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BRIEF CLINICAL REPORT

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

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Abstract

Background: The COVID-19 pandemic highlighted the under-utilisation of statutory mental health care services by minority ethnic groups in the United Kingdom (UK).
Aim: To improve ethnicity reporting to better understand the needs of patients accessing a primary care talking therapies service.
Method: We conducted a clinical audit to observe outcomes from pre-COVID (2019), first wave of COVID-19 (2020) and 2021 for three broad ethnic categories: black African/Caribbean, Asian and white British. Intervention was conducted on staff to improve data recording of ethnicity. A patient survey was sent to those identified as dropped out from treatment from May 2020 to April 2021. A total of 229 patients responded to the survey. The survey asked for reasons that impacted on not continuing with sessions.
Results: Quantitative analysis showed a statistically significant difference on discharge outcome between white British and black African/Caribbean ($p = <0.0001$), with black African/Caribbean patients most likely to drop out of treatment, and in 2020 the Asian population was below the recovery target of 50%. Qualitative analysis revealed therapist factors included lack of confidence in therapist and not being listened to, patient factors included neurodiversity, being unsure whether it would be helpful and confidentiality concerns, and service factors included being notified of discharge from the service, remote delivery of therapy, treatment options, and treatment materials.
Discussions: Services must work towards improving service provision by capturing hidden disparities and socialising treatment to meet the needs of minority ethnic groups in the UK. The present study recommends culturally adapted treatment and co-producing therapy materials.

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

Introduction

The unequal distribution of infection and death rates of the coronavirus (COVID-19) has become a catalyst for the pre-existing racial inequalities in the United Kingdom (UK). Research has shown ethnic minorities are more likely to have negative experiences of healthcare services and worse treatment outcomes compared with their white counterparts (Mead and Roland, 2009). Studies further exposed frequent misdiagnosis, or under-diagnosis of black and minority ethnic individuals when presenting to their healthcare provider, and further reported that symptoms were routinely ignored (Dawn, 2010; Jones *et al.*, 2018).

The aim of the present study is to increase ethnicity reporting on IAPTus, to better understand cultural needs accessing a primary care talking therapy service.

Method

Procedure

The clinical audit was carried out from September 2020 to February 2021, and the analysis of referral rates and discharge outcomes was carried out over a 3-year period. The survey was sent to patients who were offered treatment over the past year, from May 2020 to April 2021. All clinical data from the point of referral to discharge are maintained within a single clinical data system, IAPTus (Mayden, Wiltshire, UK).

Patient survey

A survey was sent to 2145 patients via SMS who were identified on IAPTus as having dropped out from treatment. A total of 229 patients responded to the survey over a 7-day period of the survey being live. The survey asked for reasons that impacted on not continuing with sessions.

Data analysis

A mixed-methods approach was adopted. SPSS (version 27) was used to conduct the quantitative analysis. For qualitative analysis, a conceptual framework of synthesis was adopted. Using the synthesis matrix, each source was critically analysed and rigorously evaluated for major themes, strengths, weaknesses, and critical gaps. Data were categorised using a thematic coding approach. The key themes selected for analysis were discussed with the wider research team based on their relatedness and frequency concerning the review topic.

Results

Quantitative findings

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

British Asian recovery rates were 52.4% in 2018, 51.3% in 2019 and 47.3% in 2020. White British recovery rates were 60.5% in 2018, 59.3% in 2019 and 51.9% in 2020. Black/Caribbean British recovery rates were 54.8% in 2018, 54.5% in 2019 and 53.3% in 2020.

Treatment adherence in 2020 for low-intensity completed treatment were: Asian 38%, white British 34%, and lowest for black African/Caribbean 30%. Treatment adherence in 2020 for low-intensity dropped out (unscheduled discontinuation) highest for the Asian group 14%, white British 11%, and black African/Caribbean 12%. Treatment adherence in 2020 for high-intensity completed treatment for the Asian group was 35%, white British 42%, and lowest for black African/Caribbean 39%. Treatment adherence in 2020 for high-intensity dropped out (unscheduled discontinuation) was: Asian 13%, white British 13%, and highest for black African/Caribbean 19%.

A series of multivariate ANOVAs were conducted with the dependent variables therapy outcome (completed treatment and dropped out) and year (2019/2020) as independent variables, and with outcome and ethnicity as dependent variables. Significant associations were examined further by non-parametric testing (Tukey's *post hoc*). Tukey's honestly significant difference (HSD) test for multiple comparisons found that there was a statistically significant difference on the discharge outcome between white British and black African/Caribbean

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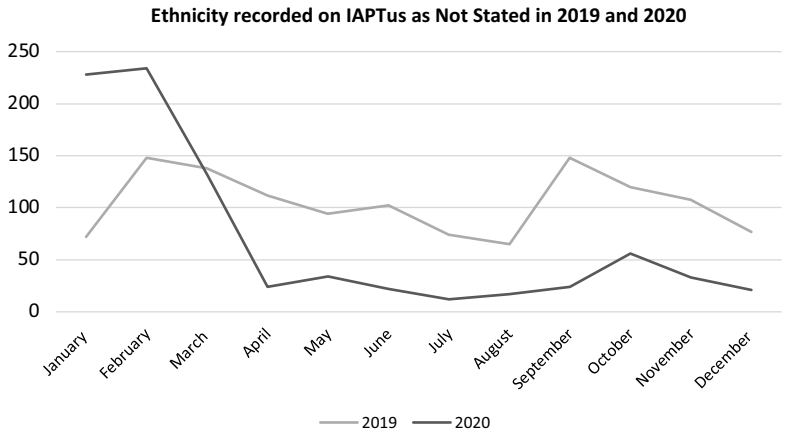

Figure 1. Showing ethnicity recorded as "Not Stated" on IAPTus in 2019 and 2020.

