduction in access for the 'White' ethnic group was the smallest.

This may have been linked to the pandemic, as the differences are most pronounced in 2020–21 and 2021–22, but it may also represent access to treatment may be decreasing for a number of minoritised ethnic groups.

Figure 1: Access rates for the high-level ONS categories of ethnic groups

IAPT access rate by ethnicity groups (ONS categories) each financial year
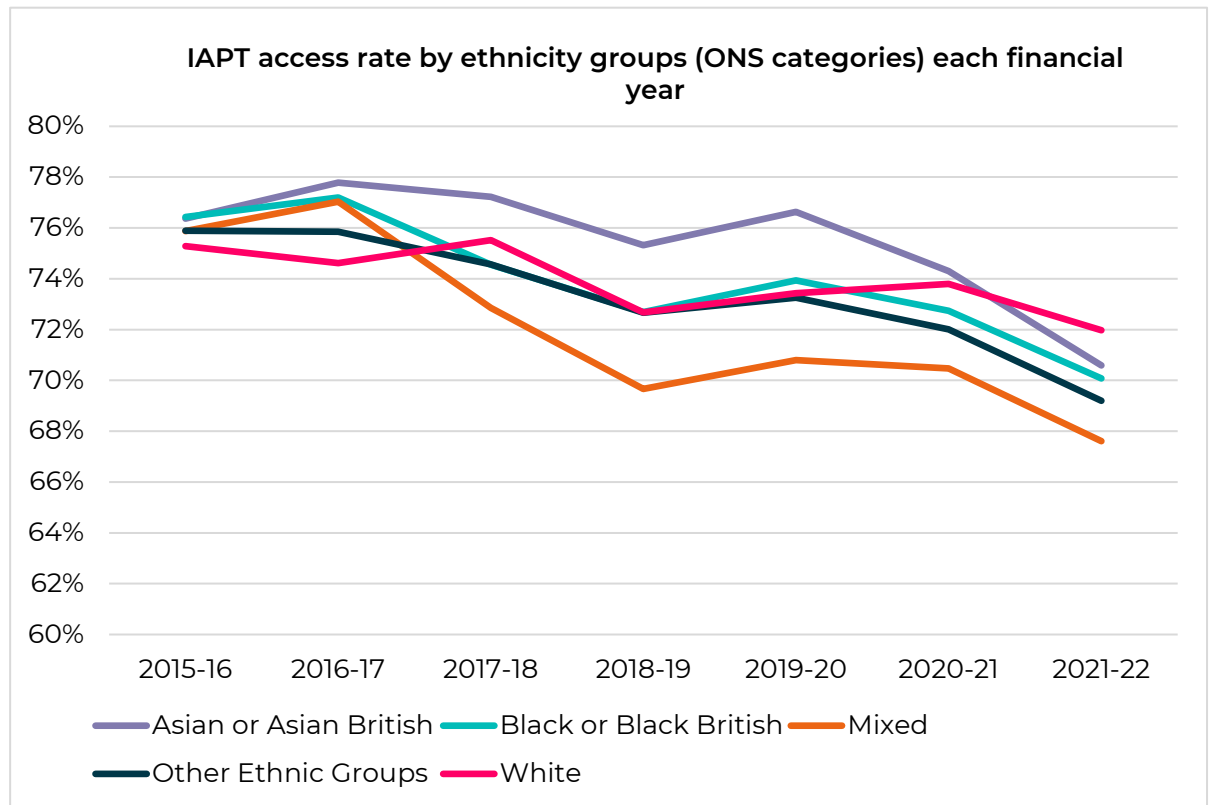
3.4.2. Receiving treatment (NHS Digital reported data)

The proportions of people from the five high-level ethnicity categories who received a course of IAPT treatment (defined as having two or more treatment sessions) after initial access are presented in Figure 2. Only individuals who accessed the services are included in the denominator for these analyses.

Figure 2 shows that people from 'White' ethnic groups were more likely to have a course of treatment after initial access to services compared with all other ethnic groups.

Figure 2: Course of treatment rates for the ONS high-level ethnic groups

IAPT course of treatment rate by ethnicity groups (ONS categories) each financial year

Legend:
- White
- Asian or Asian British
- Black or Black British
- Mixed
- Other Ethnic Groups
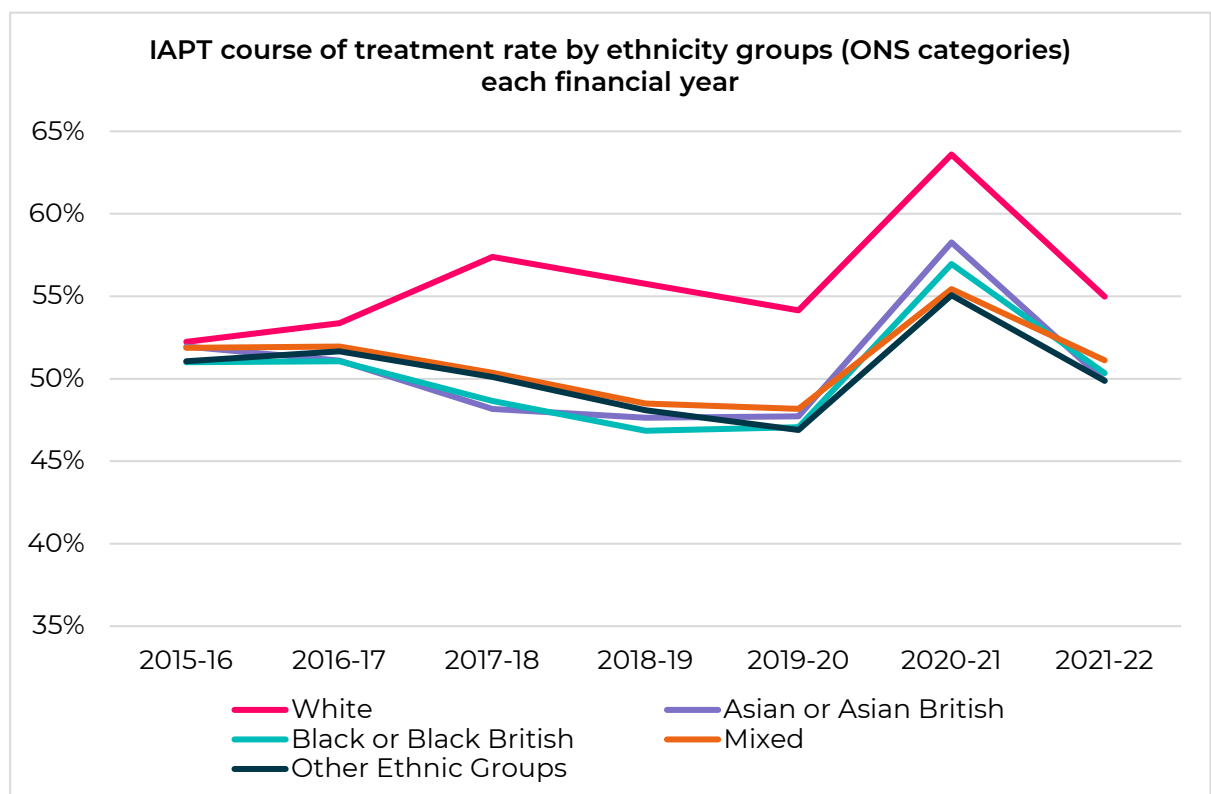
The spike in the 2020–21 financial year is likely to be due to the effects of the COVID-19 pandemic. For several months during the pandemic, there was a large decrease in the number of referrals to the services and there were changes in service delivery, with all services moving to remotely-delivered treatment for some time.[9–11]

However, Figure 2 also shows that since the 2017–18 financial year, the likelihood of receiving a course of treatment after initial assessment is significantly higher each year for people from 'White' ethnic groups compared with people from 'Black or Black British', 'Asian or Asian British', 'Mixed' or 'Other Ethnic groups'.

Appendix 1.2.2. presents trends in course of treatment rate by the detailed ONS ethnic categories. These show that, although all ethnic groups are less likely to receive a course of treatment than the 'White: British' group, the 'Asian: Bangladeshi', 'Asian – Pakistani, and 'Black: African' groups were also less likely to have a course of treatment when compared with people of the same high-level ONS category.

3.4.3. Access to services (individual patient data)

Analyses were conducted on individual patient data from all services nationwide, encompassing those referred to the services from 2015–16 to 2018–19 (in the MODIFY dataset).

Logistic regression models (that is, statistical tests that assess whether there are differences in the likelihood of an event – here, accessing services) between variables of interest were fitted to compare the odds of accessing services between each ethnic group when compared with the 'White: British' group (the reference group).

This modelling approach was used to identify whether and to what degree there are differences in the likelihood of individuals being assessed by IAPT services based on self-reported ethnicity compared with the 'White: British' group (that is, if any ethnic groups are more or less likely to be assessed than the 'White: British' group).

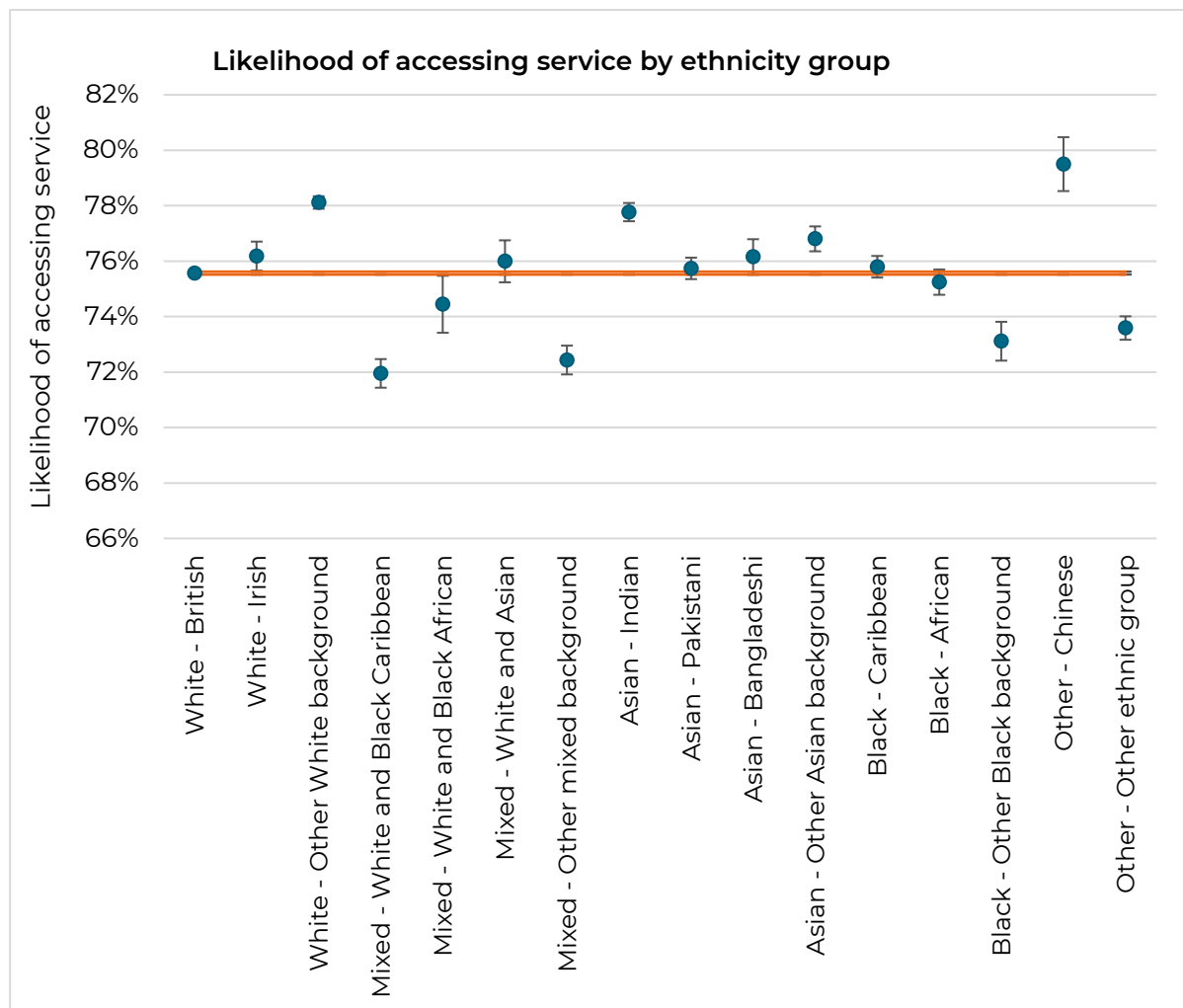The odds ratios and 95% confidence intervals for these analyses are presented in *Appendix 1.2.3.*

The estimated likelihood of accessing services between 2015–16 and 2018–19 by ethnic group is presented in Figure 3. The horizontal red line indicates the 'White: British' group as the reference category.

Compared with the 'White: British' group, individuals of 'White: Other White Background', 'Mixed: White and Asian', 'Asian: Indian', 'Asian: Other Asian background', as well as 'Other: Chinese' backgrounds were more likely to access services.

In contrast, people of 'Mixed: White and Black Caribbean', 'Mixed: Any Other Mixed Background', 'Black: Any Other Black Background' and 'Other Ethnic Groups' were less likely to access services.

There were no statistically significant differences in the likelihood of accessing services between the 'White: British' group and the 'White: Irish', 'Mixed: White and Black African', 'Black: Caribbean', and 'Black: African' groups.

Figure 3: Likelihood of accessing treatment by ethnic group (2015–16 to 2018–19, national individual patient data)

3.4.4. Receiving treatment (individual patient data)

Logistic regression models were fitted to the national IAPT individual patient data to estimate the likelihood of having a course of treatment after initial assessment for each ethnic group, compared with the 'White: British' group. Odds ratios and 95% confidence intervals are presented in *Appendix 1.2.3*.

In Figure 4, the estimated likelihood of having a course of treatment between 2015–16 and 2018–19 by each ethnic group is presented. The odds of receiving a course of treatment were significantly lower for all ethnic groups when compared with the 'White: British' group.

