OLADAPO A. OLAFIMIHAN BSc Hons MSc

UNDERSTANDING INTERVENTIONS AIMED AT DEVELOPING CULTURAL COMPETENCE

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Declaration

I declare the work demonstrated in this document is original and any outside sources that have been quoted or written about have been cited.

Acknowledgement

Thank you to the cultural consultants and the CAMHS team who were so enthusiastic about me doing this work.

Thank you to my two supervisors. It’s been a rocky road, but you’ve stuck with me – I really appreciate all of the support.

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Summary of the MRP

Section A: Research suggests that BAME service users access mental health services less than White British services users; the reasons reported include experiences of stigma and a lack of cultural appropriateness. This systematic review explored research evaluating interventions to improve cultural competence. The findings of this systematic review indicated that these interventions: can be acceptable to ethnic minorities; strengthen relationships with local BAME communities; and, improve clinical outcomes. However, as most studies did not include a comparison group, further research is needed to determine whether these interventions are more effective than treatment as usual (TAU).

Section B: This study explored how NHS clinicians working with embedded cultural consultants experience its impact and its implications for existing theory on the development of cultural competence. Ten participants were recruited who took part in semi-structured interviews about their experiences. The data was analysed using Interpretive Phenomenological Analysis (IPA). The findings suggested that embedded cultural consultation invited clinicians to reflect upon culture in ways that enhanced their cultural competence in line with existing theoretical understanding. The findings also suggested that embedded cultural consultation enables reflection on culture that extend further than the therapy room.

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Abstract

Background: Research indicates that ethnic minorities have more challenging experiences of mental health care; suggested reasons for which include stigma and a lack of cultural sensitivity.

Aim: To carry out a narrative review based on a systematic literature search to synthesise the outputs from research that has explored interventions aimed at improving cultural competence of UK NHS mental health services.

Method: Using the PRISMA method, literature was systemically searched, screened, and selected using inclusion and exclusion criteria. Using quality appraisal tools, selected papers were assessed, following which, a narrative synthesis of the findings was presented.

Results: Eleven studies were found. Types of interventions included: novel group interventions for ethnic minority groups; service development to improve outcomes for cultural minorities; culturally-adapted psychological therapy; and, non-clinical interventions for service improvement. The findings were associated with improvements in the cultural competence of services and BAME service users' experience of mental health services.

Discussion: The review aims were successfully addressed. The findings indicated that interventions to improve cultural competence can be acceptable and effective. However, all studies involved small sample sizes and most did not include a comparison group. Future research should compare adapted/novel interventions with TAU and explore the perspective of clinicians.

Introduction

Prevalence of mental health difficulties across ethno-cultural groups

Amongst the different ethnic groups in the United Kingdom (UK), research suggests that there is a substantial difference in the prevalence of mental health problems. For example, prior research suggests a greater prevalence of anxiety and depression amongst south Asian women (63.5%) when compared with White females (28.5%), along with Black men (3.1%) when compared with White men (0.2%) in England (Weich et al., 2004). Mental health difficulties were found to be more prevalent amongst Irish and Pakistani men aged 35 – 54, when compared to their White counterparts; Black men have been diagnosed with psychotic disorders more frequently when compared to their White counterparts (Rees et al., 2016; Public Health England, 2018). Suicidal ideation is lowest amongst South Asian men; however, anxiety and depression difficulties are higher for South Asian women than women from any other ethnic group (Rees et al., 2016). There is evidence to suggest that Irish Traveller communities are six times more likely to die by suicide than those from non-travelling communities. Research suggests that asylum seekers and refugees are more likely to have poor mental health and are five times more likely to have mental health needs than the general population, due to trauma and violence (Mental Health Foundation, 2016). The Stuart Hall Foundation (2021), an organisation addressing race in inequalities, also makes the case that policy work has tended to undermine the role of ethnicity in significant policies and argues for a greater consideration of the social meaning attached to ethnicity and the socio-economically “determined” nature of health. Additionally, The Kings Fund (2021) acknowledged that ethnic minority groups in particular are disproportionately affected by “socio-economic deprivation”, which is a prominent determining factor of health in all communities. Research indicates that people with a serious mental illness are more likely to experience poverty and to be in precarious employment.

Experiences of mental health services across ethno-cultural groups

Research indicates that there are substantial differences in the prevalence of mental health problems and the ways in which different ethnic groups interact with mental health services (Memon et al., 2016). Research suggests that those from ethnic minorities in England are less likely to contact their GP for mental health support (Morgan, Mallet, Hutchinson et al., 2005). Bhui et al. (2007) reported that Southern Asian individuals experiencing low mood were more often recognised by their GPs as having physiological problems when compared to their White counterparts. There is evidence indicating that Black men are three to five times more likely to be given a diagnosis and hospital admission for schizophrenia than any other ethnic group (Mental Health Foundation, 2019). The women's mental health taskforce review reported that BAME women experienced "cultural naivety, insensitivity and discrimination" when accessing and interacting with mental health services (Department for Health and Social Care, 2018, p. 24). BAME people have been reported to be 40% more likely than their White counterparts to access mental health services via the criminal justice system (Bradley Report, 2009; London Assembly Health Committee, 2017). African and Caribbean men have been reported to be less likely to be identified as having mental health problems or a learning disability upon entry to a prison (Lammy, 2017; Yap et al., 2018). Increasing evidence suggests that African and Caribbean women are more likely to be diagnosed with a common mental health disorder compared to White women (Department for Health and Social Care, 2018).

Madden et al. (2017) found that Eastern European patients (including from Poland, Belarus, Hungary, Latvia, Russia, Slovakia and Ukraine) reported predominantly unsatisfactory interactions with GPs. The findings indicated that a tendency of being encouraged towards self-help or 'waiting to see what happens' by GPs before being referred to specialist services was perceived as 'dismissive' and led to distrust between patients and

GPs. They reported that they were less likely to raise mental health challenges. Yin-Hur and Ridget (2011) reported that being engaged with one's wider families can be a source of resilience in Gypsy, Roma travelling communities; they also reported a lack of culturally sensitive mental health services for people from these communities.

Research suggests that people from ethnic minority groups "report less good experiences than White British people of almost every dimension of GP services" (Stuart Hall Foundation, 2021, p.16). Reports suggest that barriers for BAME groups accessing primary health care have been consistently reported as being "language barriers; lack of interpreters; lack of awareness and information about services, and discrimination" (Race Equality Foundation, 2019; p.18).

The National Audit of Schizophrenia (NAS) reported that Black African and Caribbean service users diagnosed with Schizophrenia were less likely to be offered Cognitive Behavioural Therapy (CBT) than their White counterpart whereas a large proportion of them were prescribed depot medications (Das-Munchi et al, 2018). Asian service users diagnosed with schizophrenia were more likely to be referred to family therapies; and, Chinese service users were more likely to be given a copy of their care plan compared to White English service users (Das-Munchi, et al., 2018). The Race Equality Foundation (2018) raised some concerns about the research methodology, but reported that the study highlights the need for "more research on how cultural factors shape expectations in response to treatment" (p.24) especially in relation to differences in prescribing antipsychotics or talking therapies.

Cruz et al. (2015) reported differences in the proportions of ethnic groups using secondary and tertiary services for Obsessive Compulsive Disorder (OCD) in the South London area. A high prevalence of OCD was present across this population and similar

proportions of each ethnic group were expected to be reflected in recipients of the service. However, the findings indicated that 8.4% of service users were Black, whereas Black people made up 23% of the local population. Following their findings, Cruz et al. (2015) suggested that efforts to increase service sensitivity to various cultural beliefs about mental health and recognising symptoms would improve access to services.

Mental health outcomes across ethno-cultural groups

Research suggests that people in the UK who are from ethnic minority backgrounds have worse health outcomes and face greater challenges accessing healthcare compared to their White English counterparts (Memon et al., 2016). IAPT services have demonstrated increased rates of recovery amongst their service users, however this is not uniform when the service user's ethnicity and faith is considered. Recovery rates were highest for White Irish females (50.5%), but lowest for Asian or Asian British-Pakistani males (33.5%).

Hinton and Lewis-Fernandez (2010) suggest that practitioners should be made aware of how idioms of distress from minority cultures might be interpreted, then consider how this might be communicated according the majority cultural norms. This is because it could risk a misunderstanding of what is being communicated. Increasingly, mental health services have considered the importance of understanding the cultural perspectives of service users as it relates to identifying psychological distress, but also treating it (Kizilhan, 2014). Mind (2013) have commented that services should be commissioned once they have been able to demonstrate sufficient diversity and cultural appropriateness to commissioners.

Cultural competence

'Culture' has been described as "the integrated pattern of human behaviour, that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group" (Cross et al.,1989, p.7).

Individual cultural competence is commonly proposed to consist of three components: cultural knowledge, cultural awareness, and cultural skills or behaviour. In addition, it has been suggested that ‘Culturally competent services’ must have a systemic lens through which to understand how different cultures interact and a readiness to adapt to meet cultural needs (Cross et al., 1989, p.7; Jernigan et al., 2016). A systematic review of the theoretical and empirical literature on cultural competence (Alizadeh & Chavan, 2015) concludes that developing cultural competence is an ongoing process, requiring ‘cultural humility’ (Kleinman & Benson, 2006) and a commitment to continual learning from service users and self-reflection to mitigate bias (Jernigan et al., 2016).

Cultural competence is typically understood as requiring clinicians to take personal responsibility for considering culture when engaging with service users from a different cultural background (Kleinman et al., 2006; Bhui et al., 2007). On the other hand, ‘Structural competence’ requires service providers to examine institutional biases and “structural determinants” of interactions between clinicians and service users, including physical location, working hours. In addition, this ought to consider how illness, health and culture are defined to ensure it adequately meets the needs of the community it serves (Kleinman et al., 1978; Kleinman & Benson et al., 2006; Jernigan et al., 2016).

History of interventions to improve the discrepancy in mental health outcomes between ethnic and cultural groups

1. A pathology model (1970s to 1980s) Moving from placing blame on ethnic minorities to Western public services (hard to reach groups vs hard to reach services)

Previously, attempts to include ethnic minorities in US services used a model that was not about meeting the various cultural needs of the communities. Rather, policies were based on a pathology model where barriers to inclusion were thought of as being due to the

sociocultural characteristics of Black people rather than societal racism (Metzger, 1971). These ideas were eventually admonished, and it was increasingly considered that efforts to improve services should involve understanding and empowering ethnic minority communities (Gary, 1983; Kurtz & Powell, 1987). Whilst the socio-political-cultural makeup of the UK is different to the US, reports of racism and hostility experienced by ethnic minorities who engaged with UK health services during this time (1940s to 1980s); raises questions about how ethnic minorities might have used public health services, as well as how this might have been interpreted by health commissioners (Bivins, 2017).