($p = .000$, 95% CI [–.07, .03]). There was also a statistically significant difference on discharge outcome between Asian and black African/Caribbean ($p = .029$, 95% CI [–.13, –.02]). There was no statistically significant difference on discharge outcome between Asian and white British ($p = .065$, 95% CI [.00, .09]).

Qualitative findings

Key themes from the online survey for disengagement were identified as follows.

Neurodiversity

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

Lack of confidence in the therapist

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

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

Not being listened to

Patients also frequently described not feeling heard. One respondent stated, 'the therapist did not listen to me properly during the limited sessions we had, and I did not feel confident they understood my needs or situation'. One patient explained that 'Sessions were very short – often only 20 minutes and some of my concerns or issues felt brushed or explained away and so I didn't feel listened to'. One patient reported that 'the therapist kept yawning and did not seem interested in the session or engaged to listen. Also referenced spirituality, religion several times in an attempt to comfort me. Made me feel worse'.

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Notified of discharge from the service

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

Unsure whether it would be helpful

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

Remote delivery of therapy

The service underwent changes in how we delivered therapy during the COVID-19 pandemic and government-enforced restrictions; alternative options included video call and telephone.

One patient recalled their experience explaining that 'phone talking I felt isn't the same and my anxiety would always be so bad as it would be an early call and just could ignore it easier or be distracted with something else if I was physically there maybe then I would've followed through'. Another patient mentioned that they 'felt weird to talk about difficult things on Zoom'.

Treatment options

The service offers self-guided help either via telephone, group or an online computerised course; the service also offers cognitive behavioural therapy (CBT) and counselling as additional treatment options.

One patient recalled, 'I felt pressured to choose CBT over counselling and it wasn't the right fit for me'. Another patient reflected, 'I dont think the right type of therapy was offered. I was given CBT for my anxiety but for me, trauma is a much bigger problem and that wasn't bring addressed at all'. One patient explained, 'I was only offered group sessions. This is not useful nor did I feel comfortable which I expressed before being referred'. One patient mentioned, 'Did not like the help being offered' and similarly another reported 'I don't like CBT'.

Therapy materials

During treatment, patients are provided with additional therapy materials. Patients reported that 'the material was hard to relate to, I don't think the mood tools workshop was right for what I was dealing with'.

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

Confidentiality concerns

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

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Discussion

Our findings report that black African/Caribbean patients were statistically significantly more likely to drop out of treatment, and in 2020 Asian population was below the target of 50% of patients recovered at the end of treatment. The survey findings revealed that key themes from the survey were neurodiversity, lack of confidence in the therapist, not being listened to, notified of discharge from the service, unsure whether it would be helpful, remote delivery of therapy, treatment options, treatment materials and confidentiality concerns.

A major aspect of self-guided therapy is homework, and often there is an expectation for patients to implement cognitive behavioural techniques outside of the sessions. This perception of requiring the patient to take on an active role may not be expected or familiar to many accessing support, and certainly takes time (Khan *et al.*, 2007). However, this may conflict with the short-term nature of guided-self-help in a primary mental health care setting and relate to disengagement. A possible solution suggested in previous research is providing information on the nature of treatment prior to the start of sessions and this then reinforced by the therapist during the first session (Khan *et al.*, 2007). In addition, although there is growing evidence to support the effectiveness of the use of digitalised therapy for the treatment of common mental health disorders, evidence remains very limited on the long-term impact and its effectiveness on maintaining longer term change in patients (Rauschenberg *et al.*, 2021).

Future recommendations will be to consider cultural consultations among staff to create a space to reflect on how diversity, culture and race might impact our interactions, and use this space to explore ways in which we can culturally adapt treatment and address unconscious bias in practice. Another method of improving service provision is with the involvement of service- users. Services should aim to deliver a service-user forum involving patients who disengaged from the service to help improve service policy, co-produce service materials and address what change can be made to better meet the needs of the local community and represent under-represented voices in service development.

A limitation to the present study is that the data were collected from one service, which may not be generalisable to the wider population. In addition, the analysis used broad ethnic categories; future research should look to better understand the distinct cultural dynamics beyond broad racial categorisation.

Supplementary material. The supplementary material for this article can be found at https://doi.org/10.1017/S1352465823000176

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

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Competing interests. The authors have no competing interests relevant to this article to disclose.

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

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