Figure 4: Likelihood of course of treatment by ethnic group (2015–16 to 2018–19, national individual patient data)
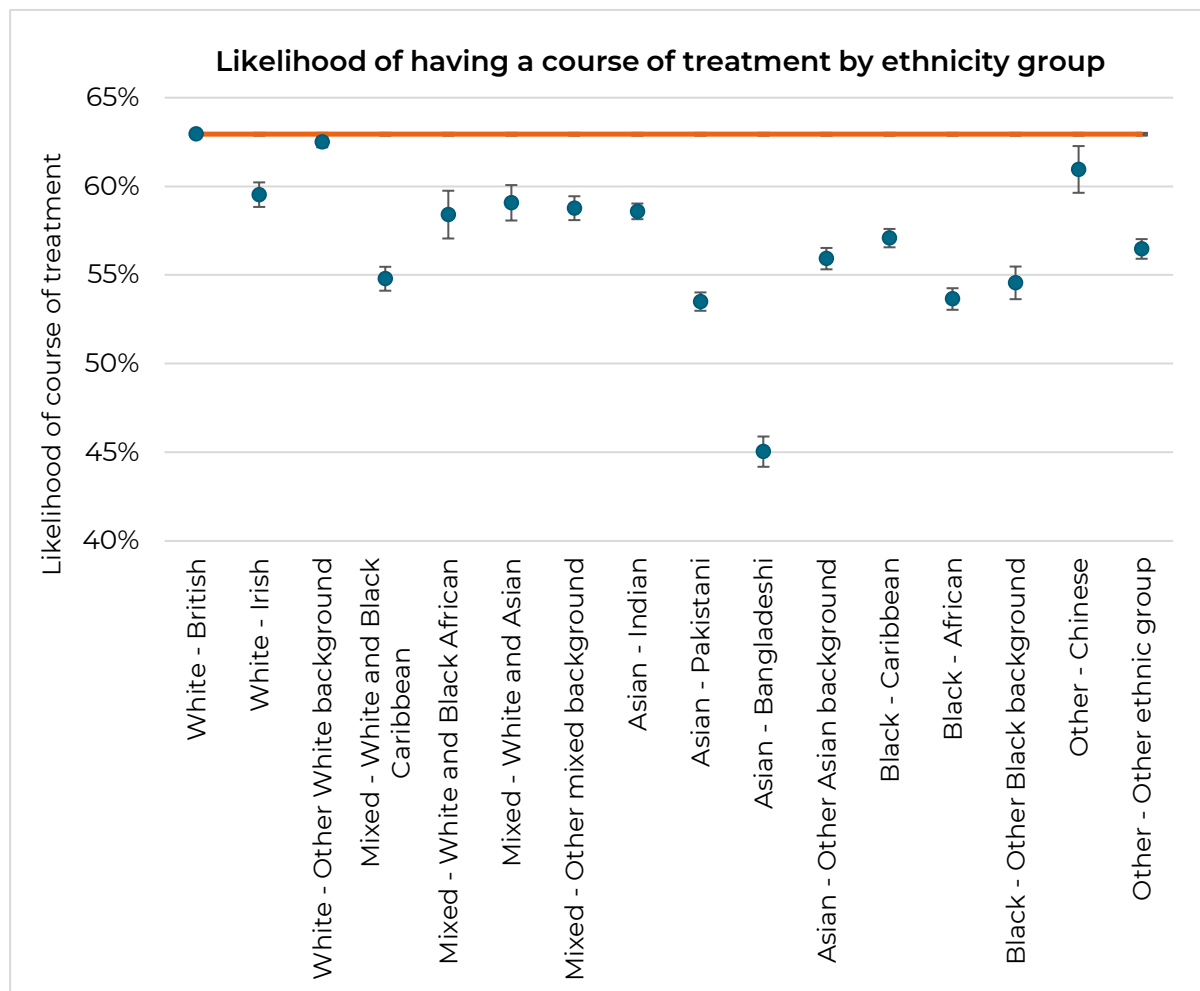
Statistically controlling for the potential impact of waiting times between referral and assessment for individuals did not result in any observed changes to these differences (see *Appendix 1.2.4.*).

3.5. Differences in presentation to services

In the next analyses, data from the 16 ethnic categories were compared on initial assessment information, including sociodemographics (age, gender and local area deprivation; see also *Appendix 1.3.*) and clinical variables (initial Patient Health Questionnaire 9-item [PHQ-9][12] and Generalized Anxiety Disorder 7-item [GAD-7][13] scores).

Three samples of people using IAPT services were compared: (1) referred to the services; (2) accessing services (who had at least an initial treatment appointment); and (3) received a course of treatment (two or more treatment sessions). As people who are referred to services but not seen (for any reason) are less likely to complete the MDS, it was important to present the information for these three different samples.

The main findings are summarised in Section 3.5.1. and full details are presented in *Appendix 1.4.*

3.5.1. Mental health at assessment

On average, the initial PHQ-9 (measure of depressive symptoms) and GAD-7 (measure of anxiety symptoms) scores (Figure 5) were lowest for the 'Other: Chinese' ethnic group and highest for the 'Asian: Pakistani' group across all three samples.

The 'White: British' group had among the lowest initial PHQ-9 scores, indicating less depression, although the 'White: Irish', 'White: Other White Background', 'Other: Chinese' and 'Asian: Indian' groups had lower average scores than the 'White: British' group.

Average GAD-7 scores were higher for the 'White: British' group on average, indicating more anxiety, compared with ethnic groups that included 'White: Irish', 'White: Any other White Background', 'Mixed: White and Asian', 'Black: African', 'Black: Caribbean', 'Black: Other Black background' and 'Other: Chinese', depending on the specific sample.

The 'White: British' group were most likely to be prescribed and taking psychotropic medication.

Full analyses are presented in *Appendix 1.4*.

Figure 5: Comparison of (a) mean initial PHQ-9 and (b) GAD-7 scores across ethnic groups, among those who completed a course of treatment. Error bars indicate 95% confidence intervals

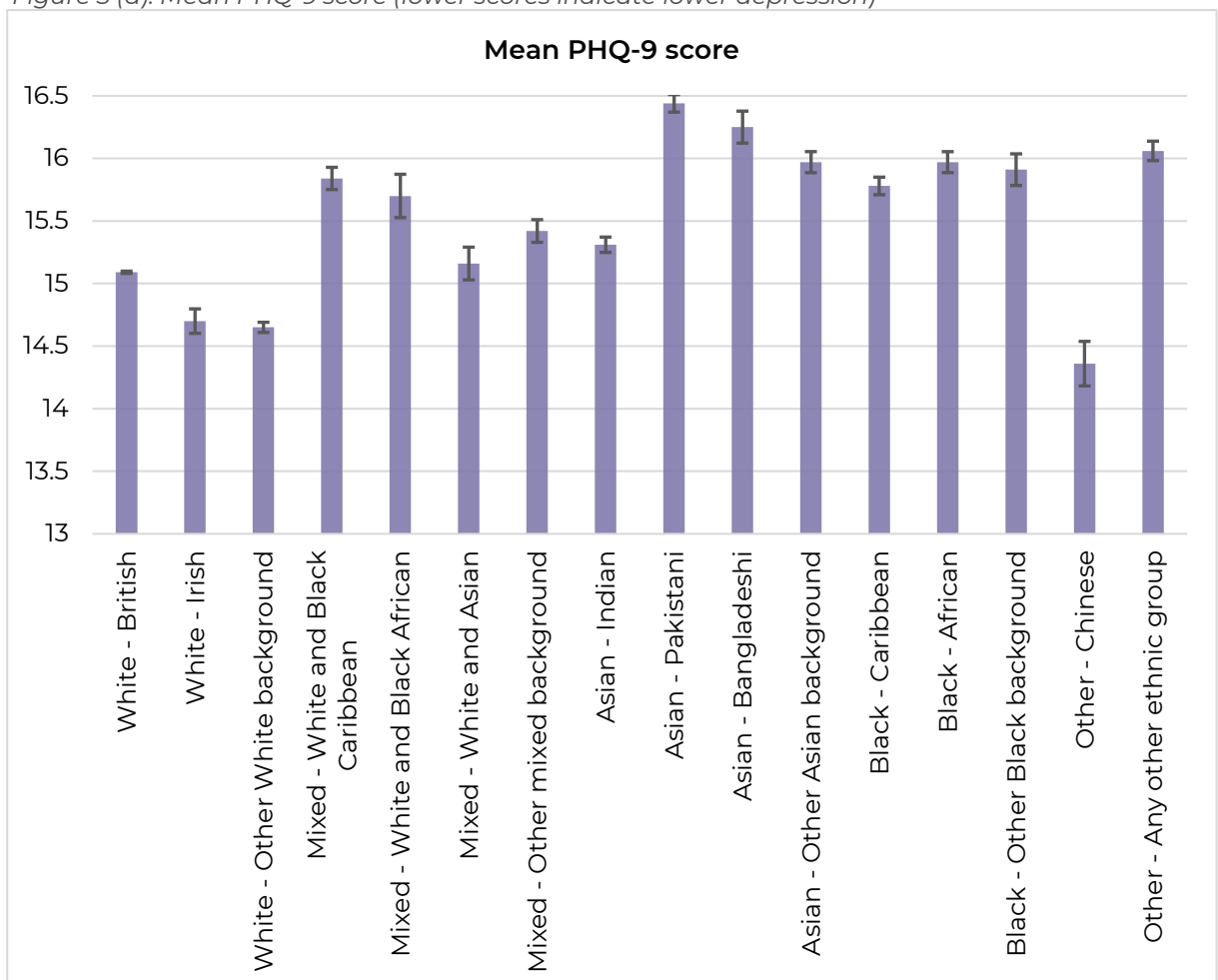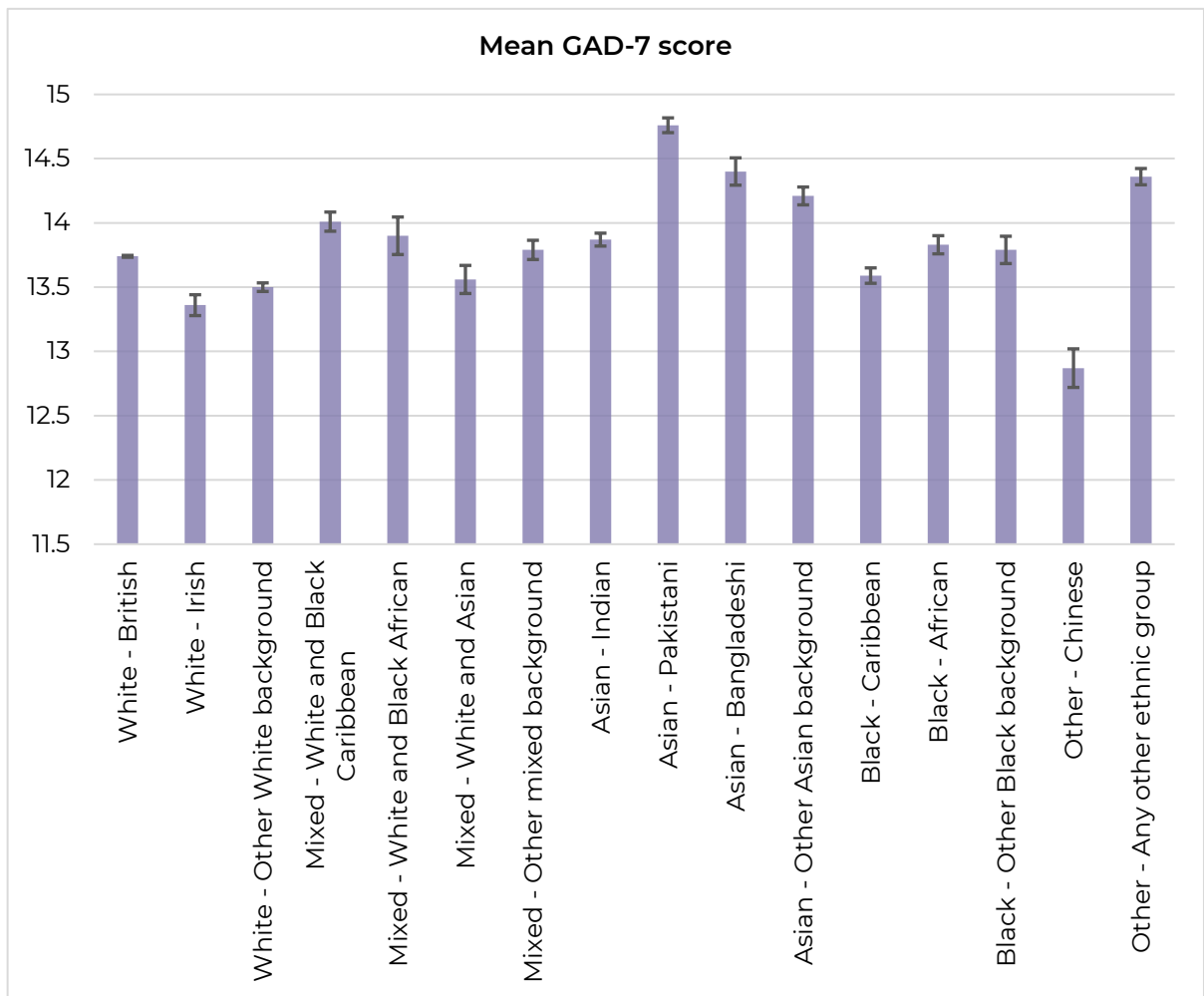*Figure 5 (a): Mean PHQ-9 score (lower scores indicate lower depression)*

Figure 5 (b): Mean GAD-7 score (lower scores indicate lower anxiety)

Mean GAD-7 score

3.6. Differences in outcomes

3.6.1. Changes in outcomes in the national dataset

The NHS Digital website provides annual IAPT outcome rates for the overall programme, including by ethnicity. Outcome rates by ethnicity were compiled for this report.

Three main outcomes are used in national reporting of IAPT services. The first is **'recovery'**, defined as people scoring above the clinical threshold on a clinical measurement of depression or anxiety before treatment (at assessment), and then scoring below the clinical threshold for both depression and anxiety on clinical measures at the last treatment appointment with the service.

The second outcome used by services is **'reliable improvement'**, defined as a decrease in either a clinical measure of depression or anxiety symptom severity that is large enough to be considered unlikely to have occurred due to chance (assessed by comparing first and last scores).

The third outcome is **'reliable recovery'**, which combines the other two outcomes and is achieved when people meet the criteria for 'moving to recovery'

and have reported a decrease in scores greater than expected by chance ('reliable improvement').

Full details on the calculation of IAPT outcomes are provided in *Appendix 1.5*.

Probability of outcomes

Figure 6 displays these three outcomes using the NHS Digital national report data for the high-level ethnic categories (Figure 6a shows recovery; Figure 6b shows reliable improvement; Figure 6c shows reliable recovery). Figure 6 shows that all three outcomes have increased year by year for most ethnic groups between 2015–16 to 2020–21, before levelling or slightly decreasing in the 2021–22 financial year.

People from the 'White' ethnic group typically had the highest rates of recovery, reliable improvement and reliable recovery, although in the 2020–21 and 2021–22 financial years, outcomes for the 'Black' ethnic group were very similar to those of the 'White' group.

Outcome rates for the 'Asian', 'Mixed', and 'Other' ethnic groups all improved year on year and the gap has narrowed between the outcomes for these three groups relative to those of 'White' ethnicities.