2. Kleinman et al.(1981; 2006): 'Cultural humility'; 'Patient Centredness'; 'Structural Competence (1990s - Present)

As ideas surrounding cultural competence developed further in the 1990s, the concept of 'cultural humility' emerged, which acknowledges that it is impossible for a person to be fully competent in someone else's culture (Kleinman & Benson, 2006a). This concept remains pertinent within health services, as identified by the systematic review on cultural competence carried out by Alizadeh and Chavan (2015). it encourages a commitment to continual learning from service users and self-reflection to mitigate bias (Jernigan et al., 2016). Alizadeh and Chavan (2015) regard cultural competence as an ongoing process, as opposed to an endpoint, where one's competence can continuously improve over time (Jernigan et al., 2016).

Kleinman et al. (1978) introduced other concepts to support current understandings of cultural competence. This includes; 'patient centredness', which is the focus on service user values and preferences in clinical interaction; the 'golden rule' of treating service users as the provider (themselves) would like to be treated; and, lastly, 'structural competence'. This latter concept highlights the importance of service providers examining institutional

biases and “structural determinants” of interactions between clinicians and service user interactions, which includes physical location, working hours, as well as “definitions of illness, health and culture” (Kleinman et al, 1978; Kleinman & Benson et al., 2006, p.9; Jernigan et al., 2016). It is noteworthy that ‘cultural humility’, ‘patient centredness’ and the ‘golden rule’ are concepts of cultural competence that require clinicians to take personal responsibility to consider culture when engaging with a service user from a different cultural background. However, ‘structural competence’ requires clinicians to examine whether the service is adequately culturally accessible to the community it serves.

NHS England and NHS Improvement have identified several actions to improve the current differences in service user experience between BAME and White British service users by 2023/2024. This includes services seeking out models of positive practice where cultural competence is developed amongst staff teams (NHS England & NHS Improvement, 2020 p.2, 4, 9).

Various service models have been developed to meet this clinical challenge, including having specific mental health services for particular ethnic groups; services with mental health trained translators; and/or staff who work as cultural consultants (Kirmayer et al., 2003; Kizilhan, 2014; Bhui, 2015). Efforts have also included: training; engaging with external groups who specialise in meeting the needs of particular ethnic groups; as well as ‘cultural adaptations’ made to interventions or practice, to more appropriately meet the needs of service users from minority cultural backgrounds.

Aims of the current review

This literature review aimed to synthesise the research literature on interventions seeking to improve cultural competence in UK NHS mental health services. This review focused on research within the UK and NHS mental healthcare to ensure greater homogeneity

between studies. For the purposes of the review, interventions were defined as: efforts made by mental health services to improve the experience of service users engaging with their services; improving service users' experiences of accessing the service; improving wellbeing outcomes of service users; and/or improving clinicians' cultural competence. The review aimed to addresses the following questions:

- How do service users, staff or carers perceive the acceptability and/or feasibility of interventions seeking to improve the cultural competence of UK NHS mental health services?
- How do service users experience these interventions?
- What changes might have been observed/reported in clinicians' cultural competence change following an intervention?
- What changes have been observed in participants' wellbeing following the intervention?

Methods

Design

A narrative review based on a systematic literature searching methodology was conducted to synthesise the outputs from research exploring interventions to improve cultural competence in UK NHS mental health services. This approach assists with "clarity in thinking about concepts and possible theory development" (Coughlan et al., 2007; Henwood & Pidgeon, 2006, p.350). A narrative synthesis was used to examine similarities and differences between studies, assess the strengths of the evidence and summarise the key findings in relation to the review questions (Lisy & Porritt, 2016). Taking this approach can help to identify areas of further exploration in research and any inconsistencies in the literature. A narrative review was chosen in preference to a meta-analysis of literature due to the heterogenous nature of the studies (e.g., the range of outcome measures used). Additionally, the quality of the qualitative data did not lend itself to meta-synthesis and so findings of these studies were also described narratively.

Literature search

A literature search of the electronic databases PubMed, PsychInfo, Medline, Science Direct and ASSIA was conducted in February 2022. As previously mentioned, searches were limited to research conducted in the UK. The following Boolean search terms were used: ((cultural consultation) AND (effect*) AND (mental health service*) AND (intervention) AND (United Kingdom)); ((cultural adaptation) AND (effect) AND (mental health service) AND (intervention) AND (UK)); ((cultural adaptation) AND (effect*) AND (mental health service) AND (intervention) AND (United Kingdom)); ((cultural competence) AND (effect) AND (mental health service) AND (intervention) AND (United Kingdom)); ((cultural consultation) AND (effect*)) AND (mental health service) AND (intervention) AND (United Kingdom).

A PRISMA flow diagram (Page et al., 2021) demonstrates the process from the literature search, to the selection of the final studies included in this review (see Figure 1.). The data

extracted from the literature included their aims, methods, results, and points raised in the respective discussion sections. In addition, the reference lists of the papers identified were also searched for any relevant literature.

Inclusion criteria

Studies were included in the review if they were:

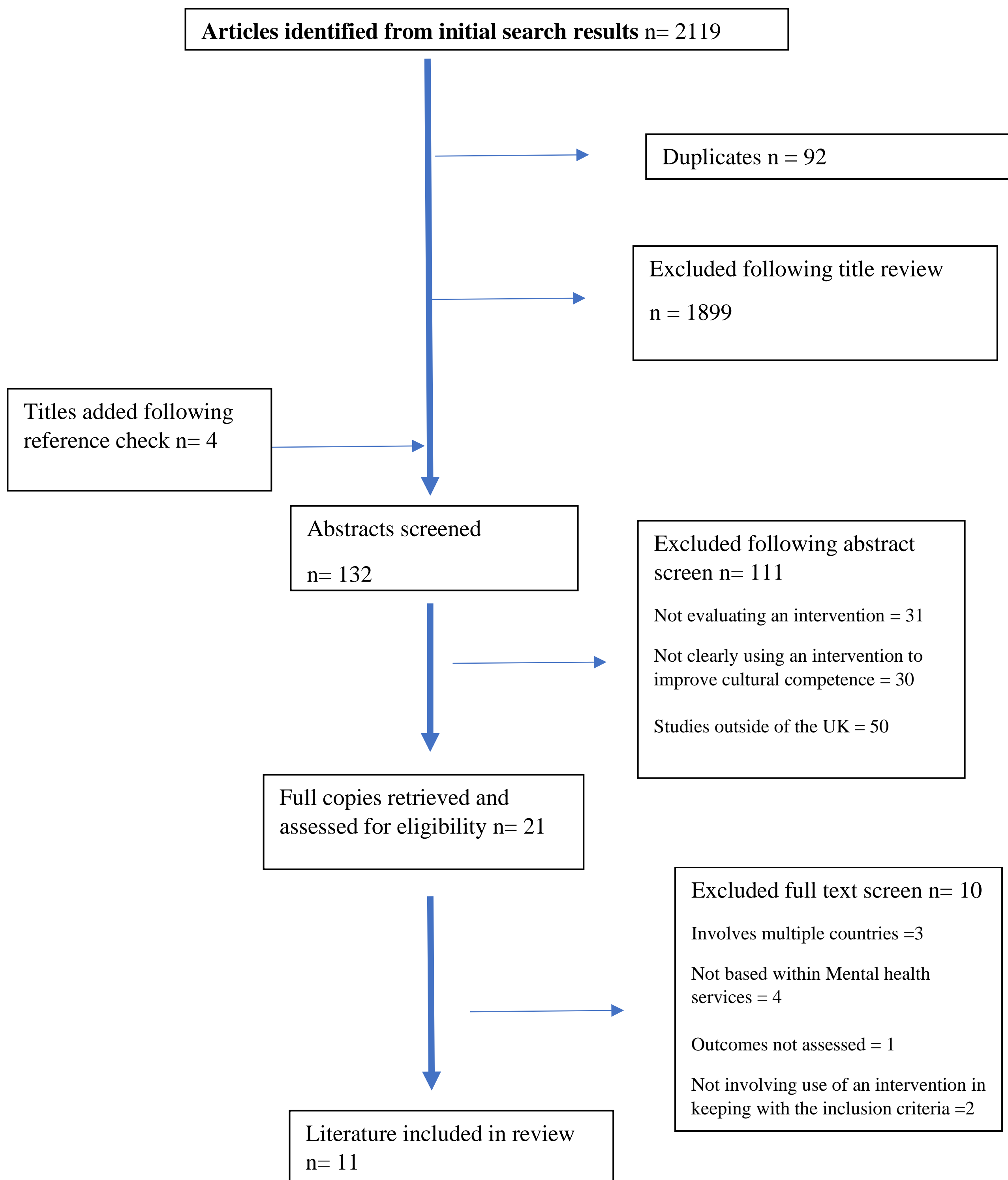
- Research studies or service evaluations published in peer reviewed journals.
- Focused on interventions to improve cultural competence of (clinicians working in) a UK national mental health service, where 'culture' is defined as "the ability to understand, appreciate and interact with people from cultures or systems different from one's own." (DeAngelis, 2015, p65).
- Written in English.

See review aims for further information on how 'interventions' were understood in this review.

Exclusion criteria:

- Research and service evaluation conducted outside of the UK.
- Studies that did not include an evaluation of the intervention aimed at improving the service's cultural competence.

Figure 1. PRISMA flow diagram illustrating the literature search process (Page et al., 2021)



Quality assessment

The NICE public health guidance (3rd edition) quality appraisal checklists for qualitative and quantitative studies were used to appraise the quality of included studies (NICE, 2012; see Appendix H and I). The checklist for quantitative studies consists of 5 criteria rated as: '++' if the study design minimises risk of bias; '+' if not all sources of bias have been fully addressed; '-', if significant sources of bias may persist; 'not reported (NR)' if relevant criteria point had not been reported; and, 'not applicable (NR)' if the criterion was not relevant for the study being appraised.