The gap in outcomes from 2015–16 to 2021–22 has decreased from between 7.3–9.8% to between 3–3.5% for the 'Asian' group, from between 4.0–7.0% to between 2.5–4.3% for the 'Mixed' ethnic group, and from between 4.3–6.9% to between 4–5.5% for the 'Other' ethnic group.

Differences in the 2015–16 and 2021–22 outcomes are presented in Table 5.

Table 5: Differences in outcomes in 2015–16 and 2021–22

	Recovery		Reliable improvement		Reliable recovery	
	2015–16	2021–22	2015–16	2021–22	2015–16	2021–22
British	47.7%	50.7%	63.6%	67.5%	45.5%	47.9%
Irish	48.7%	52.4%	63.8%	67.9%	46.8%	49.0%
Other White background	46.6%	51.7%	61.9%	67.3%	44.2%	48.6%
White and Black Caribbean	37.7%	45.1%	58.8%	65.2%	36.2%	42.7%
White and Black African	42.5%	47.7%	60.8%	66.8%	40.9%	45.2%
White and Asian	42.0%	48.2%	58.2%	64.2%	39.6%	44.8%
Other mixed background	40.3%	46.5%	58.0%	64.8%	38.3%	43.8%
Indian	42.8%	51.5%	59.2%	66.6%	40.7%	48.2%

	Recovery		Reliable improvement		Reliable recovery	
	2015–16	2021–22	2015–16	2021–22	2015–16	2021–22
Pakistani	35.1%	43.4%	54.9%	63.0%	33.5%	41.4%
Bangladeshi	37.2%	43.9%	53.9%	64.2%	35.3%	41.4%
Other Asian background	36.4%	46.6%	55.2%	63.3%	34.3%	43.8%
Caribbean	42.7%	51.1%	60.8%	67.7%	40.7%	48.4%
African	40.3%	51.5%	58.8%	68.2%	38.9%	48.9%
Other Black background	40.6%	47.5%	58.6%	65.4%	38.6%	45.0%
Chinese	46.5%	55.0%	60.6%	66.0%	43.7%	50.7%
Other ethnic group	36.3%	43.4%	55.7%	63.0%	34.5%	41.0%

Trends in outcomes

Trends over 2015–16 to 2021–22 in recovery rates for subcategories of ethnicity can be found in *Appendix 1.5.3.*

There, we can see that people from the 'Indian' data group had much higher recovery rates than the 'Asian: Pakistani' and 'Asian: Bangladeshi' groups.

Among 'Black' ethnic groups, recovery rates increased over time for both 'Black: African' and 'Black: Caribbean' groups, but not for those of 'Black: Any Other Black background'.

Recovery rates for all of the 'Mixed' ethnic groups were consistently lower than for the 'White: British' group.

Recovery rates for the 'Other: Chinese' group were higher than for the 'White: British' group, while rates for 'Other: Any Other Ethnic Group' were particularly low.

Recovery rates for the 'White: Irish' and 'White: Any Other White Background' groups were similar to those of the 'White: British' group.

These patterns were similar when looking at the aggregated data on reliable improvement and reliable recovery in the IAPT national reports (see *Appendix 15.4.* and *Appendix 1.5.5.*, respectively).

Figure 6: IAPT (a) recovery, (b) reliable improvement and (c) reliable recovery rate by (ONS categorised) ethnic group
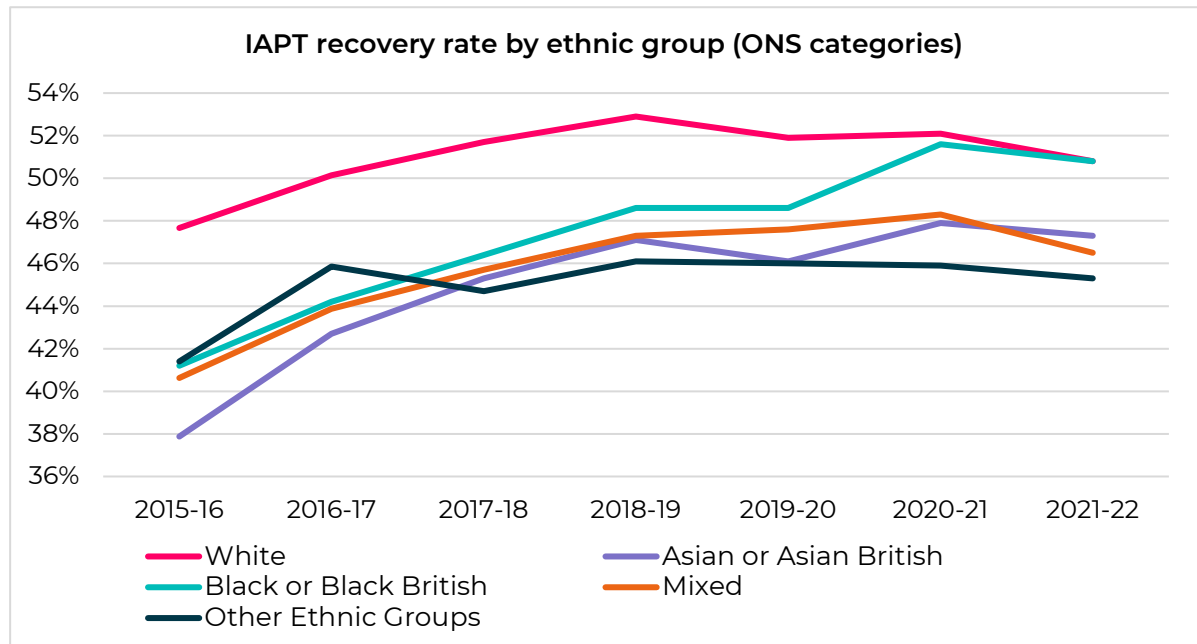
Figure 6 (a): IAPT recovery rate by ethnic group
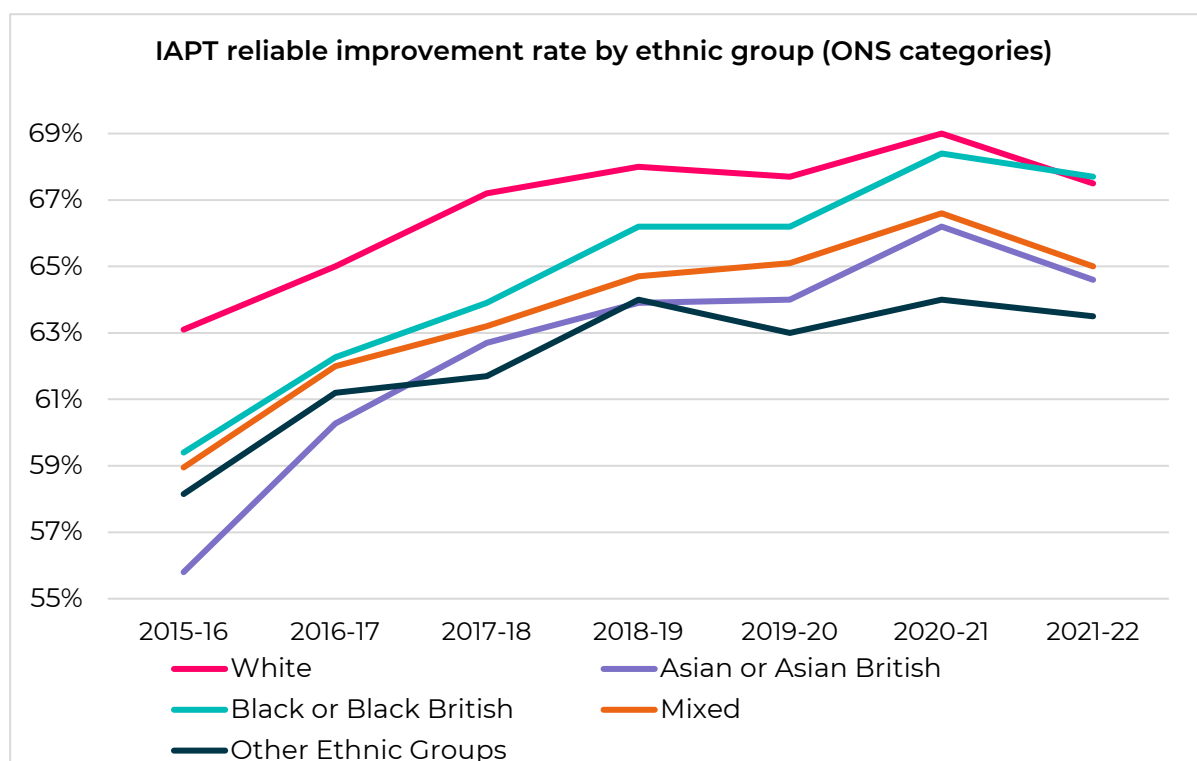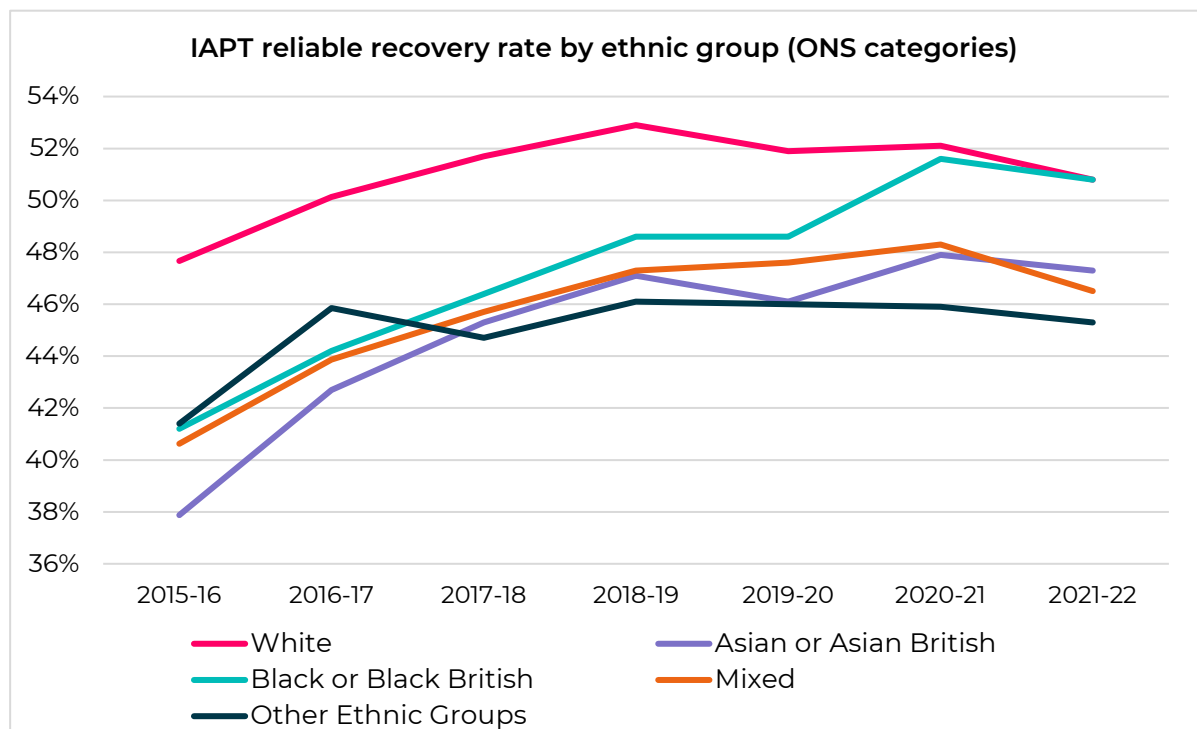

IAPT recovery rate by ethnic group (ONS categories)

Figure 6 (b): IAPT reliable improvement rate by ethnic group

IAPT reliable improvement rate by ethnic group (ONS categories)

Figure 6 (c): IAPT reliable recovery rate by ethnic group

IAPT reliable recovery rate by ethnic group (ONS categories)

Legend: White, Asian or Asian British, Black or Black British, Mixed, Other Ethnic Groups

3.6.2. Outcomes in the individual patient data

While the nationally reported data provide detail on changes in outcomes over time between ethnic groups, they do not allow the opportunity to assess or control for factors that might explain some of the differences in outcomes. These include characteristics such as age, local area deprivation and initial symptom severity, and treatment pathway information. If such factors are associated with observed differences, this might highlight opportunities for changes to clinical practice. We therefore explored differences in outcomes between ethnic groups using an individual patient dataset (MODIFY).

As well as the three outcomes in the national data, we also considered **reliable deterioration**,[i] **dropout**[j] and the **proportion of sessions attended** (out of the number of appointments offered).

Only people who received a course of treatment (two or more treatment sessions) and those who had finished their episode of IAPT treatment at the time the dataset was created were included in these analyses, mirroring criteria in the national data. Data on all patients with episodes of care from April 2015 to March 2019 who met these criteria were included in these analyses (n=1,570,994).

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[i] Worsening of symptoms by the same or greater magnitude as used to calculate reliable improvement – those that reliably improved on one outcome measure and reliably deteriorated on the other symptom measure were excluded from these analyses.
[j] Having ended contact with services before the planned end of treatment without having been referred on for treatment elsewhere.

Regression models

To explore the impact of patient characteristics and treatment pathway factors that might explain some of the differences in outcomes between ethnic groups, a series of regression models were constructed for each outcome (Table 6).

Table 6: Regression models

Model	What the model includes
Model 1	Includes only ethnic group (unadjusted)
Model 2	+ Additionally includes: age, gender and referral year
Model 3	+ Additionally includes: baseline symptom severity scores and whether taking psychotropic medication
Model 4	+ Additionally includes: employment status, presence of a long-term physical health problem and local area deprivation
Model 5	+ Additionally includes: waiting time between referral and assessment, waiting time between assessment and next treatment session, and number of sessions received

This model-staging approach gives us the opportunity to see the observed differences in the outcomes before statistically controlling for patient factors that are associated with outcomes and differ in presentation between ethnic groups.

Model 2 first controls for the impact of simple demographics (age, gender and year), before Model 3 additionally includes other routinely collected clinical patient information (symptoms and medication). Many of these factors have been associated with access and outcomes in the research literature, but are not modifiable by IAPT (baseline measures are not modifiable by services, only post-baseline measures are). Model 4 then additionally controls for factors (such as employment and deprivation) that are known to differ systematically across ethnic groups but are potentially modifiable (although by baseline variables, not by IAPT services). Model 5 additionally controls for factors that services would be able to address (waiting times and number of sessions). The results from the multilevel models are presented in *Appendix 1.6.*

Linear regression models were constructed for the 'proportion of sessions attended' outcome, and logistic regression models were constructed for the other five outcomes.

Recovery

Odds ratios for all five models, comparing the likelihood of recovery of the 'White: British' group with each ethnic group, are presented in *Appendix 1.5.6.*

In the unadjusted model (Model 1), all ethnic groups except 'White: Irish' and 'Other: Chinese' were significantly less likely to recover than the 'White: British' group.

After controlling for the impact of age, gender and year of referral (Model 2), recovery rates for the 'White: Irish' and 'White: Other White Background' groups were not significantly lower than for the 'White: British' group, while the recovery rate for the 'Other: Chinese' group became significantly higher than that for the 'White: British' group.

When additionally controlling for baseline severity and taking psychotropic medication (Model 3), findings changed so that the recovery rates were significantly lower for all groups except 'Asian: Indian' and 'Other: Chinese' groups.

Also controlling for local area deprivation, employment status and long-term health condition status (Model 4) resulted in the difference between 'Black: Caribbean' and 'White: British' groups no longer being statistically significant. This was in addition to the findings observed in Model 3 for the 'Asian: Indian' and 'Other: Chinese' groups.

Lastly, additionally controlling for waiting times and number of sessions (Model 5) meant that the 'Black: Any Other Black Background' group were no longer less likely to recover than the 'White: British' group.

For many ethnic groups, including all 'Mixed' and 'Other' (excluding 'Other: Chinese') ethnic groups, and 'Asian: Pakistani' and 'Asian: Bangladeshi' groups, the likelihood of recovery was statistically lower than for the 'White: British' group. For 'Asian: Indian', 'Black: Caribbean', 'Black: African' and 'Black: Other Black Background' groups, some of the observed differences in outcomes may be attenuated when considering differences in other patient characteristics. In particular, effects were much smaller in magnitude when controlling for the waiting times and the number of sessions of treatment received between people from these ethnic groups and the 'White: British' group.

To demonstrate the impact of adjusting for variables in the models, Figure 7 presents the estimated probability of recovery for each ethnic group: the unadjusted model (Model 1) is presented alongside a model controlling for patient characteristics and treatment pathway variables (Model 5). Figure 7 shows how controlling for these variables reduces the difference between estimated recovery rates for each ethnic group compared with the 'White: British' group (horizontal red line), apart from the 'White: Irish' and 'Other: Chinese' groups because they were not at lower likelihood of recovery compared with the 'White: British' group across models.

Figure 7: Estimated probability of recovery in (Model 1) the observed (unadjusted) data and when statistically controlling for patient characteristics (Model 2 and Model 3), treatment pathway variables (Model 4) and waiting times, number of sessions (Model 5).

Recovery: Model 3 (+severity)

Recovery: Model 4 (+IMD/employment status/LTC*)
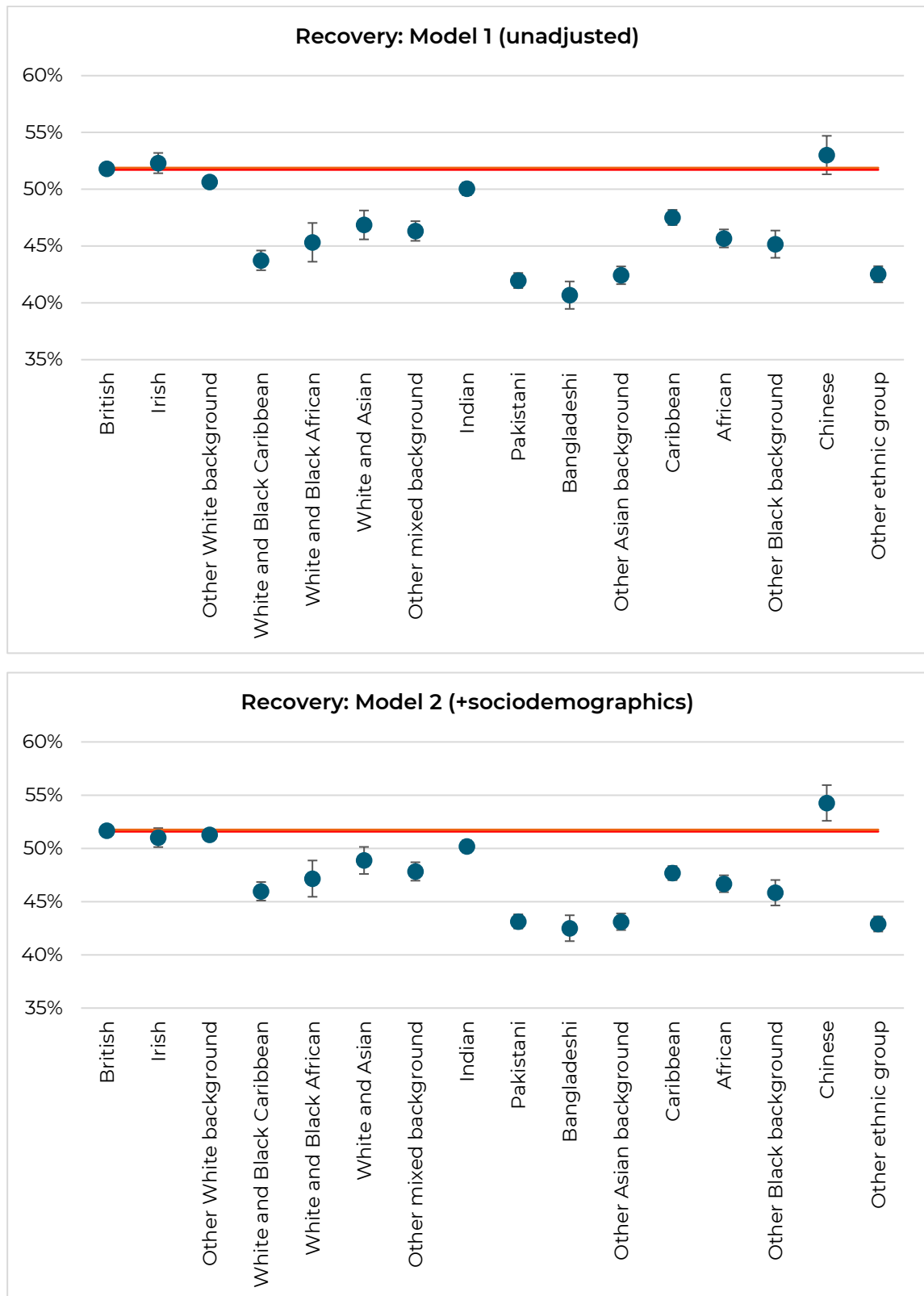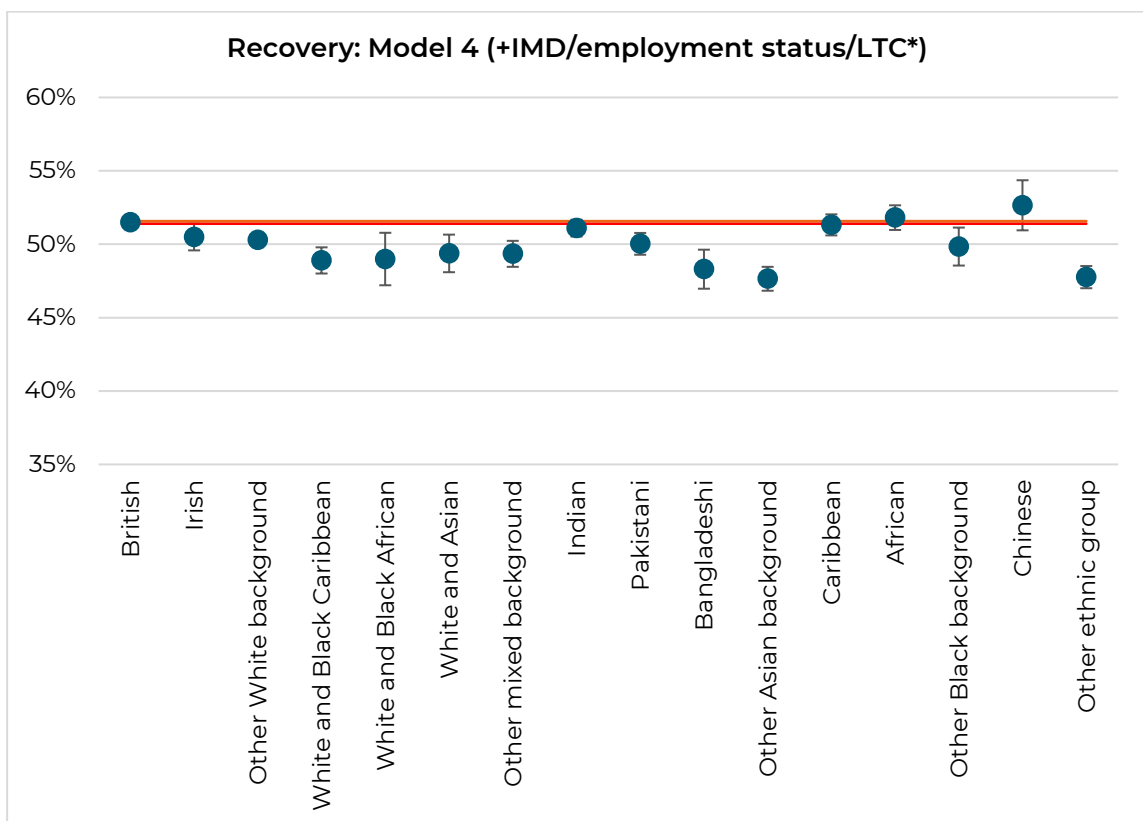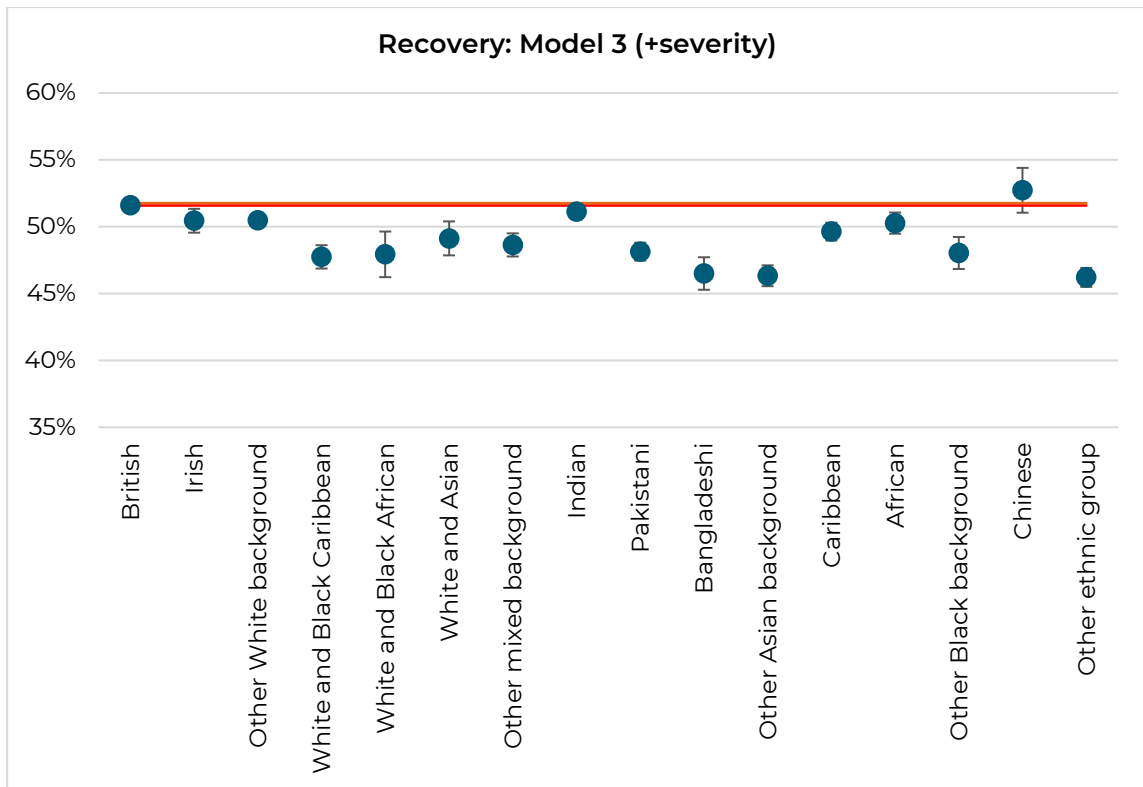
* IMD = Indices of Multiple Deprivation (measure of deprivation across different regions of country); LTC = long-term physical health condition (comorbid with mental health problem)

Recovery: Model 5 (+ waiting times/sessions
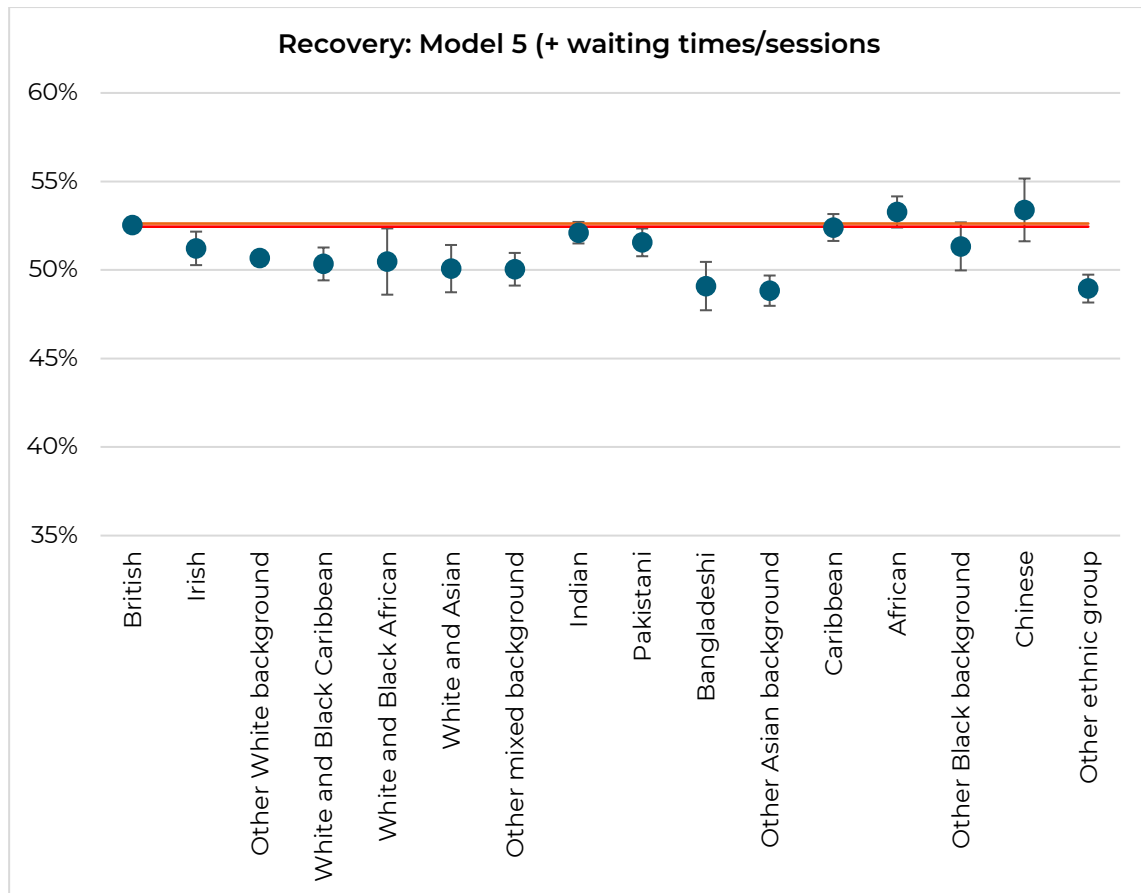
Reliable improvement and reliable recovery

Results from the logistic regression models for reliable improvement and reliable recovery outcomes are presented in *Appendix 1.5.6.*

Findings were broadly similar to those for recovery, in that when statistically controlling for patient characteristics, the likelihood of reliable improvement and reliable recovery were lower for the 'White: Irish' group compared to the 'White: British' group, and outcomes for the 'Other: Chinese' group were no different from the 'White: British' group.