The qualitative studies checklist consists of 14 criteria and three response options (different for each criterion) as a descriptor for how well the study met each criterion. The methodological critique of the studies included in this review was informed by the quality appraisal of each study based on the (quantitative or qualitative) checklist criteria.

Results

Selected studies

The systematic search identified 11 papers that met the inclusion criteria (Fig. 1). The studies have been separated into subgroups and the details of the studies are provided below (Table 1). The quality assessment of studies is followed by the presentation and discussion of review findings (NICE, 2012).

***Table 1**: Summary of the studies*

No	Study	Aims	Design	Sample	Intervention	Outcome Measures & data analysis	Findings
Novel group intervention for minority cultural group							
1	Chaudhry et al. (2009)	Assessing a culturally sensitive social group intervention for Pakistani women diagnosed with depression.	A single group design, with pre and post tests to measure change in depressive symptoms.	18 Pakistani women.	10-session culturally adapted social group intervention.	Urdu versions of the 'Self Reporting Questionnaire' (SRQ) and 'Schedule for Clinical Assessment of Neuropsychiatry' (SCAN) interview. Analysis:	Mean SRQ score at baseline =15; SD = 3.08; mean SRQ post-intervention =11.7; SD = 5.95, t = p = 0.039. Three participants also reported a reduction in suicidal ideation.
2	Lovell et al. (2014)	Assessing the feasibility and accessibility of a culturally sensitive group wellbeing intervention for ethnic minority service users.	RCT, outcomes measures taken at pre, post and follow up.	57 participants from ethnic minority backgrounds (majority were South Asian) in the North-West of England.	Participants were randomly allocated to the control (TAU) or wellbeing intervention groups.	Depression (Patient Health Questionnaire, PHQ-9), Anxiety (Generalised Anxiety Disorder -7, GAD), Global distress (Clinical Outcomes in Routine – Outcome Measure,	A reduction in psychological distress were observed in the PHQ-9, GAD, WSAS and CORE-OM. The largest effect was noticed in depressive symptoms (3.2). The intervention was acceptable to participants, and

						CORE-OM), Work and Social Functioning (Work and Social Adjustment Scale, WSAS) and Quality of life (EQ-5D). A qualitative interview to understand the intervention's acceptability was administered also. Quantitative data was analysed by comparing descriptive statistics (using intention to treat). The qualitative analysis method was undisclosed.	there was evidence of adherence to it (1 person dropped out during the intervention).
Service development to improve outcomes for cultural minority groups							
3	Owiti et al. (2013)	Evaluation of a Cultural Consultation Service (CCS) developed for ethnic minority service users	Service evaluation: Clinicians were invited to take part in the CCS and asked to give	94 clinicians across four London-based mental health service teams in the	The CCS offered support to the four health services which included: cultural consultation and training. Cultural	Tool for Assessing Cultural	Clinician's report significant improvement in their level of cultural competence, (pre-intervention, mean score =

			feedback data using evaluation forms.	community, were recruited to take part in the CCS.	competence was then assessed post intervention.	Competence Training (TACCT) using the proportion of positive answers (‘strongly agree’ and ‘agree’). Analysis: The open-ended evaluation forms for staff, were analysed using thematic analysis.	90.2; post intervention, mean score = 95.4). Qualitative reports indicated that the CCS “CCS seems to have improved the attitudes, knowledge and skills of clinicians”.
4	O’Shaughnessy et al. (2012)	Evaluation of a pilot mental health service for asylum-seeking mothers and babies.	A single group design, with qualitative data collected to evaluate the impact of the intervention	12 asylum-seeking mothers & babies	A culturally-relevant group intervention exploring attachment. The intervention also considered the wider societal factors that would be relevant for asylum seekers.	Reflective focus groups, session evaluations, the CARE index (infant led interactions which are video recorded and reviewed.) Descriptive analysis was used to interpret data from the session evaluations and	Designing service models to adapt to cultural nuance and the realities of asylum seekers’ live was found to be imperative. Themes included: the importance of feeling safe; finding value in ‘together-ness’’; learning more about

						thematic analysis was used to analyse the qualitative data.	motherhood; and, difficulties in reflecting on previous relationships.
Culturally-adapted psychological therapy							
5	Edge et al. (2018)	1. Assessing the feasibility of a culturally appropriate family-therapy intervention. 2.Testing feasibility & acceptability of family intervention via 'proxy family'.	Mixed methods, single group cohort design.	31 African and Caribbean service users diagnosed with schizophrenia were recruited from two NHS mental health trusts, along with 26 families	Participants took part in a 10-session culturally adapted family intervention.	Service users completed self-reported questionnaires: Euro Quality of Life-5D (EQ-5), General Health Questionnaire (GHQ) and Health Utility Index (HUI). Family members completed the Health Utility Index (HUI)	31 out of 74 took part in the feasibility trial. For service users. Improvements were observed in the EQ-5D utility index, as well as the health utility index. No significant difference was found between groups who had their family present and those with an alternative group. For family members, HUI scores didn't improve significantly following intervention.

6	Khan et al. (2019)	Assessing the feasibility and acceptability of a culturally-adapted, CBT-based intervention for British Pakistani mothers experiencing maternal depression.	Mixed-method feasibility study that included qualitative interviews and pre- and post-intervention measures	18 adult Pakistani mothers, whose score on the Edinburgh Postnatal Depression Scale (EPDS) measure was indicative of mild depression symptoms (at least).	Participants were invited to take part in a CBT group intervention which was culturally adapted for South Asian women.	Depressive symptoms, using the EPDS; marital relations using the Depression Anxiety Stress Scales (DASS), Social support using Multidimensional Scale of Perceived Social Support (MSPSS); Quality of life using the EQ-5D and depressive symptoms. The data were analysed using framework analysis, consisting of familiarisation of the data, identification of a theoretical framework, indexing, charting, mapping and interpretation.	Results indicated that the adapted CBT group intervention was acceptable to the target service users. Service users perceived that depression has a psychosocial aetiology. Significant improvements were observed in marital relationships, social support, depressive symptoms and quality of life.

7	Mir et al. (2015)	Evaluating the feasibility and acceptability of an adapted Behavioural Activation (BA) intervention for Muslim service users.	A single group design. Following the intervention, participants were asked to complete post-intervention interviews.	19 purposively recruited participants who were Muslim; Pakistani (n=17), African (n=1) and Indian (n = 1).	12 sessions of adapted BA to treat depression.	90 minute interviews were conducted. A 'topic guide' was used to structure the interviews. Thematic analysis was used to analyse the data.	Themes included: positive feelings about the intervention being connected with Islam; positive feelings towards therapy; and, anxieties around the relationship between service user and therapist. Faith-sensitive therapy is found to be supportive for Muslim service users.
8	Perry et al. (2019)	Exploring the cultural adaptability of the Acceptance and Commitment Therapy (ACT) model as an effective therapeutic group intervention for Turkish speaking communities.	A single group design, with pre and post tests to measure change in depression	8 self-referred adult participants from Kurdish, Turkish and Turkish Cypriot heritage. All participants wanted support for issues related to stress, anxiety or low mood.	A 7 session culturally adapted ACT group intervention.	Mixed-method analysis of self-report measures (CORE-OM, PHQ-9, GAD-7), and two patient-rated experience qualitative questionnaires.	Significant improvements on measures of depression ($p = 0.014$), anxiety ($p = 0.041$); and psychological distress ($p = 0.003$). The magnitude of these changes were categorized as large, with effect sizes from 0.90 to 2.03. Qualitative measures indicated that the groups were

							enjoyable, useful and accessible as a therapeutic format.
Non-clinical intervention for service improvement							
9	Gault et al. (2019)	Service improvement initiative to co-produce consensus on the key issues that enhance medication adherence in BAME service users.	A 2-phase, single group design where participants were invited to take part in a qualitative interview or workshop.	10 service users and 5 carers were recruited for the consensus workshop. 15 participants self-referred themselves (in response to advertised posters in a local Recovery College) to take part in the semi-structured interview.	Service users and their carers were invited to take part in a consensus workshop and service users (alone) were invited to take part in semi-structured individual interviews. The workshop and interviews explored the experience of taking prescribed medication and perspectives on adherence.	Thematic analysis was conducted to analyse transcribed data and to produce the main explanatory categories. A team of service users supported with the analysis also.	The key findings indicated SU and carer perspectives resulted in a significant difference to the original research design. They also indicated that education should focus on the impact of taking antipsychotics medication on SUs and carers. As well as, education for students rather than qualified professionals.
10	McEvoy et al. (2017)	Evaluating an intervention aimed at improving IAPT services for the Jewish	A critical reflective mixed methods approach was taken by drawing upon naturally	Alongside the naturally occurring data that was used for this study, ‘key	A combination of qualitative and quantitative data was drawn upon including	Following a review of the data, the participants were invited to engage in a	It was felt that the intervention led to improvements in accessing

		community in the North West of England	occurring data (e.g. observational notes, email correspondence; clinical outcome measures, etc).	informants' were purposively sampled using stakeholder mapping techniques. These informants included: 2 Rabbis; leaders of 2 Jewish community organisations; a service user; a GP familiar with the Orthodox Jewish community; a Jewish mental health practitioner; a clinical supervisor; a public health consultant; and, a mental health service's Managing Director.	naturally occurring data over a 4-year period, observational notes, e-mail correspondence, routinely collected demographic data and anonymised clinical outcome measures. The participants (key informants) were invited to identify how the intervention developed and its influence on the service; these individuals took a critical reflective approach to reviewing the data.	group discussion which resembled a semi-structured interview. Transcripts were produced from these recorded discussions and a thematic analysis was carried out.	mental health care amongst the Orthodox Jewish Community through three "overarching" themes from the data: establishing an arms-length relationship; building a collaborative partnership; and, building a mature collaborative partnership.
11	Yasmin-Qureshi & Ledwith (2021)	Exploring South Asian women's experiences of accessing psychological therapy following initiatives to improve access for BAME service users.	A single group design, with qualitative data collected to evaluate the impact of the intervention.	10 Indian, Pakistani and Bengali women self-referred (in response to advertisement) to take part in the study.	All 10 participants were invited to take part in an interview to explore their experience of accessing IAPT services.	Following the interviews, the qualitative data was analysed using thematic analysis	Themes identified: access, experience, cultural framework, therapist characteristics, expectations and ''sticking with it''. Also, findings indicated that having a good

	therapeutic relationship with the therapist was key to the intervention's success.