When looking at reliable improvement, the 'Asian: Indian' group had lower rates than the 'White: British' group, but their likelihood of reliable recovery was not significantly different when adjusting for both patient and treatment factors.

For the 'Black: African', 'Black: Caribbean' and 'Other: Any Other Ethnic Group' groups, differences were no longer statistically significant compared with the 'White: British' group when controlling for patient and treatment factors. In fact, the odds of reliable improvement were significantly higher for the 'Black: African' group compared with the 'White: British' group when controlling for waiting times and the number of sessions received.

Deterioration rates

Analyses of deterioration rates between ethnic groups found a more uniform pattern of results. There was no difference in the rate of deterioration between 'Other: Chinese' and 'White: British' groups across models.

Nearly all ethnic groups were at higher risk of deterioration compared with 'White: British' or 'Other: Chinese' groups except those from 'Black: Any other Black background' and 'Mixed: White and Black African' groups (when adjusting for treatment factors).

3.7. Exploratory and further analyses

To account for potential differences between services, further analyses were conducted using multilevel models. These examined the amount of variance in the likelihood of outcomes that could be accounted for by service-level clustering; that is, how much variance in the likelihood of the outcomes might be due to how different IAPT services operate, or to differences in the patient population that access the services in each geographical location. We included the service's clinical commissioning group (CCG)[k] as the service-level variable by which to cluster patients.

A series of multilevel models for the six considered outcomes, which included CCG as a clustering variable by fitting this into the statistical models with a random effect,[l] are presented in *Appendix 1.6.*, and broadly support the findings presented in Section 3.6.

The results for reliable deterioration and the proportion of sessions attended were almost identical to those reported in Section 3.6, regardless of the adjusted variables.

For the other outcomes, unadjusted results (Model 1) were largely similar, while results for models adjusted for patient characteristics and treatment pathway factors (Model 5) were often attenuated compared with when service-level variation was not accounted for; that is, there appeared to be less inequality in estimated outcomes by ethnicity when controlling for CCGs in these multilevel models than when modelling all variables without considering service-level clustering.

A notable exception to the attenuation of effects in these multilevel models was that in the fully adjusted models, people from the 'Black: African' group were even more likely to recover, reliably improve and reliably recover compared with the 'White: British' group. Furthermore, the likelihood of dropout for the 'Mixed:

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[k] The Health and Care Act 2022 took effect in July 2022, to support the full implementation of the NHS Five Year Plan. It restructured healthcare commissioning, with CCGs being replaced by integrated care boards (ICBs). Therefore, in our recommendations and when referring to the present and future we refer to ICBs, while our review refers to commissioners and CCGs.
[l] Random effect is a statistical method of accounting for the fact that people receiving treatment from the sample IAPT will have similarity, both among themselves but also in the treatment delivered.

White and Black Caribbean', 'Black: Caribbean' and 'Black: Any Other Black Background' groups were estimated to be higher when accounting for service-level variation with random effects. These findings acknowledge differences in treatment pathways, including sessions delivered, variation in waiting times and other differences in local practice, which may include how dropout is recorded.

The intra-class correlations (ICCs)[m] across the models were limited to:

- around 1% for recovery, reliable improvement, reliable recovery and deterioration
- around 3% for the proportion of sessions attended
- 15–16% for dropout.

Higher variance attributed to services in analyses of dropout compared with other outcomes has been observed in similar analyses of IAPT data.[14] While the higher variance might reflect some systematic differences in engagement across services (regardless of ethnicity), it might also reflect systematic differences in how services choose to use the codes that calculate the outcome as 'dropped out' to describe discontinuation from treatment.

See also *Appendix 1.7.* for an analysis of the data on the impact of own group ethnic density.

3.8.   Patient Experience Questionnaire

People using IAPT services are asked to complete the Patient Experience Questionnaire (PEQ) both at the end of their initial assessment (PEQ-A) and at the end of their episode of treatment (PEQ-T).[n]

Although services are requested to collect PEQ data for patients, data completion remains low in practice. In the national MODIFY dataset, of the 3,699,969 episodes that accessed the service, only 437,778 (11.83%) had matched PEQ-A data and 351,142 (16.52%) of 2,125,501 patients who received a course of treatment had PEQ-T data for analysis. Therefore caution should be noted when interpreting the findings from the subsample of patients seen by IAPT services nationally.

Of those who did respond, there were few differences found, but there was a small difference between people who are 'White: British' and other ethnic groups. People from the 'White: British' ethnic group were more likely to say that they had received sufficient information with which to choose their treatment.

PEQ-A and PEQ-T questions and response options are shown in *Appendix 1.8.*

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[m] ICCs indicate the proportion of variation in outcome that is attributed to the service-level clustering.
[n] Both PEQs are available from The IAPT Manual.

3.9.   Limitations of the data analysis

While these analyses benefit from national-level data over six financial years to explore trends, there were several limitations:

Individual patient data was not available after 2019 for this analysis, and aggregate data was only available up until 2021–22 for during the writing of this report. Given that differences in outcomes between some ethnic groups and the 'White: British' group appear to have reduced in the last financial year, it would be of value to explore these in the most recent dataset when NHS Digital have made those data available.

The granularity of ethnic categories based on the 2001 census may not reflect the way people would choose to identify their ethnicity and there are some major gaps, including Middle Eastern, Arab and Jewish ethnicities.

While the IAPT MDS contains a large amount of information about patient characteristics, data on preferred language were not available in the dataset. This information was included in the most recent version of the IAPT MDS and will eventually be released, allowing examination of the impact of language and use of interpreters on outcomes.

Potential confounders including religion and sexuality, which may be associated with access and outcomes, were not included in the current analysis as they are not mandatory to report, and therefore substantial missingness was observed in the dataset.

The PEQ measures were only available for a small proportion of the overall sample of people using IAPT services. There may be biases in score availability, which would warrant further investigation.

People who are referred to IAPT but do not access services are much more likely to be missing key information, including ethnic group data, and therefore there is potential for selection biases and the existence of unmeasurable differences in the IAPT dataset.

It is acknowledged that this analysis only includes individuals who have been referred to services and is not able to examine individuals who were not referred. Previous analyses have used census data linked to the IAPT national dataset and have identified that individuals of Asian ethnic backgrounds were underrepresented in IAPT services.[15]

4. Focus groups with people using IAPT services and IAPT therapists

The focus groups explored the experiences of people from minoritised ethnic groups when accessing IAPT services, and of IAPT therapists providing IAPT care and treatment.

The focus groups considered participants' perceptions of the quality of service provision and how it could be improved, and their views on the suitability of treatment provided in line with published guidance.

The focus groups with IAPT therapists also explored their experiences of delivering care to people from minoritised ethnic groups, and of making adaptations, to facilitate access to and experience of IAPT.

The findings from the focus groups complement the findings from analyses of the IAPT dataset, the literature review and the surveys.

Five topic areas were explored in the focus groups (two groups with people using IAPT services and two with IAPT therapists). The topics were categorised as:

1. Access to IAPT: Experiences of referral to, and assessment and starting treatment in IAPT services
2. Treatment delivery: Including therapist characteristics (age, gender and ethnicity) and cultural sensitivity
3. The service: Making appointments, treatment settings and their impact on treatment
4. Changes and improvements to IAPT: Participants suggested improvements to IAPT services
5. General experience: Any other relevant positive experiences or challenges with delivering or receiving IAPT treatment.

Appendix 2 contains further detail about the focus groups, including methods used.

4.1. Summary of findings from focus groups

From the four focus groups a number of key themes emerged which are detailed in *Appendix 2.*

In this section, we set out the themes and factors that were considered important.

Table 7 summarises the findings from the focus groups, and shows how much agreement there is between therapists and patients about what might help.

Table 7: What people from minoritised ethnic backgrounds using IAPT services and IAPT therapists considered important about access, treatment delivery and the service

Participants considered these things to be important	Service users	Therapists
Provision of clear, accessible and timely information about the IAPT service, including explanation of exactly what the service can offer including setting expectations	✓	✓
Service promotion, information provision and outreach work with communities	✓	✓
Making information about IAPT as accessible as possible (e.g. language translation needs)	✓	✓
Helping people to understand waiting times and prevent dropout due to long waits	✓	✓
IAPT therapists showing cultural awareness and sensitivity; accommodation of culture and religion when appropriate	✓	✓
Accommodation of preferences for therapists with certain characteristics (e.g. ethnicity, gender)	✓	✗
Flexibility over session timing, location and delivery method (e.g. face-to-face or video call) to suit individual needs	✓	✓
Better provision of therapy in different languages (e.g. by recruiting more diverse therapists to the service/ diversity of the workforce reflecting the population served) and, especially, the need for diversity in leadership positions, (e.g. equal promotion opportunities)	✓	✓

4.1.1. Access

Across focus groups, the key theme that emerged was **information about IAPT**, a lack of which was seen as creating barriers to access. For people using IAPT services, other themes were access and assessment. For IAPT therapists, other key themes were outreach work, language and access.

For full findings of focus group discussion on access, see *Appendix 2.2.1.*, *Appendix 2.2.4.* (people using IAPT services) and *Appendix 2.3.1.* (IAPT therapists). See *Appendix 2.5.2.* for similarities and differences across focus group feedback.

IAPT therapists identified the following **challenges and barriers**:

- **Outreach work** takes time from clinical work and has already been affected by the pandemic
- **Digital communication** can be a barrier for some minoritised groups who may be more likely to experience digital poverty and lack of access to a mobile phone or the Internet. Lack of translated information from the service can also present a challenge
- **Clinical terminology** about mental health is different or non-existent in some languages.

4.1.2. Treatment delivery

The key theme that emerged across focus groups was **cultural sensitivity**, including the cultural sensitivity of therapists and a change in service culture.

Across all four focus groups, **therapist characteristics** (such as gender, age and ethnicity), **cultural sensitivity** and the **language in which therapy is delivered** were considered important for improving IAPT treatment delivery for people from minoritised ethnic groups, and not having them in place creates barriers to access.

The views that emerged in the focus groups align with recommendations made in the PPG, which advocates for changes to how treatment is offered (for example, offering flexibility around timing of appointments, location of treatment and sessions held remotely versus face-to-face), developing culturally adapted/responsive therapies, and training and supervision for staff. Therapists identified several further key **challenges and barriers, and ways they could be overcome**, such as:

- Providing interventions in other languages for people whose first language is not English – could be overcome by **recruiting multilingual therapists**. Services providing care in areas with a wide range of languages should ensure translation and interpretation services are provided for key groups
- The presence of an interpreter or using a different interpreter mid-treatment can affect the therapeutic dynamic – could be overcome by aiming to **use the same interpreter as much as possible**, informing that interpreter about IAPT services and ensuring there are good links with interpreter services
- Translation services can need more time – could be overcome by ensuring there is adequate **time to allow for access to translation services** and offering alternative methods of support to people while they are waiting.

General issues that affect but are not limited to people from minoritised ethnic groups were: accessibility of treatment sessions during the working day (overcome by offering flexibility around the time that appointments can be offered), and the resource-intensive nature of face-to-face appointments (overcome by ensuring there is flexibility in the format treatment is delivered in and its frequency; for example, providing every other treatment session face-to-face, if appropriate for the person).

Other findings from the focus groups are that **recommendations from the PPG could be implemented better and with greater consistency across services**. There was general consensus that the PPG is helpful and should be adhered to, but that it was challenging to do this meaningfully because of time and resource constraints.

For people using IAPT services, other key themes were therapist characteristics and practical aspects of the service. For IAPT therapists, other key themes were treatment offered and training and supervision.

For full findings of focus group discussion on treatment delivery see *Appendix 2.2.2.* (people using IAPT services) and *Appendix 2.3.2.* (IAPT therapists), and *Appendix 2.4.* for similarities and differences across focus group feedback.

4.1.3. The service

The key theme that emerged across focus groups was **service resource**, described by people using IAPT services as 'practical aspects of the service'.

On diversity in IAPT services, the PPG suggests that services should not automatically assign staff from minoritised ethnic backgrounds as diversity leads. The PPG also suggests that services should not make assumptions about people's capabilities to advocate for diversity. Such assumptions and assignations can hinder promotion and leadership opportunities outside of this remit. However, the IAPT therapist focus groups said that this often occurs, with such staff having to take the initiative to welcome, lead on and promote diversity opportunities.

Challenges and barriers to implementing recommendations from the PPG were identified by IAPT therapists as:

- Expectations that all staff should engage in outreach work, making building trusting relationships with communities more difficult and taking time away from delivering treatment
- High workloads reducing staff's time for outreach and improvement work
- Adaptations taking extra time to prepare for and introduce the recommendations
- Extra time not always given for interpreters/translation.

For full findings of focus group discussions of the service, see *Appendix 2.2.3.* (people using IAPT services) and *Appendix 2.3.3.* (IAPT therapists), and *Appendix 2.4* for similarities and differences in findings across focus group feedback.

4.1.4. Suggested changes and improvements for IAPT services

In the focus groups, dedicated time was allocated for participants to suggest changes and improvements to IAPT services that would reduce inequalities in access, treatment and outcomes. Both groups were asked the same question, and had different views on potential changes and improvements to IAPT services. This is likely because of differences in their perspectives, priorities and needs.

The **key themes** from people using IAPT services were:

- **Education and training** for staff, on the needs of the population served
- **Therapist characteristics** such as ethnicity, age and gender, that match the preferences of the person receiving treatment may be beneficial for some people
- **Information provision** on what IAPT services offer and what people can expect from them
- **Language used to describe the service** including the term 'IAPT', clinical language and cultural differences in language to conceptualise mental health
- **Involvement of people with lived experience** in IAPT services
- **Links with community partners** or organisations, to promote IAPT services in underserved communities and support appropriate pathways into care.

Themes from IAPT therapists were **targets and key performance indicators, diversity monitoring and integrating feedback**.

As can be seen from the key themes above, the people using IAPT services emphasised previously made points about access, treatment delivery and the service.

The points made by IAPT therapists about changes and improvements for minoritised ethnic groups align broadly with the PPG recommendations. The PPG acknowledges that extra time (50–100%) or sessions may be needed when working with interpreters and for community work. This could impact the achievement of targets and key performance indicators, but re-evaluation of these is beyond the scope of this project, though local staff and services may be able to address this.

More detail on the suggested changes and improvements can be found in *Appendix 2.2.4* (people using IAPT services) and *Appendix 2.2.4.* (IAPT therapists).

4.2.   Limitations of the focus groups

Many attendees had participated in other focus groups. This could bias some people to be more confident speaking in groups and thinking critically about topical issues.

We did not ask therapists about their experience of providing care as a therapist from a minoritised ethnic background. This was beyond the scope of the work, but it came up in one therapist focus group and several participants identified as belonging to a minoritised ethnic group. We may not have gained a full picture of therapists' views on their own backgrounds as time was not built in for such discussions.

To take part, participants needed access to the Internet or a stable phone connection, which may have excluded some. Digital exclusion can skew the representation in a sample, and can be tackled by offering both online and in-person focus groups, though to do so requires time and resource.

Our design may have been limited if people using IAPT services felt uncomfortable or anxious being in a group setting. One-to-one interviews could be more inclusive and accessible, but would require additional time and resource.

5. Surveys of IAPT clinical leads and commissioners of IAPT services

Two online surveys were co-produced with patient and carer representatives, one for IAPT clinical leads and one for commissioners of IAPT services. The methods used to develop the survey and the survey questions can be found in *Appendix 3.1.* to *Appendix 3.3.*

From the surveys, we aimed to gain an understanding of:

- Service strategies for improving access, experience and outcomes for people from minoritised ethnic groups (including those put in place since the publication of the PPG) and the data available to evaluate effectiveness of the strategies
- The use of data by services to inform treatment delivery for current or future users of IAPT services from minoritised ethnic groups
- The level of co-production and community engagement in the service
- Challenges and barriers associated with changes to IAPT service provision to reduce ethnic inequalities
- Clinical leads' and commissioners' knowledge and familiarity of the PPG.

Surveys were promoted through social media, 'word-of-mouth' and in the focus groups run with therapists. Data was collected between 1 June and 5 July 2022.

5.1. Summary of findings from the surveys

5.1.1. Summary statistics

Clinical leads (n=41) and commissioners (n=11) responded to the survey. Table 8 and Table 9 show the respondents by region. See also *Appendix 3.4.* for bar graphs of the data.

Table 8: Clinical lead respondents by region (N=41)

Region	n
East of England	2
London	8
Midlands	4
North East and Yorkshire	4
North West	14
South East	3
South West	6

Table 9: Commissioner respondents by region (N=11)

Region	n
East of England	1
London	2
Midlands	1
North East and Yorkshire	3
North West	2
South East	1
South West	1

5.1.2. Knowledge and implementation of the IAPT Black, Asian and Minority Ethnic Service User Positive Practice Guide

Survey respondents were asked a series of questions about their knowledge and implementation of the PPG in their service.

Clinical leads rated their knowledge of and familiarity with the PPG higher than commissioners. More than half (55%) of clinical leads rated their knowledge of the PPG as 'good' or 'excellent'. Interestingly, 0% of the 11 commissioners reported 'good' or 'excellent' knowledge of the guide, though they all reported that the PPG was being implemented in their service, and 40% had 'little to no knowledge'.

Over half (56%) of clinical leads and over one-third (36%) of commissioners reported that the PPG had been implemented 'moderately well' in their service. More than half (55%) of commissioners rated it as being implemented 'slightly well' and 0% 'not well at all'. Given that none of the commissioners rated their knowledge of the PPG as 'good' or 'excellent', it may be that most were unable to say that it was implemented very or extremely well. We assume that the respondents who said that the PPG was implemented are those who rated their knowledge as 'fair' or 'minimal'. Despite coming from a very small sample, this finding is disappointing and unacceptable, demonstrating a gap in knowledge on the part of the commissioners surveyed.

55% of clinical leads surveyed rated their knowledge of the PPG as 'good' or 'excellent'.

In comparison, **0% of commissioners surveyed** rated their knowledge as 'good' or 'excellent'.

See *Appendix 4.3.* for responses to survey questions about the PPG.

Clinical leads and commissioners provided further comments in a free-text box. Responses indicated varying levels of staff involvement, with services being at different stages in PPG implementation mostly due to resource, time and capacity constraints. Some respondents indicated that the guide has not been adopted in its entirety, or that resources needed to be put in place before implementing the recommendations.

Examples of aspects of the PPG that were identified included the use of the PPG-recommended audit tool, the creation of groups (such as an anti-racism group and a Black, Asian and minoritised ethnic working group), and use of the PPG in training and CPD. Some respondents also noted that their workforces reflected the diversity of local populations.

Respondents felt there were areas that could be improved on and progress to be made, with some stating that it was the responsibility of individuals (such as 'BAME [Black, Asian and minority ethnic] Champions') to implement certain parts of the PPG and clinicians did not have up-to-date information on how much progress was being made. Different responses to questions about the PPG included people not having used or heard of it, that its concepts were too vague and that there were barriers (such as not having enough time) to implement it.

See *Appendix 3.4.1.* for tables of the responses to survey questions about knowledge, familiarity and implementation of the PPG.

5.1.3.   Use of ethnicity data and data quality

About half (49%) of clinical leads reported that they had a 'very good' understanding of how the service uses data on ethnicity, compared with just 9% of commissioners. However, 73% of commissioners responded that their knowledge of how the service used ethnicity data was 'fair'.

All clinical leads reported their service's ethnicity data as being collected 'consistently' or 'extremely consistently'. There was a range of responses from commissioners, with 36% rating their service's ethnicity data as being collected 'neither inconsistently nor consistently'.

In terms of the quality of the ethnicity data collected by IAPT services, just over half (54%) of clinical leads and just under half (46%) of commissioners rated the quality as 'high', and 34% and 36%, respectively, rated it as 'adequate'. Both clinical leads and commissioners reported that ethnicity data are used 'moderately well' to understand the needs of people from minoritised ethnic groups.

See *Appendix 3.4.2.* for tables of the responses to survey questions about ethnicity data and data quality.

5.1.4. Strategies to support access

Clinical leads and commissioners were asked what strategies their services had in place to support better access for people from minoritised ethnic groups apart from implementing the PPG. They were invited to give illustrative examples of the strategies, and reported that some of the examples were works in progress or had been impeded by the COVID-19 pandemic and restrictions. **Strategies involving staffing and workforce** were:

- having appropriate training aimed at increasing understanding and delivering adapted/culturally appropriate therapies
- employing specific members of staff to drive change, or nominating 'BAME Champions'
- creating staff working groups that focus on improving access for minoritised ethnic communities.

Other strategies considered important for increasing access included **connecting with VCSE groups and organisations** that can give advice. **Creating targeted or translated information and marketing materials** (and promoting them using social media, websites and other ways that reach specific minoritised ethnic groups), and **using translated materials and interpreters** in services were also considered important.

Most clinical leads and commissioners reported having a number of strategic components in place to support better access and mitigate access challenges for people from minoritised ethnic groups. Both reported mapping the ethnicity of the local population.

For clinical leads, these other strategies included:

- Providing information about the service in languages used by the local population
- Having information about services that was co-produced with service user and community representatives
- Staff having access to materials and resources to support adapted therapy.

For commissioners, these other strategies included:

- services being held to account by the CCG (now ICB), to ensure they meet the needs of minoritised ethnic groups
- The CCG (now ICB) ensuring there are resources for outreach work with minoritised ethnic communities
- Language translation (such as translated resources and access to interpreters) being provided and funded.

Interestingly, **neither commissioners nor clinical leads explicitly discussed using local data** as a tool to support better access.

Co-production of information was rated the least implemented strategy by clinical leads, with just over one-quarter reporting having adopted this strategic component. For commissioners, ensuring availability of funded outreach work was rated the least implemented strategy. However, it is important to note that these views conflict with reports of increased co-production and outreach work being undertaken by many mental health services. See also <u>Section 5.1.6.</u> for more discussion of co-production.

See *Appendix 3.4.3.* for tables of the responses to survey questions on strategies to support access.

5.1.5. Culturally sensitive interventions

On a scale of 1 ('Extremely poor, not available') to 5 ('Extremely good, readily available'), the majority of clinical leads rated the availability of culturally adapted therapy[o] as 'Fair' (44%) or 'Good' (10%), but a significant proportion rated it as 'Poor' (27%) or 'Extremely poor' (20%).

On the availability of 'culturally responsive therapy'[p] in their service, the majority of clinical leads gave a rating of 'Fair' to 'Extremely good' (77%). *Appendix 3.4.4.* presents bar graphs of all clinical lead ratings for the questions.

Clinical leads could give examples of other strategies for 'cultural adaptation' in a free-text box. Some examples were given, but answers were less concrete, poorly integrated and less detailed than those about increasing access for minoritised ethnic groups.

Some suggestions of strategies were to:

- better use 'BAME Champions' to address some of the PPG recommendations (such as outreach into communities)
- allow extra time when needed (for example, to support people using an interpreter or for whom English is not their first language)
- offer staff the opportunity to work with and learn from specialist community services to improve cultural awareness as a specific training exercise.

Clinical leads acknowledged that there was room for improvement in training. One respondent expressed the view that core IAPT training did not support cultural competence skills enough, often leaving it up to individual organisations. This can depend on the service staff and whether or not ideas from staff are enacted after they leave the service.

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[o] From the PPG, '*Culturally adapted therapy takes an existing therapy as a starting point and then specifically adapts the language, values, metaphors and techniques of that approach for a particular community. The adaptation and provision of this therapy is typically carried out by therapists who are members of that community. This ensures that the work is done by staff who have an inside knowledge of the language, values and beliefs of that community.*'
[p] From the PPG, '*Culturally responsive therapies may be more helpful for teams which do not reflect the ethnic composition of the communities served. [...] This approach means that therapists are able to recognize and value diversity and draw on the support of team members and supervisors to make adaptations to evidence-based therapies, so that they will fit with the particular culture and context of the service user.*'

5.1.6. Organisational-level adaptations

Percentages of clinical leads and commissioners who agreed with certain statements about organisational-level adaptations that were implemented in their services are shown in Table 10 (and presented in a bar graph in *Appendix 3.4.5.*).

Table 10: Percentage of clinical leads and commissioners agreeing with statements about organisational-level adaptations in their services

	Clinical leads (%)	Commissioners (%)
The service enables service users to access therapy via several different routes/pathways (that is, there is more than ONE access route such as self-referral or GP)	95	73
The service is flexible in offering treatment sessions at different times of day if needed (for example, outside of office hours)	98	64
The service is flexible in offering treatment sessions of different lengths (for example, 30 minutes, or 1 hour, or 90 minutes, and so on)	90	36
The service offers service users the option of having face-to-face or remote therapy sessions	98	82
The service offers the provision of treatment in different locations other than the clinic (for example, at locations in the local community such as community halls, places of worship, and so on)	63	45
The service/organisation does specific and targeted outreach work with communities at risk of inequality	56	55

Many clinical leads and commissioners noted that while progress in making organisational and service adaptations had been impeded by the COVID-19 pandemic, efforts were underway. Such adaptations included changes at staff level (for example, 'BAME/Culture, Ethnicity and Diversity Champions' and 'BAME/Equality, Diversity and Inclusion networks'), with one person saying they had appointed a 'BAME Representative' at board level.

Other service adaptations included specific and targeted outreach work, such as offering services in multiple locations and setting up an engagement forum for people using IAPT services that can reach people from communities at risk of inequality. Respondents also cited changes to process, for example having a standard question at assessment that asks about identity (gender, sexuality, ethnicity, disability and so on) and changing the opt-in policy for people who need an interpreter.

Community engagement strategies

Almost half of clinical leads (44%) and commissioners (45%) agreed that there were regular co-production and community engagement strategies in place in their service or CCG.

The co-production opportunities that were described included forums, meeting groups and online platforms, helping to explore challenges to access, and co-developing leaflets or co-producing service developments.

Community engagement strategies included visiting organisations, places of worship or local community centres, and holding events such as drop-ins in the community to promote the service, deliver tailored workshops and engage underrepresented groups.

Respondents answered 'No' if schemes were in the planning stage or a work in progress, if there was room for improvement (for example, integrating the work into staff training) or if the schemes were irregular. Some respondents said that more community engagement work was being carried out pre-pandemic and COVID-19 restrictions had delayed progress. Some were hoping to re-establish work (such as an associates programme for people who have used services to become involved in service provision/development).

Clinical leads were asked to indicate their agreement with a series of community engagement strategies in place for people from minoritised ethnic groups in their services. Commissioners were asked to indicate which of the strategies were in place in the IAPT services that they commissioned. See Table 11, and see *Appendix 3.4.6.* for bar graphs of the survey results on community engagement.

Table 11: Percentage of clinical leads agreeing with, and commissioners having in place, certain community engagement strategies for people from minoritised ethnic groups

	Clinical leads (%)	Commissioners (%)
There are workshops on mental health and accessing support held with local Black, Asian and minoritised ethnic communities	34	36
There are participation groups that involve stakeholders who reflect the ethnic composition of the population served	29	55
There are stakeholder groups which include organisations that reflect the ethnic composition of the population served	27	45

In a free-text box, respondents could describe other strategies their services used to engage with communities. Community engagement strategies included discussions, events and feedback through community engagement platforms. Community engagement was often organised or facilitated by people in specific community outreach roles or teams. Outreach work was often carried out using the radio or local media. However, respondents noted that recently this work was being carried out less often and needed to be developed.

Services' collection of data on experience of care

Almost all (98%) clinical leads and over half (55%) of the commissioners reported having methods in place to collect data on experiences of care and treatment. Methods included feedback tools (such as the PEQ and the Friends and Family Test) and other quantitative surveys.

Respondents who reported not having data collection methods in place were either still developing the data collection or needed more resources, and that targets for PEQ returns would be helpful when collecting feedback.

The feedback tools were routinely administered post-assessment and post-therapy by clinical leads, on discharge forms and by text message or in social media posts. Other methods were focus groups, advisory groups, case studies and peer wellbeing workers (who helped with research studies, such as on the evaluation of new service developments).