Quality assessment

Design

A single group 'pre test-post test' design, where pre and post-outcome measures were taken, was the most common design, used by seven studies (Chaudhury et al., 2009; Edge, 2018; Khan et al., 2019; Mir et al., 2015; Owiti et al., 2013; O'Shaughnessy et al., 2012; Yasmin-Qureshi & Ledwith, 2021). The remaining four studies employed a mixed method design, using both quantitative (pre and post) and qualitative outcome measures (Chaudhry et al., 2009; Edge et al., 2018; Khan et al., 2019; Mir et al., 2015; Owiti et al., 2013). Only one study (Lovell et al., 2014) used a comparison group (TAU).

Many of these studies made use of data which is measurable (quantitative), whilst also enabling the depth of information which can be gleaned (qualitative). However, most the studies do not have a comparison group which limits the conclusions that can be drawn from those studies about the effectiveness of the studied interventions.

Participants & sampling

The samples used in these studies included service users and carers of BAME heritage, as well as clinicians who work in mental health settings in the UK's National Health Service. The sampling approach and details of the participants were well outlined in the reports. Most studies involved small samples (n), most of which had less than 19 participants (except Owiti et al., 2013; and, Edge et al., 2018), as is typical in clinical and counselling psychology (Coolican, 2009). This limits the generalisability of the findings. That said, some of the studies were service evaluations and as such generalisability was not part of their aim. The inclusion and exclusion criteria for each of these studies were clear.

Intervention

These studies clearly report the details of their interventions. In most subgroups, participants' engagement in therapeutic interventions (e.g. attendance) demonstrated exposure to the intervention, representative of what might be received according to NICE guidelines (NICE, 2022). One study, O'Shaughnessy et al. (2012) reported that after starting the intervention, six other participants joined the study, but the rationale for this was unclear; similarly it was unclear how the researchers accounted for all the participants at the study's conclusion. Other studies clearly explained the intervention and how the participants engaged with it (Owiti et al., 2014; Mir et al., 2014; Khan et al., 2019). Most studies did not have a comparison group, despite this, the researchers had been reasonable efforts to minimise internal bias, given what is typical in outpatient mental health settings (Fernández et al., 2021).

Data collection

Studies which used quantitative approaches measured: participants' moods (anxiety and depressive symptoms); quality of life; relationship challenges; overall wellbeing; demographics; and, cultural competence (e.g. CORE, PHQ-9, GAD-7, SRQ, TACCT, EQ-5D, MSPSS, DAS, etc); a number of these assessments are routinely used in adult mental health services. The outcome measures used were reliable and valid, including the cross-cultural assessment tools (Crittenden, 2007; Renshaw, 2008; Désirée et al., 2008; Edge et al., 2018). Most measures used were self-report measures, thus making the data collected at risk of response bias.

Five studies gathered qualitative data. These appeared appropriate as the authors reported illuminating insights into the processes or structures impacting the participants as individuals, but also as a collective (e.g. asylum seeking mothers, Black service users, women of Pakistani heritage), which is unlikely to have been gleaned from quantitative data alone.

Most studies involved the use of semi-structured interviews, open ended questionnaires conducted in-person or via telephone. The studies used a systematic approach to gathering and organising their qualitative data (e.g. use of programmes, such as NVivo), except Mir et al. (2015) where there was no framework reported regarding their data collection process. The studies that used qualitative methods clearly described their rationale and approach to the methodology.

Three studies conducted a follow-up. There was some variation in follow-up times across the studies, but most studies that requested follow up, did so in a reasonable length of time (3 to 6 months) to assess for long term benefits or harm. Edge et al. (2018) and Khan et al. (2019) gathered follow-up data after three months while Lovell et al. (2014) did so after 20 weeks. Studies focusing on qualitative outcome measures typically did not collect follow-up data (Yasmin-Qureshi & Ledwith, 2021; Mir et al. 2015).

Data analysis

Quantitative data were typically analysed using a paired t-test to evaluate the possible impact of the intervention (pre and post). Most studies analysed qualitative data using thematic analysis whilst one study employed framework analysis (Khan et al., 2019).

It was unclear whether an intention-to-treat analysis was used in most of the quantitative studies. This information would have been useful to report as those who do not adhere to the full intervention may differ significantly in their experience (including outcome measures) when compared to those participants who were fully adherent. Lovell et al. (2014), Owiti et al. (2014) and Perry et al. (2018) report large pre-to post-intervention effect sizes for service users however the remaining eight studies do not, which limits what can be concluded about the associated improvements in outcomes post- interventions. Despite the small

numbers, the data analytical methods used were appropriate, also the rationale and approach were generally well described across both quantitative and qualitative studies.

The themes that were developed from the qualitative data were clearly described in all the studies. For most studies that gathering qualitative data an additional researcher to code and review the transcripts was recruited (Gault et al., 2019; Khan et al., 2019; Yasmin-Qureshi & Ledwith, 2021), whereas the others did not clearly identify this as a strategy to minimise the risk of researcher bias or inaccurate coding.

Researcher reflexivity

There was some variation in the ways the researchers explained the relationship between the researcher and the participants. Some studies described the ‘researcher’ or ‘faculty’ without any further detail (Mir et al., 2015; Gault et al., 2019; Yasmin-Qureshi & Ledwith, 2021); it would be important for these studies to clearly describe this given the limited geographical areas that these studies were operating in. If there had been prior relationships it would have been helpful to consider its impact on participant engagement in the study and the researcher’s position to the topic of study (Kornhaber et al., 2016).

Respondent validation

Some studies involved participants in the analysis of the research, but there was little reported about their feedback on the transcripts and coding. Doing so, might have helped to further validate their attempts to minimise bias.

Summary and synthesis

The review of study findings will be presented according to type of intervention used. Interventions were grouped into: i) novel group interventions for minority cultural groups; ii) service development to improve outcomes for cultural minority groups; iii) culturally-adapted

psychological therapy; and, iv) non-clinical intervention for service improvement. Each section was further organised by discussing the outcomes of each group; along with participant perspectives where applicable.

Novel group interventions for minority cultural groups

This sub-group consisted of two studies, Chaudhry et al. (2009) and Lovell et al. (2014). Both studies assessed the effectiveness, feasibility and acceptability of a therapy group where the content and design were specifically developed for particular cultural groups. In the case of Lovell et al. (2014) a culturally sensitive wellbeing group intervention 'ethnic minority' service users and for Chaudhry et al. (2009) a social group intervention for Pakistani women diagnosed with depression.

Outcomes

Reduction in depressive symptoms. Chaudhry et al. (2009) and Lovell et al. (2014). reported that the participants presented with reduced scores on measures of depressive symptoms (including suicidal ideation) after engaging with their respective culturally sensitive interventions. Lovell et al. (2014) reported additional improvements in wellbeing, post-intervention compared to TAU.

Participants' perspectives

Significance of transport as a cultural consideration. Transport appeared to be an important factor when considering the acceptability of the interventions. For example, participants in Chaudhry et al. (2009) described that transport being provided for was an "absolute necessity" for this group; adding that using public transport would have been a great barrier to their attendance. Chaudry et al. (2009) considered that it was important to fund free travel whilst being accompanied by female Urdu speaking 'transport facilitators', "to ensure that the family and community did not object to women going out alone with a taxi

driver" (p. 505). Similarly, Lovell et al. (2014) gave participants the option to engage in the intervention from their homes, which the participants highlighted as valuable, although the rationale for offering home-based intervention was not reported in this study. The participants in Lovell et al. (2014) also highlighted that travelling to the location of the intervention was a challenge for them.

Whilst transport and location of the intervention were thought about by the researchers, neither study reported how issues around transport or location might have impacted on recruitment, findings, future research or how researchers were able to glean knowledge about cultural issues that might impact upon engagement from participants within this population.

Summary

The findings of these studies indicate that novel group interventions for cultural groups were perceived as acceptable and feasible interventions. Further attention given to the role of transport in this subgroup would be valuable, however the outcomes indicate that these groups can improve wellbeing, particularly as is relates to low mood.

Service development to improve outcomes for cultural minority groups

This sub-group consisted of two studies, Owiti et al. (2013) and O'Shaughnessy et al. (2012). These studies evaluated newly developed services that were aimed at improving outcomes for BAME service users. In Owiti et al. (2013) the service was concerned about meeting the needs of all ethnic minority service users and in O'Shaughnessy et al. (2012) the participants concerned were asylum seeking mothers and babies (with a focus on West African families).

Outcomes

Improvements observed by clinicians and service users. Owiti et al. (2013) reported improvements in the cultural competence of multidisciplinary staff members when evaluating the cultural consultation service. O'Shaughnessy et al. (2012) reported highly positive responses in the session-by-session evaluations, with 96% of participants reporting that they perceived the intervention helped mother and baby play, that they enjoyed being around other babies and that they would enjoy returning. Seventy-six percent of mothers reported feeling "better" after attending the group.

Attrition (drop-out rates). A limitation of the studies was the attrition rate of participants recruited into the studies and limited consideration of how this might have influenced the findings. O'Shaughnessy et al. (2012) reported that the attrition rates of participants who were recruited in the therapeutic groups were due to changes in immigration and asylum status, changes in familial support and 'a fear of gossip' within the community. O'Shaughnessy et al. (2012) had a few participants who only attended a few sessions. However, they did not clarify the number of sessions for the intervention that each participant attended and it is not obvious how this may have influenced the outcome data; compared to Owiti et al (2014) who did this.

Participant perspectives

Emergent themes about the group experience. The themes from the thematic analyses (across both papers) included: the importance of feeling safe; finding value in 'together-ness''; learning more about motherhood; and, participants reported finding it difficult to reflect on previous relationships.

Summary

Findings suggest that service developments to improve outcomes for cultural minorities_were acceptable and feasible to service users and clinicians. The drop-out rates

observed in the services could be explored further, but there was an understanding of the role of asylum status, family support and fears around gossip. These are factors that would be difficult for a service to manage, but ought to be considered for future interventions like this. The interventions in this subgroup received positive feedback from participants, with improvements in cultural competence in clinicians and parent-child relationships in service users.

Culturally-adapted psychological therapy

This was the most common form of intervention, examined by four studies: Edge et al. (2018); Khan et al. (2019); Mir et al. (2015); and, Perry et al. (2019). These studies evaluated psychological therapies (Family intervention, CBT, BA and ACT, respectfully) which were adapted to be culturally sensitive to different cultural groups. The ethnic groups included: Black African and Caribbean families (Edge, 2018); British-Pakistani mothers (Khan et al., 2018); Muslims (Mir et al., 2015); and, Turkish speaking service users (Perry et al., 2019). Three of the four studies employed a mixed method design, using both quantitative and qualitative outcome measures (all except Mir et al., 2015).

Outcomes. ***Reduced depressive symptoms.*** Khan et al. (2019) and Perry et al. (2019)'s participants reported significantly reduced scores on depressive symptoms (including suicidal ideation) after engaging with their respective culturally sensitive interventions.

Quantitative and qualitative data. Edge et al. (2018), Khan et al. (2019) and Mir et al. (2015) employed a mixed method design using both quantitative and qualitative measures to determine the effect of their respective culturally adapted intervention on wellbeing. This allowed for some depth of understanding regarding the potential impact of the intervention, alongside the quantitative changes that were observed.

Feasibility and acceptability. Participants perceived the interventions as feasible and acceptable (Mir et al., 2015; Edge et al., 2019; Khan et al., 2019); they viewed the intervention as worthy of replicating or expanding.

Participant perspectives. Having greater opportunity to explore the role of context, culture and relationships appeared significant (Mir et al., 2015; Khan et al., 2019). The participants in Mir et al. (2015) reported feeling positive about an intervention where their faith (Islam) was considered. Participants in Khan et al. (2019) reported an awareness of the social role that depression has and reported that the intervention led to improvements in their relationships.

Summary. Most of the studies that made up this subgroup (Edge et al., 2018); Mir et al., 2015., Khan et al., 2019) were single group pre-test, post-test design studies, without a control. This limited what can be concluded about the impact of these culturally adapted clinical interventions when compared to TAU. However, participants of the studies found the interventions feasible and acceptable to meet their needs; pre-to post-intervention improvements in depressive symptoms were also observed. Participants were recruited from a wide range of locations that vary in population density, rurality and participants were likely to vary in socio-economic status too. This indicates that culturally adapted interventions may be effective for service users from a wide range of backgrounds (Mir et al., 2015; Edge et al., 2018; Khan et al., 2019).

Non-clinical intervention for service improvement

This sub-group consisted of three studies: Gault et al. (2019); McEvoy et al. (2017); and, Yasmin-Qureshi & Ledwith (2021). These studies evaluated non-clinical interventions that were carried out with the aim of improving the outcomes for BAME service users. This included: co-production efforts to enhance medication adherence in BAME service users

(Gault et al., 2019); training and community engagement efforts to improve accessibility for the Orthodox Jewish community (McEvoy et al., 2017); and co-production efforts to improve access to services for South Asian women (Yasmin-Qureshi & Ledwith, 2021).

Outcomes. ***Trust in relationships between clinicians and cultural groups.*** McEvoy et al. (2017)'s findings indicated that the intervention led to improvements in access to mental health services for Jewish participants. The themes from this study included: the importance of building collaborative partnership with NHS services and members of Jewish community organisation; enabling existing partnerships to mature; and building relationships between mental health professionals and members of the Jewish community through informal means, all of which enabled a greater sense of "trust" and "confidence" from the Jewish community members. Similarly, Yasmin-Qureshi and Ledwith (2021) reported themes from their study such as: service users feeling that concerns had to deny their culture and/or religion to access therapy; and, good therapeutic relationship being "key". Considering the themes from both studies, it appears that developing trusting and respectful relationships with clinicians is a significant feature of service improvement when engaging cultural groups. Gault et al. (2019) describe their underpinning assumptions that mental health professionals coming to understand different perspectives on medical adherence, will make them more effective in supporting service users to accept medication. Gault et al. (2019) used a systematic coding process and cited Charmaz et al. (2004) regarding their approach to grounded theory whilst Khan et al. (2019) clearly described how themes were identified in the thematic analysis of the data (Gault et al., 2019; Khan et al., 2019; Yasmin-Qureshi & Ledwith, 2021).

Summary. Whilst clarity around the researcher's role would be valuable to ascertain, particularly as it relates to bias and replicating the study, the findings suggest that non-clinical interventions for service improvements were associated with improvements in accessibility from BAME service users. Improvements in cultural competence across the studies were also observed, in particular, information gleaned about the importance of therapeutic relationships and the diversity of perspectives around medication. A limitation of the studies in this subgroup is that there was some variation in the ways the researchers explained the relationship between the researcher and the participants. Some studies described the 'researcher' or 'faculty' without any further detail (Gault et al., 2019; Yasmin-Qureshi & Ledwith, 2021).

Discussion

This review aimed to synthesise the research literature on interventions seeking to improve cultural competence in UK NHS mental health services. Four review questions were explored: a) What is the acceptability or feasibility of these interventions from the perspective of service users, staff or carers? b) How do service users experience these interventions? c) How might clinicians' cultural competence change following these interventions? d) What changes have been observed in a service user's wellbeing? Eleven studies were included in this review and the types of interventions used in these studies were put in four subgroups: a) novel group interventions for minority cultural groups; b) service development to improve outcomes for cultural minority groups; b) culturally-adapted psychological therapy; and, d) non-clinical intervention for service improvement.

Review findings suggest that service users found that all four types interventions aimed at improving cultural competence acceptable and feasible. It is noteworthy that studies in this review typically explored this from the service user perspective (all except Owiti et al.,

2013 and McAvoy et al., 2017). These studies appeared to be designed in keeping with the ideas introduced by Kleinman et al. (1981; 2006) around 'cultural humility', 'patient centredness', and 'structural competence' as a means to improve cultural competence.

Data collected from all intervention types 'a' to 'c', indicated that participants found engaging with those interventions a positive experience (Mir et al., 2015; McEvoy et al., 2017; Yasmin-Qureshi & Ledwith, 2021). Findings from all interventions indicated that they improved trust, and helped to improve access to mental health services (McEvoy et al., 2017; Perry et al., 2019; Yasmin-Qureshi & Ledwith, 2021). This indicates that these interventions can have a positive impact on cultural competence as understood by Kleinman et al. (2006). Participants noted that highlighting the relationships to their cultural group, family and other significant relationships was important, as well as participants' (service users & carers) relationship to clinicians and educating clinicians to for their work to be more culturally informed (O'Shaughnessy et al., 2012; Gault et al., 2019; Khan et al., 2019; Yasmin-Qureshi & Ledwith, 2021). This suggests that interventions aimed at cultural consultation in mental health services could mitigate the impact of "cultural naivety" the service users of NHS services have previously reported (Department for Health and Social Care, 2018, p. 24). Considering previous literature, it appears that the participants' were informing and engaging with the structural competence of the services (Kleinman et al., 1978; Kleinman & Benson et al., 2006; Jernigan et al., 2016).

Studies that gathered data on staff experience reported that they experienced improvements in their cultural competence following these interventions (Owiti et al., 2013; McAvoy et al., 2017). Owiti et al. (2013) reported improvements in the cultural competence of multidisciplinary staff members when evaluating the cultural consultation service.

As it relates to changes observed in wellbeing health outcomes, the research indicated that service users reported that their interventions had resulted in improvements in depressive symptoms (including suicidal ideation) in particular. Other changes in wellbeing that were observed included improvements in the quality of significant relationships and decreased symptoms of anxiety (Chaudhry et al., 2009; Lovel et al., 2014; Khan et al., 2019; Perry et al., 2019; Yasmin-Qureshi & Ledwith, 2021).

Whilst significant differences were observed in several the studies, the sample sizes were small. A number of these researchers have considered their research to be feasibility and pilot studies and do not claim that the findings will have a high generalisability. Despite this, the findings indicate that interventions aimed at improving cultural competence in mental health services were associated with significant improvements in mental health challenges, quality of life, relationships (namely groups ‘a’, ‘b’, ‘c’), cultural competence and access to services (group ‘d’). In particular, the use of culturally adapted interventions for service users, non-clinical interventions and service development initiatives (clinical and non-clinical).

Strength and limitations

Strengths

This review was based on a systematic literature search and involved a thorough narrative synthesis of studies of interventions that aimed to improve cultural competence within the UK NHS mental health services. This review also provides examples of efforts made to provide a methodological critique of the studies that were included . As such, it could be consulted by clinicians and service providers who wish to adopt and/or expand upon cultural competence interventions presented here. The findings might also be generalisable to

other countries that employ the Beveridge model of national health services such as Cuba, Italy, Spain, etc (Lamire, Joffe & Wiederman, 1999).

Limitations

This review did not involve studies from other countries (using the same healthcare model or otherwise) due to the time constraints of this study. As such, its generalisability may be limited to the UK and possibly other countries adopting the Beveridge model. Another limitation of this review is that it does not consider interventions to improve cultural competence in privatised or 3rd sector mental health services in the UK. Including these services within the review would have better reflected the full offer of mental healthcare within the UK.

Clinical implications

Considering the role of family, community gossip and trust in the relationship between service user and professional have been highlighted as considerably important factors when UK mental health services engage in interventions aimed at improving cultural competency. This also highlights the importance of using qualitative methods when exploring the impact of a culturally sensitive intervention on participants requiring mental health support. It is unlikely that the quantitatively designed outcome measures used in these studies, would have enabled the researchers to acquire the data that feels so uniquely pertinent to the experience of those from cultural and ethnic minority groups in the UK.

These studies highlight the importance of a therapeutic relationship that is built over time between cultural and ethnic minority groups and how trust can be built from service users toward mental health services. They also highlight the role that therapeutic and professional relationships can have in a professionals' (and therefore a service's) cultural competence.

Directions for future research

There is a clear need for studies comparing culturally adapted interventions to TAU. Future research should include larger scale studies that make a comparison between more traditional therapeutic interventions and culturally sensitive/adapted interventions for service users from cultural or ethnic minority groups.

It appeared that group interventions were valued by participants (across a number of studies), although participants regularly expressed a fear of gossip and cultural stigma. Further research ought to explore the ways in which group interventions for cultural minorities might enhance or mitigate the effectiveness of an intervention in these populations.

As mentioned previously in the 'limitations' section, this review did not explore the efforts made by privatised and 3rd sector mental health services to improve cultural competence. Future research could explore how non-NHS services have sought to improve cultural competence and how ethnic minorities make use of non-NHS services that were developed to meet mental health needs in a culturally sensitive way.