5.1.7. Workforce and staffing

Almost half (46%) of clinical leads and over one-third (36%) of commissioners 'agreed' that in their IAPT services the clinical staff group broadly reflected that of the population served. However, just over one-third of clinical leads (34%) and commissioners (36%) 'disagreed' or 'strongly disagreed' with this statement. See *Appendix 3.4.7.* for the full responses to these survey questions.

Almost all (93%) clinical leads and almost half (46%) of commissioners 'agreed' or 'strongly agreed' that staff from minoritised ethnic groups have the same access to CPD and career development as White British staff. The other half of commissioners 'neither agreed nor disagreed' about equal CPD and career development opportunities. This contrasts with reports from staff, and could indicate a lack of true awareness of CPD access inequalities experienced by staff from minoritised ethnic groups.

Almost two-thirds (63%) of clinical leads 'agreed' or 'strongly agreed' that development for staff from minoritised ethnic groups was guided by the [Workforce Race Equality Standard](). Just over one-third (34%) of clinical leads and almost two-thirds (64%) of commissioners indicated that they 'neither agreed nor disagreed'. The remaining third of commissioners 'agreed' or 'strongly agreed'. See *Appendix 3.9.* for the full responses to these survey questions.

Over two-thirds (70%) of commissioners either 'agreed' or 'strongly agreed' that the senior staff group reflected the ethnic diversity of the community served. There was a greater range of results from clinical leads: 39% 'agreed' or 'strongly agreed', while a further 32% indicated that the senior staff group did not reflect the include ethnic diversity of the community served.

5.1.8. Resources and funding to address inequalities

Almost half of the commissioners (45%) reported that there were no resources or funding for addressing ethnic inequalities in their service, while just over one-quarter (27%) said that the services did have dedicated funding or were not sure. Clinical leads' awareness of allocated resources or funding for addressing ethnic inequalities in IAPT services was split evenly, with about one-third being aware, one-third being unsure and one-third responding that there was no allocation of resources.

Of the clinical leads and commissioners who did not know of or think there was any dedicated funding, 37% of clinical leads and 11% of commissioners responded that additional resource or funding was needed to address ethnic inequalities. See *Appendix 3.4.8.* for the full responses to these survey questions.

In a free-text box, clinical leads and commissioners were able to detail how resources and funding for addressing ethnic inequalities in IAPT services were allocated. Funding was described as having gone towards:

- staffing (for example, psychological wellbeing practitioners, 'BAME Champions' or staff who were responsible for addressing ethnic inequalities/supporting people in their roles)
- outreach work (such as establishing outreach schemes or groups, forging relationships with community partners or setting up mentorship schemes)
- creating resource materials
- specialist training
- data analysis.

Clinical leads generally agreed that there was a need for additional resource or funding to address ethnic inequalities, and gave examples of possible actions and suggested uses for funding. These included training, such as:

- on how to increase access
- on how to increase confidence in talking about ethnicity and experiences of racism
- outreach work
- building stakeholder or community partnerships.

However, clinical leads also spoke about feeling that their available time and funding was too limited, while commissioners reported that additional funding was not needed because the work was already being undertaken. There was a marked contrast between commissioners' and clinical leads' responses to this question, with clinical leads expressing a need for funding and commissioners indicating that it was not required.

5.1.9. Challenges and barriers to addressing inequalities

Commissioners were asked if there were any challenges or barriers associated with changing IAPT service provision to reduce inequalities and implementing the PPG. The greatest barrier, according to 82% of survey respondents, was **staff/workforce shortages**. This was followed by **poor quality data/information on specific inequalities** and the people affected by them, which just over half (55%) of commissioners agreed with. See *Appendix 3.4.9.* for the full responses to these survey questions.

5.2. Discussion

It is positive that clinical leads generally had good knowledge of the PPG and that aspects of the PPG have been implemented (such as the use of the audit tool and forming anti-racism groups). However, there is a need for more national consistency in PPG implementation given the limited knowledge of the PPG by commissioners.

Clinical leads reported having good understanding of their service's data use on ethnicity, and consistent collection of quality ethnicity data. However, based on their survey responses, services should consider improving the quality of information gathered on specific and intersectional inequalities and their impacts.

Staff should have access to co-produced materials and resources to support culturally sensitive therapy that improves access for people from minoritised ethnic groups. Other strategies include:

- provision of appropriate training (to improve understanding and delivery of culturally sensitive therapies)
- nominating 'BAME Champions'
- creating working groups.

There is evidence to suggest that organisational adaptations can provide additional benefit to people from minoritised communities.[6] Services should consider further developing culturally appropriate pathways into care in collaboration with local community organisations.

5.3. Limitations of the surveys

We did not get many responses to the surveys (clinical leads, n=38: commissioners, n=10). Given the scale of IAPT services in England, the number of respondents do not reflect the national picture.

6.   Rapid literature review

The aim of the rapid review was to explore how access and outcomes vary by ethnicity in IAPT services, and to identify any factors that might be associated with ethnic inequalities in access to and the outcomes of IAPT services.

The method (including the review protocol, full search strategy, data extraction, descriptive data), and article inclusion and exclusion criteria are provided in *Appendix 4.*

6.1.   Summary of findings from the literature review

6.1.1.   Published literature

The published studies included in the literature review are summarised in Table 12, with the most recent studies first. Further detail on the included studies is provided in *Appendix 4.*

Table 12: Published studies included in the literature review

Study ID (author/year) • Study design	Study characteristics	Variation in access and outcomes between ethnic groups: areas explored	
		Access	**Outcomes**
Quantitative studies			
Bhavsar2021[16] • Cohort study	**Sample size:** *n*=1,455 **Participants:** Aged 16+ 52% women **Setting:** South East London IAPT services	**Referral and pathways into care** Found strong evidence for a significantly lower rate of GP referrals for the most recent migrants. **Appointments and treatment attendance** People who had recently migrated were less likely to attend IAPT services than people who had lived in the UK for more than 20 years.	Not reported (NR)
Buckman2021[17] • Retrospective cohort study	**Sample size:** *n*=20,293 **Participants:** Aged 18–25 Young adults whose episodes of care were in 8 participating IAPT services between 2008 and 2020 **Setting:** London IAPT services	**Assessment and treatment attendance** Comparison of outcomes of IAPT treatment for young adults not in employment, education or training (NEET) with outcomes for young adults in work or education. NEET young adults from minoritised ethnic groups were found to have attended more appointments.	**Recovery and improvement** NEET young people from minoritised ethnic groups were more likely to reliably recover and improve (measured using the PHQ-9 and GAD-7) compared with people categorised as ethnically White.
Harwood2021[18] • Clinical data analysis	**Sample size:** *n*=85,800 **Participants:** Aged 16+ 63% women Data from IAPTUS electronic patient database in South London, and referred in 2013–16 **Setting:** IAPT services in South London & Maudsley NHS Foundation Trust	**Referral and pathways into care** Found that people from minoritised ethnic groups ('Black African', 'Black Other', 'Asian', 'Mixed Ethnic', 'White Other' and 'Other') were less likely to self-refer to IAPT than the 'White British' group. **Assessment** Minoritised ethnic groups were less likely to be assessed after referral than White British people. People from Black African backgrounds were most likely to decline a	NR

Study ID (author/year) • Study design	Study characteristics	Variation in access and outcomes between ethnic groups: areas explored	
		Access	**Outcomes**
		mental health assessment (26.5%). People who identified as 'Black Other' had the highest percentage of referrals to non-IAPT services (19%) after assessment.	
Firth2020[19] • Individual patient data analysis	**Sample size:** *n*=2,071 **Participants:** Mean age 43 years 63% women Data from care records in the Northern IAPT Practice Research Network, from patients who attended stress control interventions **Setting:** NHS IAPT services in the North of England	**Appointments and treatment attendance** Linear regression analyses showed age, severity of depression and unemployment were significant predictors of 'adequate attendance' (at least 4–6 treatment sessions). No such significant finding was observed for ethnic group, gender, anxiety severity or size of the group receiving group treatment. 'Adequate attendance' was associated with better outcomes.	NR
Rimes2019[20] • Prospective clinical cohort study	**Sample size:** *n*=132,923 **Participants:** 65% women Patient data routinely collected across IAPT services when people had attended at least 2 treatment sessions between 2013 and 2015, and when outcomes were available **Setting:** All NHS IAPT services in England	NR	**Recovery and improvement** Mixed differences in outcomes between genders were observed when comparing gay or bisexual people with heterosexual people. However, when adjusting for ethnicity, there were no significant differences in treatment outcomes between people from minoritised ethnic groups who identified as gay, lesbian or bisexual and White people of the same sexual orientation.
Delgadillo2018[21] • Cross-sectional survey	**Sample size:** *n*=144 (IAPT services across 180 CCG areas); *n*=6875.26 (workforce size in full-time equivalent units across all surveyed areas)	**Referral and pathways into care** Authors reported that being from a minoritised ethnic group was not significantly associated with the mental health 'access gap', defined by the authors as: '*the percentage of cases that did not*	NR

Study ID (author/year) • Study design	Study characteristics	Variation in access and outcomes between ethnic groups: areas explored	
		Access	Outcomes
	Participants: Workforce and patient data from 144 IAPT services identified from the national register **Setting:** IAPT services in England	*receive treatment, from the wider pool of cases referred for psychological care*'. Workforce size was also not found to be significantly associated with the access gap.	
Green2015[22] • Observational retrospective discriminant analysis	**Sample size:** *n*=7,388 (completed therapy *n*=4,393) **Participants:** Historic data from people who attended community mental health services providing psychological therapies between 2009 and 2012 **Setting:** 2 London IAPT services	NR	**Recovery and improvement** Explored individual and treatment factors affecting clinical outcomes of psychological therapy through the development of predictive models. Analyses indicated that ethnicity, anxiety and depression severity, deprivation and gender were pre-treatment predictors of recovery.
Brown2014[23] • Cross-sectional analysis	**Sample size:** *n*=4,781 (Southwark IAPT services), *n*=852 (South East London Community Health Study) **Participants:** Aged 16+ People using Southwark IAPT services, sourced via IAPTUS (digital care records), compared with a sample of South East London Community Health Study survey participants **Setting:** IAPT services in South London	**Referral and pathways into care** Authors reported a higher proportion of GP referrals to IAPT for people from 'White Ethnic Backgrounds' compared with the 'Black African' group. However, authors found no significant differences between ethnic groups in terms of self-referral to IAPT.	NR
Evans2014a[24]	**Setting:** 23 GP practices in Ealing, London, of which 6 incorporated mental health link workers	**Referrals and pathways into care** Authors observed that when services used practice-based staff as link workers, people from minoritised ethnic groups had a	NR

Study ID (author/year) • Study design	Study characteristics	Variation in access and outcomes between ethnic groups: areas explored	
		Access	**Outcomes**
• **Observational study (natural experiment)**		higher base referral rate compared with services without link workers. **Adapting treatment and services** Findings suggest that implementing systems for collaboration and information-sharing in the service, between mental health practitioners and primary care GP staff (link workers), can increase IAPT referrals of people from minoritised ethnic groups.	
Evans2014b[25] • **Observational study (natural experiment)**	**Setting:** 23 GP practices in Ealing, London, of which 6 incorporated mental health link workers	**Adapting treatment and services** The authors reported that adapting service provision by employing link workers contributed to improved referral and access rates for people from minoritised ethnic groups. Effects continued for 18 months after the first pilot link worker was introduced.	NR
Clark2009[26] • **Observational prospective cohort study**	**Sample size:** n=1,654 (Doncaster); n=249 (Newham) **Participants:** Aged 18+ 65% women (Doncaster); 60% women (Newham) Patients seen for at least 2 treatment sessions **Setting:** 2 IAPT pilot sites in Greater London and South Yorkshire	**Referral and pathways into care** Published very early in the development of IAPT services, this study explored treatment outcomes from the Newham IAPT pilot site. Authors reported on the association between ethnicity and both self-referral and GP referral to IAPT, noting that people from Black ethnic groups were more likely to self-refer than to be referred by a GP.	**Recovery and improvement** This study did not find any significant association between treatment outcomes and ethnicity in the Newham site and concluded that recovery rate outcomes (changes in GAD-7 and PHQ-9 scores) were not significantly associated with ethnicity. Newham has an ethnically diverse population with a significant number of non-English speakers while Doncaster is 96% White.

Study ID (author/year) • Study design	Study characteristics	Variation in access and outcomes between ethnic groups: areas explored	
		Access	**Outcomes**
Qualitative studies			
Yasmin-Qureshi2021[27] • **Qualitative study using semi-structured interviews**	**Sample size:** *n*=10 **Participants:** Aged 20–53 100% women Participants from Pakistani, Bangladeshi or Indian ethnic backgrounds, who currently attend or recently completed psychological therapy using the IAPT model **Setting:** Psychological therapies services using the IAPT model across NHS trusts in London and the West Midlands	**Referral and pathways into care** Participants perceived a reluctance in GPs to make referrals to psychological therapy. **Waiting time** Participants reported that a long wait for treatment can have a negative impact and may push people to develop coping mechanisms to deal with their symptoms. **Health promotion and mental health awareness** Stigma and shame were themes in the interviews. **Adapting treatment and services** Location of services was deemed significant, in particular for there to be several options for where people could go for treatment, and using interpreters reduces language barriers in access and engagement. When culture and religion are not included in the therapeutic process, people felt that the helpfulness of treatment was impacted.	**Patient experience** Participants reported on how the perceived lack of cultural and religious awareness impacted their experiences of treatment.
Jackson-Blott2015[28] • **Qualitative study using semi-structured interviews**	**Sample size:** *n*=8 **Participants:** Aged 17–50 (mean age 35) 50% women Asylum seekers who completed a 4-week group-based low-intensity intervention	**Adapting treatment and services** Some participants found that changing the location of the service was helpful, especially when the course venue was familiar and in their community, because they felt more 'comfortable' and 'secure' in attending. Similarly, familiarity with people	**Patient experience** Developing helpful coping techniques and more resilience after treatment were 2 positive reported patient experiences. Participants also spoke positively of increased social contact and reduced feelings of isolation.

| Study ID (author/year) • Study design | Study characteristics | Variation in access and outcomes between ethnic groups: areas explored | |
		Access	Outcomes
	Setting: The 'Least Intervention First Time' service, a treatment in the IAPT programme in Swindon	running the course was considered a positive by some participants. **Health promotion and mental health awareness** Stigma and shame were common themes in interviews. This study highlighted the importance of increasing engagement (through health promotion) and mental health awareness (making use of signposting methods, including posters and letters, and by giving information directly to people in more underserved communities).	
Loewenthal2012[29] • Qualitative study using focus groups	**Sample size:** Aged 50+ years: Bengali-speaking participants (n=14) Aged 40+ years: Urdu-speaking participants (n=21); Tamil-speaking participants (n=18); Somali-speaking participants (n=24) **Participants:** 2 focus groups, each with participants from all four language-speaking groups **Setting:** IAPT and other NHS services	**Health promotion and mental health awareness** The study explored experience and perception of mental health treatment. Stigma and shame were discussed by focus group participants, especially perceptions of strength and how seeking help can be perceived as weak which can delay help-seeking. Implications for IAPT services pertain to availability of culturally sensitive psychological programmes which could be made more relevant for underserved communities. Education at a community level was suggested as a way to promote services and reduce stigma.	NR

6.1.2.   Grey literature

The grey literature included in the literature review are summarised in Table 13, starting with most recent studies. More detailed information on the included studies is provided in *Appendix 4.*, which includes information about the variation in access and outcomes for different ethnic group categories.