Also, further research exploring the ways in which therapeutic and professional relationships can contribute to cultural competence would be valuable as it is lacking in current research. Studies by Kirmayer et al. (2003) and Owiti et al. (2013)'s work, suggest that mental health professionals valued cultural consultation. Looking at the limitations and points from this research and expanding upon these, may provide valuable insights that would benefit the current literature in this field, as well as mental health services supporting service users from diverse backgrounds.

Conclusion

The studies included in this review indicate that interventions aimed at improving cultural competence are feasible and acceptable to service users of NHS mental health

services. Participants report positive experiences of these interventions and improvements in the accessibility of mental health services as a result. These interventions are associated with improvements in psychological distress, quality of life and relationships post-intervention; especially, improvements in low-mood. In addition, the studies are associated with improvements in the cultural competence of mental health clinicians post-intervention. However, most studies in this area of research do not have a comparison group and so it is difficult determine whether any observed changes can be attributed to these interventions.

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PART B:

‘Interpreting culture’: Exploring the experiences of NHS professionals co-working with embedded cultural consultants in CAMHS services

Abstract

Background: Research into cultural consultation lacks data which reflects mental health professionals' perspective on these consultations; and, how consultation might be received when embedded in an existing service.

Aims: To explore how NHS clinicians experience working with embedded cultural consultants, along with how this work impacted their practice, and if this work influenced their practice over time.

Methods: A qualitative interpretative phenomenological analysis (IPA) of semi-structured interviews with ten NHS CAMHS clinicians about their experience of working with embedded cultural consultants.

Results: Three group experiential themes (and eight sub-themes) were developed from the interviews: i) the experience of enhancements to the service user experience; ii) enhancement to the professionals' experiences; and, iii) connection to the local community.

Discussion: In keeping with the theoretical framework outlined by Owiti et al. (2014), the findings suggested that working with embedded cultural consultants invited participants to reflect upon the various cultural factors that impacts on the therapeutic work. However, clinicians also found that they reflected on this work beyond the clinical encounter and across their work overall. This enabled participants to feel more developed in their cultural competence.

Introduction

A common definition of individual cultural competence is where three components are being developed: cultural knowledge, cultural awareness, and cultural skills/behaviour. In addition, it has been suggested that 'culturally competent services' must have a systemic lens through which to understand how different cultures interact and a readiness to adapt to meet cultural needs (Cross et al., 1989, p.7; Jernigan et al., 2016). A systematic review of the theoretical and empirical literature on cultural competence (Alizadeh & Chavan, 2015) concludes that developing cultural competence is an ongoing process, requiring 'cultural humility' (Kleinman & Benson, 2006) and a commitment to continual learning from service users and self-reflection to mitigate bias (Jernigan et al., 2016).

Mental health difficulties across ethnic groups

Research suggests that there is a substantial difference in the prevalence of mental health problems amongst ethnic minorities in the UK. Research also suggests that people from ethnic minority backgrounds have worse health outcomes and face greater challenges accessing healthcare in primary and secondary services when compared to their White English counterparts (Memon et al., 2016; Stuart Hall Foundation, 2021). For example, reports indicate that Black service users diagnosed with Schizophrenia were less likely to be offered CBT than their White counterparts. Research has also shown differences in healthcare experiences across ethnic groups. For example, Das-Munchi et al. (2018) found that Asian service users diagnosed with schizophrenia were more likely to be referred to family therapies than other ethnic groups. They also report that Chinese service users were more likely to be given a copy of their care plan (Das-Munchi et al., 2018). This highlights the need for "more research on how cultural factors shape expectations in response to treatment" (The Race Equality Foundation, 2018, p. 24).

Cultural competence

Cultural competence has been typically understood as requiring clinicians to take personal responsibility for considering culture when engaging with service users from a different cultural background (Kleinman et al., 2006; Bhui et al., 2007). On the other hand, there is 'Structural competence' which requires service providers to examine institutional biases and "structural determinants" of interactions between clinicians and service users, including physical location, working hours, "definitions of illness, health and culture", to ensure it adequately meets the cultural needs of the community it serves (Kleinman et al., 1978; Kleinman & Benson et al., 2006; Jernigan et al., 2016). NHS England and NHS Improvement have identified a number of actions to improve the current differences in service user experience between BAME and white British service users by 2023/2024. This includes services seeking out models of positive practice where cultural competence is developed amongst staff teams (NHS England & NHS Improvement, 2020 p2, 4, 9).

Theory and conceptual framework for cultural competence

Aggarwal (2012) conceptualised the clinical encounter as being influenced by a process of 'hybridity and intersubjectivity'. Here clinical teams (multidisciplinary teams) made up of individuals from various cultural backgrounds are attempting to generate explanations for the service user's (patients) health challenges. Lo and Stacey (2008) describe that a service user's culture can be conceptualised as the 'hybrid habitus'; which is a combination of the service user's culture, context and social structure. Owiti et al. (2014) expand on this, considering the client within the context of the clinical encounter. Here Owiti et al. (2014) describes that each component of the clinical encounter has its own 'hybrid habitus'; the clinical encounter itself, is composed of: the service user; the clinician; the healthcare organisation; and, socio-economic factors. In light of this, the clinical encounter

involves a complex interaction of different cultural assumptions and orientations (see Figure 1). Through this interaction the outcome is often a co-created narrative of a service user's challenges and recovery plan; regardless if the meanings of this narrative are made explicit or not.

Figure 1. *Owiti et al (2013)' conceptual framework of the interaction of the 'hybrid habitus' in the clinical encounter.*

With this theoretical understanding in mind, in a circumstance where there is limited skill between members of the interaction to effectively "deconstruct and negotiate for shared meaning" out of the complex narratives that are present; it is likely that there will be conflict

between the clinician and service user (Owiti et al., 2014; page 3). Owiti et al. (2014) then theorise that navigating the clinical encounter is useful forum through which cultural competence can be developed. As it is through engaging in the interplay of the various narratives (Figure 1) that the skills of deconstructing and negotiating shared meaning can be developed.

Addressing cultural competence in mental health services

Teaching and training (such as lectures and coursework) are seen as important in developing cultural competence, but there is a lack of research into how effective professional training is in enhancing cultural competence (Owiti et al., 2014). Furthermore, Owiti et al. (2014) critique these current methods of training for lacking integration with "day-to-day clinical practice" (clinical encounters). Efforts to meet this clinical challenge include: working with translators (with some mental health training), staff working as cultural consultants, and separate mental health services to meet the needs of particular ethnic groups (Kirmayer et al., 2003; Kizilhan, 2014; Bhui, 2015). Cultural consultants often have the role of working with professionals to interpret a client's cultural perspective on a range of matters (Kirmayer et al., 2003). Considering the aforementioned, receiving cultural consultation in clinical settings may provide innovative, interactive learning for clinicians within their local setting (Owiti et al., 2014).

Kirmayer et al. (2003) conducted a service evaluation exploring whether an external cultural consultation service used in a Canadian primary care service might improve their delivery of care. Using self-reporting measures, they found that 86% of referring clinicians were satisfied that the consultation helped staff members to support service users, particularly as it related to increasing their knowledge of clients' culture and religion, along with improvements in the therapeutic alliance. However, clinicians (n=29) also highlighted some

difficulties, including the unavailability or inappropriateness of recommended resources (14%), lack of follow-up (14%), and concerns about the consultant's competence (10%).

More recently, Bhui et al. (2012; 2015) conducted a service evaluation of a tertiary 'Cultural Consultation Service' (CCS) developed for services across East London. Common referrals to the CCS included: the exploration/resolution of cultural conflict amongst parents and children; discrimination; and complex clinical presentations which required further understanding. All staff (n = 15) and service users (n = 15) involved in the qualitative evaluation reported that the cultural consultation process was helpful. Staff reported that the process allowed service users to "talk about things they had not talked about before", with 71% reporting that it helped them to make appropriate changes to treatment plans. Clinicians perceived that cultural consultation was associated with significant improvements in their cultural competence, whilst service users reported that cultural consultation was associated with significant improvements in their mental health and overall functioning. Clinicians' suggestions for improvement included having a cultural consultant permanently based within their team, to support the management of complex cases, contribute to more efficient working and cost saving. Arguably, embedding cultural consultants in mental health services would enable consultants to have specialist knowledge of the client group, the service and suitable training (Bhui et al., 2012; Islam et al., 2015), which may overcome the challenges raised in Kirmayer's (2003) study of external consultation.

Embedded cultural consultants

The embedded cultural consultants' approach involves consultants who have been employed to work within a mental health service. The consultants support clinicians to better understand the cultural and religious factors that are pertinent to understanding the perspectives of a chosen cultural group(s).

Research Aims

There is a gap in the literature as it relates to embedded cultural consultation in mental health services and how embedded cultural consultation as an intervention might interact with existing theoretical understandings.

The proposed study aimed to explore how mental health professionals experience embedded cultural consultation. Unlike the aforementioned studies, which are service evaluations (Kirmayer et a., 2003; Bhui et al., 2012; 2015), the proposed study aimed the explore how clinicians experience embedded cultural consultation in the context of the 'clinical encounter' and the various hybrid habitus that is present within the encounter (Lo & & Stacey, 2008; Owiti et al., 2014). It is hoped that the outcome of the study will enhance current theoretical understandings of the development of cultural competence, particularly how embedded cultural consultation can support the development of cultural competence. As such, the study aimed to address the following questions:

A. How do purposively sampled NHS clinicians experience co-working with embedded cultural consultants in CAMHS services?
B. How do purposively sampled NHS clinicians describe the impact of co-working with embedded cultural consultants in CAMHS services, on their clinical practice?
C. What changes (over time), if any, do purposively sampled NHS clinicians co-working with embedded cultural consultants experience in their understanding of the work with clients belonging to different cultures?

Context

Within a diverse inner city in the UK, there is an NHS based Child and Adolescent service which offers mental health support to local young people and families (commonly

referred to as Child and Adolescent Mental Health Services, CAMHS). The make-up of the staffing in this team includes clinicians from a range of disciplines including: psychotherapists; family therapists; physical health medics; psychiatrists; clinical psychologists; and, nurses. Given where the service is situated, there is a large Bangladeshi population which the service is in regular contact with. To engage better with the local Bangladeshi community, the service employed embedded cultural consultants. These consultants had a dual role of: translating the Sylheti language for non-Sylheti speaking clinicians; and, offering support for professionals to better of Bangladeshi service users and carers that interact with the service. To gain a sense of the role of embedded cultural consultants, three embedded cultural consultants were spoken to, all of whom had worked for a considerable amount of time in the CAMHS service (spanning between 3 months and 15 years).

Methods

Design

The study used a qualitative design, involving the interpretative phenomenological analysis (IPA) of semi-structured interviews with purposively sampled clinicians working with embedded cultural consultants in a CAMHS service.

Sampling strategy

A purposive sampling strategy was used to recruit NHS clinicians (including psychologists, nurses, social workers, family therapists, psychiatrists, and psychotherapists) from a CAMHS service where cultural consultants are embedded within its service (cultural consultants). Potential participants were approached in the first instance by the external supervisor who works within the CAMHS team. There are approximately 40 clinicians in the service and each clinician works across two of four pathways that make up the service: internalising emotional and behavioural difficulties (e.g., anxiety, depression); externalising emotional and behavioural difficulties (e.g., conduct problems); bipolar difficulties and psychosis; and, neurodevelopmental-related challenges. Clinicians in all four pathways have access to support from cultural consultants.

Procedure

Recruitment involved the study's external supervisor sending an email to eligible members of the CAMHS team, explaining what the research was about, along with the Participant information sheet (see Appendix E). The eligible staff members were encouraged to contact the research team if they were interested in taking part by, following which a time was appointed for the participant(s) to complete the interview. The interview was semi-structured and lasted 45 to 90 minutes.

Participants

Ten clinicians in the CAMHS service were recruited for this study. This is in line with the recommended number of participants when using IPA at doctorate level (Smith et al., 2022); it allows for attrition whilst still allowing for enough data to remain to conduct high quality analysis (Smith & Eatough, 2011).

Inclusion and Exclusion criteria. Participants must have been a qualified mental health professional working CAMHS service where cultural consultants are embedded; all of whom would be involved in the assessment and treatment of mental health difficulties amongst children and adolescents in the service. The participants must have worked with a cultural consultant within the service on at least three occasions, to support their assessment, formulation and/or treatment (individual or group treatment) of young people from culturally diverse backgrounds. There were no exclusion criteria.

Origins of embedded cultural consultation in the service

The embedded cultural consultant role in this service has had several iterations before taking its current form. Twenty years ago (approximately), there was a desire for Sylheti interpreters who could take on a role which involved supporting the clinical team to better engage with the Bangladeshi families that were referred to the service. Two posts were initially created and then more roles eventually became available over the years. Initially the main role of these staff members was to offer translation support. However, there was an increasing understanding that supporting clinicians to think about cultural matters (e.g. perspectives on childhood development, family, sexuality, cross-cultural life, etc.) would enhance the service's offering to the local community, particularly where the cultural perspective may be different to what is culturally normative in the western context. As a result, cultural consultation became a more prominent feature of the team's work.

Features of the work

The Cultural consultants are employed staff members who work within the CAMHS team structure, receiving supervision for their work with clients and clinicians. The working format is that clinicians within the service, will approach Cultural consultants directly or with the support of administrative staff, to schedule a time for the Cultural consultants to join clinicians in the work with service users. This work can include interpretation and/or cultural consultation. The work itself can take a range of forms; including, but not limited to, a single appointment with a new service user; long term therapy with a service user; or a long-term group programme for parents.

Ethics

Informed consent was required of all participants. Potential participants will be given an information sheet that explains the details of the proposed study and given at least 24 hours before deciding whether they would like to take part in the study. All participants were informed that their participation is voluntary and that should they agree to take part they will have the right to withdraw from the study up to two weeks after the interview has been completed. To minimise participant burden and distress, all participants were briefed and de-briefed at the start and end of the interview and they will be offered opportunities to take breaks during the interview. In the moment they present or share feelings of distress, they will be reminded that they can take a break and they can confirm if they would like to no longer participate. The data gathered were anonymised and personally identifiable data along with the unique identifier code will be stored separately on password protected secure devices. Participants were informed that recordings made from the interviews would be erased from the device once it has been transcribed. Electronic copies of consent forms, audio

files and transcripts will be securely stored on password protected devices which securely kept. physically stored in securely locked areas. To evidence that the participants have understood all of this, they were sent a consent form to complete prior to engaging in data collection (See Appendix F).

Data collection

Interview

Semi-structured interviews are well suited to IPA as they allow participants to provide rich, detailed accounts of their experiences. The interview schedule included rapport building questions followed by broad, open-ended questions relating to the research questions (see 'Interview Schedule' Appendix D). The interviews were conducted using video conferencing tools, namely Microsoft Teams, or Zoom; all of which are compliant with General Data Protection Regulation (GDPR).

Demographic information

Participants were asked to provide the following demographic information: gender, ethnicity, profession, length of time working in their professional capacity, length of time working in the service, amount and type of work completed with a cultural consultant (e.g., assessment, intervention), religious/spiritual affiliation. Participant demographics are summarised in Table 1.

Table 1: Demographic information

Demographic		*n*
Gender	Male	3
	Female	6
	Non-binary / third gender	1
	Total	10
Religious/spiritual affiliation	Christian	2
	Buddhist	1
	Hindu	1

	Other None	1 5
Ethnicity	White Mixed or Multiple ethnic groups Asian or Asian British Black, African, Caribbean or Black British Other ethnic group	5 1 1 2 1
Professional discipline	Family Therapy Medicine Nursing Psychology Occupational Therapy Art Therapy	2 2 3 1 1 1
Time working in professional discipline	6 - 10 years 11 - 15 years 16 - 20 years Over 20 years	5 1 1 3
Time working in the CAMHS service	Less than a year 2 - 5 years 6 - 10 years	2 6 2
No. of times participant worked with an embedded cultural consultant	3 - 5 times 6 - 10 times 11 - 15 times Over 15 times	2 1 2 5

The demographic information reflects that the majority of the 10 participants were female, which proportionately reflects the proportion of women in the NHS workforce (NHS England, 2021). There was a range of religious or spiritual affiliation amongst the participant group, with most participants identifying as having no religious or spiritual affiliation. There was diverse mix of ethnicity and professional disciplines represented in this study. All participants had been practicing in their chosen profession for a significant length of time (6+ years).

None of the participants were working in the service during the initial formation of the embedded cultural consultant role. Rather, the embedded cultural consultants had already been long established members of the CAMHS team before any of the participants joined the team. Participants in the study were likely well-versed in working with and around Cultural

consultants. as the majority of participants had engaged with Cultural consultants 15+ times (*n*=5).

Analysis

IPA aims to offer insights into how a person, in a context, makes sense of their experience of a phenomenon (Smith et al., 2022). Thus, it is well suited to exploring how NHS professionals experience co-working with cultural consultants within CAMHS services IPA requires that the researcher is reflective on their work and considering this I kept a reflective journal and engage in a bracketing interview (Rolls & Relf, 2006; see Appendix 5 & 6). When carrying out the research I followed the quality criteria for qualitative research outlined by Yardley (2000). To increase the internal validity of the data analysis, both supervisors regularly reviewed process of coding and development of themes.

Ten interview transcripts were produced, following which 'Exploratory notes' were detailed, then these were compiled to produce 'Personal Experiential Statements' (see Appendix B). Themes were developed from the experiential statements made in each transcript and following this the themes across the 10 transcripts were cross-examined to establish 'Group Experiential Themes' (GET) which make up the findings of this study. 3 of these GETs emerged from the data and 8 sub-themes, exploring clinicians working with Cultural consultants embedded in CAMHS services. In keeping with the IPA reporting process, quotes from the interviews will be provided whilst elaborating on the GETs; pseudonyms are given alongside these quotes in order to uphold confidentiality. In presenting the findings below, attention will be given to explore any patterns as well as any divergence noted within those patterns in order to grant a richer understanding of the themes presented (Smith et al., 2022).

Positionality statement

Reflecting on my own position when engaging in this research, I had assumptions that this workforce would be diverse in their professional experience, ethnicity and time spent in the service, given how large the service is and its position in a large city. I was conscious that I am also an ethnic minority (which is visually apparent) and carry an accent which is local to where the service is based. I noticed that I had a lot of respect for the work that these clinicians were doing and I imagined that this would be presumed by the participants. I also anticipated that given these clinicians had chosen to work with this uniquely diverse community, that more of them would be passionate about this research too. With this in mind, I considered the possibility that the participants would be more personally reflective if their personal values informed the decision to work with this particular community (Smith et al., 2021)

Results

Three group experiential themes were developed from the analysis: 'enhancing the service user experience', 'enhancing the professional's experience', and 'connection to the local community' (see Table 2). This section will elaborate on each of the group experiential themes and associated sub-themes (Table 2) and include illustrative quotes from participants' interviews. A double hermeneutic was at play, given that the researcher attempted "to make sense of the participant trying to make sense of what is happening to them" (Smith et al., 2021, p.3). This was engaged in carefully, where the attempt was to interpret what was being said, in the context of their broader answers (Smith et al., 2021, p.27).

Table 3: *Overview of 'Group Experiential Themes and group-level sub-themes*

Group Experiential Themes	Group Level Sub-Themes

Theme	Subtheme
Enhancing the Service User experience	Enhancing empathy through understanding.
	'A safety net' for clinicians
	'The dance': sharing power and relinquishing control
Enhancing the professional's experience	A sense of containment: brought about by consultants' various skills
	Enjoying learning in and out of the clinical encounter: informal and formal.
	A mutual learning experience
Connection to the local community	Greater sense of urgency in having an accessible service
	A desire for further expansion of the embedded cultural consultation resource

Enhancing the Service User experience

Participants shared that they felt the presence of an embedded cultural consultant in clinical practice/encounters enhanced the experience of Bangladeshi service users who came into contact with the CAMHS team.