Table 13: Grey literature included in the review

Study ID (author/year) Note on source • Type of literature	Study information	Variation in access and outcomes between ethnic groups: areas explored	
		Access	**Outcomes**
Baker2021[30] **(House of Commons mental health statistics report)** • Report	Government report on mental health statistics for England outlining referral rates into IAPT services using the national NHS Digital dataset.	**Referral and pathways into care** According to the reports for 2019/20 and 2020/21, people from White ethnic groups made up 85.5% and 83.6% of referrals, respectively. This could indicate that referrals from people from White ethnic groups fell during this time, or it may be an artefact of better data coverage. The report also found that women were more likely to be referred into IAPT services across ethnic groups.	**Recovery and improvement** Statistics from 2019/20, show some improvements in recovery rates across minoritised ethnic groups; however, only people from White ethnic groups had a recovery rate over 50% at this time. By 2020/21, however, people from Black/Black British ethnic groups also had a recovery rate over 50%, demonstrating that the gap appears to be narrowing with time for some minoritised ethnic groups. People from Bangladeshi and Pakistani groups remained less likely to recover than people from White British and Indian groups.
NHSDigital2020 (updated 2021)[31] • Report	NHS Digital report summarising national IAPT treatment outcomes and the changes in improvement and recovery rates since 2015.	NR	**Recovery and improvement** Between 2015–16 and 2018–19, improvement in every ethnic group increased. The smallest increase was in people from White Irish ethnic groups (from 63.5% to 65.5%). In 2018–19, people from White ethnic groups had the highest rate of improvement (68%) and lowest of deterioration (5%), closely followed by people from White other and Chinese ethnic backgrounds (both 6% deterioration). People from Bangladeshi backgrounds had the lowest rate of improvement (60.8%) and the highest rate of deterioration (8.8%). The gap between White and Asian ethnic groups decreased from 6.8% to 4.1%, and the gap

Study ID (author/year) Note on source • Type of literature	Study information	Variation in access and outcomes between ethnic groups: areas explored	
		Access	Outcomes
			between White and other ethnic groups decreased from 7.1% to 4.0%.
Rathod2020[32] (Synergi Collaborative Centre) • Working paper	Paper summarising studies since 2012 that looked at national referral rates by ethnicity, showing changes in referral patterns by ethnicity and regional differences.	**Referral and pathways into care** Authors summarised data from NHS Digital in 2019/20 and reported on increases in referrals for some minoritised ethnic groups, but highlighted regional differences. There were higher referral rates for people from Black Caribbean ethnic groups in Leeds and London (reflecting the national pattern), but in Manchester and Birmingham there were higher referral rates for people from White British and Irish groups. Birmingham and Solihull observed an increase in referrals from 'other ethnic' groups.	NR
Bignall2019[33] (The Race Equality Foundation, Literature review and evidence synthesis) • Report	Review and evidence synthesis summarising rates of recovery by ethnicity and gender reported in the NHS Digital national dataset from 2016.	NR	**Recovery and improvement** Women from White Irish backgrounds had the highest rate of recovery (50.5%), while men from Asian/Asian British Pakistani groups had the lowest rate of recovery (33.5%).
NHSEnglandAnalyticalServices2017[34]	Report on national IAPT outcomes comparing recovery rates from	NR	**Recovery and improvement** In comparing the national recovery rate in 2014/2015 with 2015/2016, an increase was recorded for most ethnic groups apart from

Study ID (author/year) Note on source • Type of literature	Study information	Variation in access and outcomes between ethnic groups: areas explored	
		Access	**Outcomes**
(NHS England Analytical Services & the Equality and Health Inequalities Unit) • Report	2014/15 with 2015/16 by ethnicity.		Chinese (no change), White and Caribbean ethnic groups (slight decrease).[35]
NICE2017[36] (Birmingham Healthy Minds, National Institute for Health and Care Excellence[34]) • Qualitative research	Local report into the Birmingham Healthy Minds initiative, which tackled cultural barriers experienced by people from minoritised ethnic communities in Birmingham. The initiative adapted local IAPT services, creating a culturally sensitive environment in which people's ethnic, cultural and spiritual needs were addressed, to try to increase the number of people accessing treatment. It focused on South Asian migrant communities underserved by local mental health services.	**Adapting treatment and services** Qualitative feedback described multilingual facilitators as helping support people to engage with the service. They learned that cognitive behavioural therapy delivered through IAPT can be successfully adapted and delivered, to increase and maintain engagement of people from minoritised communities, while providing good clinical outcomes.	**Recovery and improvement** Authors reported on recovery rates and gave qualitative data, and found that people from the Step 2 intervention had a 54% completion recovery rate. However, the study did not compare these results with other ethnic groups and focused on a single service that covered one geographical area. **Patient experience** Qualitative findings showed positive changes in participants' outlook and experience of treatment.
Little2015[37] • Audit	Local audit produced for Derbyshire County Council exploring representation of ethnic groups in IAPT treatment in the area.	**Appointments and treatment attendance** Audit showed that White British people were overrepresented in IAPT treatment in the area, while people from minority White,	**Recovery and improvement** The audit found little difference in equity of outcome scores (the number achieving recovery in a population group, divided by the number who completed treatment within a population group having attended at least

Study ID (author/year) Note on source • Type of literature	Study information	Variation in access and outcomes between ethnic groups: areas explored	
		Access	**Outcomes**
		Black, Asian and 'other' ethnic groups were underrepresented. **Health promotion and mental health awareness** The associated report referenced the stigma associated with mental health conditions in some minoritised ethnic communities and recommended that locating IAPT services in venues that offer confidentiality might help tackle this.	2 appointments, ×100) between different ethnic groups.

6.2.   Discussion

Findings from the review align with those from the IAPT data set analysis and qualitative research undertaken for this report. The review suggests that there are ethnic inequalities in IAPT access and outcomes, but that there are likely multiple factors that contribute to them.

Evidence on referral pathways is limited, but there is some evidence to support the development of specific referral pathways or the refining of existing pathways for minoritised ethnic groups.

The review found few studies that discussed cultural sensitivity in detail, but those that did supported the idea that appropriate cultural adaptations can help towards reducing inequalities.

Evidence on appointments and treatment attendance is, again, limited.

Culturally appropriate dissemination of information about mental health conditions may help improve perceptions of mental health, and in turn encourage engagement with mental health services for underserved groups.

6.3.   Limitations of the rapid review

While rapid reviews are fast and efficient for literature searching, the time-limited nature might make them more vulnerable to bias and error.

Several studies that used qualitative methods had very small samples (though a strength of the review is its inclusion of qualitative research). Some (especially older) studies reported missing ethnicity data, which limited their ability to draw firm conclusions about patterns between ethnicity and access or outcomes.

Several studies used ONS census data and ethnicity categories from 2011. An update to the census is under way.

Finally, as is often the case with mental health and psychological research, many studies had a higher percentage of women than men. This highlights the need to explore the experiences of men in future research, especially when reflecting on findings from studies that touched on gender-related perceptions of mental health, stigma and shame that can impact access to treatment.

7. Community engagement – case studies from voluntary, community and social enterprise organisations

To explore good community engagement with and pathways into IAPT services for people from minoritised ethnic groups, recommendations were sought from VCSEs organisations that work closely with IAPT services. These were used as case studies. Five VCSE organisations provided information about their services and how they work with local IAPT services to improve access and engagement for minoritised ethnic groups, describing:

- **How they tackle challenges and barriers**, including:
  - building relationships in the local community
  - building community networks to promote mental health recovery
  - providing information in languages other than English
  - cultural competence training
  - filling the gaps for communities underserved by NHS services

- **How they engage with people**, for example:
  - working with health and social care partners
  - encouraging self-referral
  - targeted promotion and communication
  - free workshops and events to target specific groups

- **How they promote IAPT access and engagement**, for example:
  - actively promoting talking treatments on initial assessment
  - establishing a network of community groups to promote talking treatments in communities
  - making/receiving referrals to/from IAPT services

- **What support they offer**, for example:
  - signposting
  - mental health support during waiting times
  - support with referrals and self-referrals
  - low-level mental health support in the community
  - Islamic-centred therapy
  - debt support
  - support for carers

- **Which roles support communities to access and engage with local IAPT services**, for example:
  - community mental health champions
  - community engagement officers
  - bi-lingual support workers
  - culturally sensitive practitioners
  - translation and interpreter services
  - triage officer, to refer to IAPT services

Information provided by the VCSE organisations about their services is in *Appendix 5.*

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Contributors

NCCMH/UCL project team

Laura-Louise Arundell, Lead Researcher and Developer, NCCMH

Tom Ayers, Director of NCCMH

King Chi Yau, Trainee Clinical Psychologist, UCL

Iyinoluwa Oshinowo, Research Assistant, UCL

Prof. Steve Pilling, Academic and Strategic Director, NCCMH

Dr Rob Saunders, Associate Professor in Mental Health Data Science, UCL

Dr Lade Smith CBE, former Clinical and Strategic Director, NCCMH

Dr Clare Taylor, Head of Quality and Research Development, NCCMH

Hazel Webb, Project Manager, NCCMH

Juliette Westbrook, Research Assistant, NCCMH

Expert advisers

Dr Lorraine Gordon, Consultant Counselling Psychologist, Head of Psychology and Psychotherapy (Southwark), Patient and Carer Race Equality Framework Senior Lead, South London and Maudsley NHS Foundation Trust.

Toni Wilkinson, Clinical Director IAPT/Primary Care Services, Sheffield Health and Social Care NHS Foundation Trust.

National advisers

Abiola Johnson, Patient and Carer Adviser

Satwinder Kaur, Patient and Carer Adviser

NCCMH Equality Advisory Group

Jo Bentley

Ulysses Carbon

Alysha Carter

Shalisha Davis

Hannah Fox

Karen Joseph

Satwinder Kaur

Sarah Markham

Garrick Prayogg

Isaac Samuels

Jerome Sewell

Ben Walford

Special thanks

For contributing to the data analysis:

Dr Joshua Buckman, Acting Professor in Clinical Psychology, UCL

Henry Delamain, Research Assistant, UCL

Dr Jae Won Suh, Research Fellow in Mental Health Data Science, UCL.

For editing:

Nuala Ernest, Senior Editor, NCCMH

For design:

Helen Greenwood, Research and Design Officer, NCCMH

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The authors and contributors declare that there is no conflict of interest.

Terminology and abbreviations

Terminology

Cultural sensitivity, safety and competence

Culturally sensitive care is that which is relevant to service users' needs and expectations while practising cultural safety[38] by considering power relationships and imbalances. This involves considering any attitudes, feelings, experiences or circumstances that may be common to the person's racial, national, religious, linguistic or cultural background. Cultural competence involves responding effectively to all people in a way that preserves their dignity and is respectful, while utilising and valuing differences. It includes being committed to bringing their culture/s into an organisation's policy and practice.

People who use IAPT services

In this report, we say 'people who use services' rather than 'patients', 'clients' or 'service users'. We decided to do this after consultation with lived experience advisers and the NHS Race and Health Observatory team, and discussion in the NCCMH project team. All preferred the term 'people who use IAPT services' because it is inclusive, non-judgemental, more humanising and less hierarchical. In this report, you will find that these terms appear in quoted material, references to other work and the data analysis (for example, discussing the 'IAPT patient data set').

Race and ethnicity[q]

'Race' and 'ethnicity' are often used interchangeably. While there is some overlap, they have different meanings. Race assigns people to 'racial groups' based on perceived shared physical attributes or traits, such as similar facial characteristics and skin colour. Race is a social construct without a biological basis that has been used throughout history to categorise people and inflict notions of superiority of White over non-White. 'Ethnicity' refers to the experiences of groups of people based on shared culture, national origins, religious practices, traditions, language and other factors.

Ethnicity is a preferred and more accurate term because it takes into account the many factors that contribute to a person's sense of identity and community.

Use of 'minoritised ethnicity' or 'minoritised ethnic community/group'

When we say 'minoritised ethnicity', it is to recognise that social processes of power and domination have constructed how different groups of people are perceived. Some ethnic groups might be minorities in the demographics of the

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[q] Adapted from A guide to race and ethnicity terminology and language (The Law Society, 2022).

UK, but are majorities in the global population, so from that wider perspective it is incorrect to say 'ethnic minorities'.

Other common terms about ethnicity[r]

- Ethnic minority
- Racial minority
- Black, Asian and minority ethnic (sometimes abbreviated to BAME or BME)
- People/person of colour (sometimes abbreviated to PoC).

Ethnicity categories in the IAPT minimum data set

The data we have analysed is categorised using the categories in the IAPT minimum data set. There are five high-level categories, and then 16 subcategories. Where we have presented the data in graphs, we have shortened the high-level categories for the sake of space. So, 'Asian or Asian British' is shortened to 'Asian' and 'Black or Black British' is shortened to 'Black'. However, these should be read as the full category, and the data includes people who are Asian British and Black British.

Sex and gender

People using IAPT services are asked to self-report their gender as 'male', 'female' or 'non-binary'. 'Unknown' is used when gender is not reported. The terms used in this report reflect those used in the IAPT dataset, although 'male' and 'female' refer to biological sex rather than gender identity.

Abbreviations

BAME	Black, Asian and Minority Ethnic
CCG	clinical commissioning group
CPD	continuing professional development
GAD-7	Generalized Anxiety Disorder 7-item
IAPT	Improving Access to Psychological Therapies
ICB	integrated care board
ICC	intra-class correlation
LTC	long-term condition
MDS	minimum data set
NCCMH	National Collaborating Centre for Mental Health
NEET	not in employment, education or training
NR	not reported
ONS	Office for National Statistics
PCREF	Patient and Carer Race Equality Framework

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[r] These terms are used only when referring to other existing work or in direct quotes.

PEQ(-A, -T)   Patient Experience Questionnaire (– Assessment, – Treatment)

PHQ-9   Patient Health Questionnaire 9-item

PPG   Positive Practice Guide

UCL   University College London

VCSE   voluntary, community and social enterprise organisation

WTE   whole-time equivalent