Enhancing empathy through understanding

Participants reported a sense of relief from observing that input from embedded cultural consultants enable carers who do not have a strong command of English to communicate with service users and clinicians. Simultaneously participants experienced that they in turn felt more comfortable engaging families in clinical work, as communication is a

less challenging experience for all parties in the clinical encounter. This appeared to be a profoundly important experience for the participants, which raises the value of what embedded cultural consultants offer. Similarly, participants consistently reported a sense of relief knowing that the embedded cultural consultant has the contextual knowledge around what is being said by clinicians, and that they would be able to effectively communicate what is desired to the service user. For example, Jordan in explaining how she find that cultural consultants helped their work describes "*I think probably it was a mix of really wanting both parties [service users and carers] to feel understood… I think sometimes the family kind of do feel a bit more comfortable, you know, kind of speaking, when they've got someone present, who shares our cultural understanding. And that kind of families, community kind of view of things*"

As demonstrated in this extract, participants noted their desire to comprehensively understand their clients' experiences and the cultural lens through which their distress can be understood more meaningfully. The participants noted that the embedded cultural consultants invest in finding ways to communicate terms in the Sylheti language, in a way that enables a communication of what the clinician *meant* instead of just what is being said. As such, the participants reported a greater sense of enlightenment about the distress their service users were experiencing; viewing this experience as 'interesting' and valuable for the effectiveness of their interventions. Participants felt that the work of embedded cultural consultants actively helps to remove barriers in rapport because of their approach: Omar describes this, saying "*So it's actually quite interesting how we make sense of what's going on for us, in relation to other cultures and personal experiences. I just find that fascinating. And so I suppose, since I started working in mental health, and working with people… you need to use someone to help translate because it's not just translating the words, it's translating the meaning as well*)"

The participants felt that working with embedded cultural consultants has led clinicians to more reflecting about their own cultural heritage, and consider the similarities or differences that they might personally have with their service users. Taylor describes: *"And there were times when I would talk with a cultural consultant about being born in this country, [and] my parents were migrants to this country…They [the service users] were kind of a matriarchal, very structured [in their culture], [and] there are things quite often that I could relate to"*) As depicted by the excerpt, there was a sense that participants could engage in deeper expressions of empathy because of the greater understanding that the embedded cultural consultants had enabled. Similar to Taylor, other participants enjoyed the opportunity that consultants had provided to reflect upon their cultural heritages and the cultural backgrounds of their clients and UK, Bangladeshi and Sylheti culture. In this work, I noted how much I also enjoyed hearing participants reflect on their backgrounds; in so doing, I felt as though I could empathise with the pleasure experienced from cultural learning. I also recognised that a part of me hoped this would be the case. Participants described that the embedded cultural consultants supported them to consider intersections of religion and culture in their service users too.

Only one participant described having received cultural consultation of some kind in the past, stating that in this previous instance, the consultants were external professionals. Comparing this to the experience of embedded cultural consultation approach, the participant experienced the embedded model as one which offered them a contained space to reflect on cultural factors which are relevant to the clinical encounter. The participants appeared to develop an awareness of occasions where cultural knowledge is needed, and occasions where it would be helpful to reflectively and reflexively consider culture. This was observed amongst other participants also. The participants considered this beneficial to help them 'navigate' cultural matters with greater confidence; which they felt results in a better service

for the service user; as described by Taylor *"It feels different when I need an interpreter and when I need help thinking …often if I need an interpreter, I'll just send an email and ask them to do a, B or C...Whereas when I need help thinking, that's more of a reflective space, and kind of an open space for it. And some cultural consultants will relate to those ideas in their own way"*.

The participants appeared to experience a shift in their perception of what embedded cultural consultants offer service users; from an interpretation service to viewing them as a beacon of accessibility for service users. Participants reflected on the various thoughts and emotions they had upon becoming aware of the embedded cultural consultant role. Typically, participants were unsure of how best to draw upon support and that earlier in their roles, they might have requested for translation support. Then over time, participants reported that embedded cultural consultation is enabling clinicians to reflect about the meanings behind expressions of distress, engagement/lack of engagement. As such, they felt that working with the embedded cultural consultants makes the service feel more accessible for services users; and the participants knew that the reflections and learning can extend beyond the therapy room. Morgan reflects on this *"when I think about other jobs I've had where I've worked with clients that are from a different culture…I found before that sometimes actually, those families [are] much, much harder to engage. I often found that the DNA rates were much higher. I often found that if there was a high, like number of professional agencies involved, like they were often families… basically, the thing I'm trying to get is… I know that there were so many families we've labelled as being difficult and not able to engage. And… there was so much support, they've got so much input [and], actually, nothing is changing. And I just think, now that has really shifted. I am like, yeah, it wasn't about them not being able to engage. It was about us not being able to meet their needs or understand what their needs were"* .

'A safety net' for clinicians

A number of participants experienced a greater sense of confidence that the service user's issues were being heard and that their distress was being contained. Led by a desire to care for clients, there was a sense that the participants found it disconcerting to be unclear whether their clients were overwhelmed in therapeutic work. As such, the support from embedded cultural consultation to manage clients' distress was a containing experience for participants. Omar described a situation where language barrier added to the distress of a client *"He didn't speak any English; his wife doesn't speak any English. And they both were highly, highly, highly anxious, and what heightened their anxiety was the fact that they couldn't really communicate"*.

The participants felt that this was achieved through the Cultural consultants work with clinicians to effectively navigate cultural and religious factors in a service user's life to develop a more robust understanding of the service users' needs. The participants felt that they were in a safer position in their practice, because working with cultural consultants minimises the likelihood that the *meaning* behind what is being expressed by Bangladeshi/Sylheti carers and service users would be missed by clinicians. Thus, helping participants to navigate the hybrid habitus with more confidence. Aisha described that: *"[Cultural consultants act as] a bit of a safety net that if either myself, or somebody else were to make a suggestion in a care plan, or say something that was a bit insensitive, or was out of keeping with the cultural background of the patient or their family that would be caught up immediately, basically going through the care plan and losing the rapport with the patient and their family, and losing the buy-in"*.

The dance: sharing power and relinquishing control

Participants reported feeling as though they could share some of their responsibility and ‘power’ when working with service users. This is because participants felt that embedded cultural consultants had strong therapeutic skills and knowledge of the service alongside their cultural knowledge. This relationship with the embedded cultural consultants had been made possible over time spent working together. Conversely, some participants reported feeling cautious about support from external translators, since it is harder to predict the quality of service they would provide: *“ it’s quite a different position to take as well [with embedded cultural consultants] because you’re perhaps a lot less active than you expect to be and maybe it’s a bit about sometimes relinquishing control…it sounds like you’re both doing the work, wherever you might have [to] come in, with your training or expertise as facilitating this, but you’ve got another person there, who’s also got their own skills and expertise. You’re both kind of meeting [in the middle] somewhere that will support this client”* (Lou). Lou continues, but compares this experience with working alongside external interpreter*: “It’s completely different to working with an interpreter because if an interpreter starts talking to the family on their own and saying their own thing, normally. You’re going to interrupt and be like hang on a minute. This is not what you’re supposed to be doing”.*

This excerpt from Lou reflects sentiments expressed by other participants that suggest a ‘dance’-like therapeutic approach with the embedded cultural consultants in which the participants and consultants alternated in taking the lead and taking a different position. Participants remarked on how the nature of the ‘dance’ or negotiation of power could be pre-arranged before an appointment or, arise in a more impromptu manner during the appointment, navigated through using therapeutic instincts. There is a sense that the shifting of power between the staff members enhance the quality of the work and is improved upon through positive professional relationships and trust. As such, participants suggest that this quality of the ‘dance’ cannot be replicated with a new ‘dance partner’, i.e. untrained external

translators. Participants also reported feeling ‘bad’ or sometimes that it was less appropriate to contact embedded cultural consultants if they only required translation, as there was an awareness that the Cultural consultants are a highly-requested and special resource in the service. It is possible that the participants didn’t necessarily view the resource in this way when they first started the role. Sam (P8*): “Because they [Cultural consultants), are also very full on…there’s not much time for rescheduling”*.

Enhancing the professionals’ experience

A sense of containment: brought about by consultants’ various skills

There was sense from participants that working with embedded cultural consultants enabled the therapeutic work to be more containing because of the combination of skills and experience that embedded cultural consultants offer. Embedded cultural consultants bring skill in language interpretation, therapeutic skills, as well as additional training. It is noted that in addition to the benefits to co-working with the consultants in the clinical setting; it is likely that the consultants having a range of skills, some of which being formal training, are likely to feel more appeasing to staff members who are seeking to maintain the integrity of therapeutic intervention and manage the risk matters.

There’s is sense that participants enjoy work with the embedded cultural consultants because they also operate in a way that makes their resource accessible for clinicians, since their offering is in keeping with their hybrid habitus, as trained healthcare professionals.

As Taylor described *“I also wanted to work with the cultural consultants, alongside me, it is to help me think about the family context, as well as to interpret…The [embedded cultural consultant] I worked with, was a family worker….so I want that kind of breadth of experience”.*

Few participants described that support from embedded cultural consultants would feel appropriate to call upon, depending on the kind of work the participant was doing. It is noteworthy, that these participants had commonly described working with the Cultural consultants in single session appointments e.g., triage, where it as not as appropriate to develop a detailed understanding of the service users' challenges. As described by Tristan: *"I haven't actually needed or used cultural consultants as of yet to help with cultural considerations, specifically within my casework, but I know that would be absolutely what I would be calling them on if there was a need"*.

For these participants, the benefits of having embedded cultural consultants in the team were less obvious. However, the opportunities to make use of cultural and religious expertise would have been limited. The participants all expressed that the Cultural consultants were a valuable resource that they would like to work alongside more in their practice.

Enjoying learning in and out of the clinical encounter: informal and formal.

A number of participants described that they felt appreciative of the informal, unplanned conversations that they were able to have with Cultural consultants. They reported that this helped them to ask questions that required a brief answer and have ongoing conversation to reflect on working with the local Bangladeshi community. This form of learning about a culture appeared more akin to the informal/intuitive ways in which humans might learn about their own cultural practices; participants reported that they found this approach enjoyable, perhaps because the approach felt more interwoven in their daily work. A majority of the participants also noted that the COVID-19 pandemic, which more widely brought about a shift in 'hybrid' working in the NHS, had impacted the ways in which staff members could seek support from the embedded cultural consultants team. Participants

described that they were able to ‘walk’ over or ‘turn a chair’ to speak to an embedded cultural consultant prior to COVID-19 social distancing measures, but since home-working had become more mainstream in this team and hybrid working began become a norm, accessing Cultural consultants had become more challenging. Omar described this *“of course, we have supervision, and we have team meetings and things. But I think having those casual encounters with colleagues can be helpful. And it’s something that was missing during lockdown, where we didn’t have those chair swivel moments where you could just grab someone”.*

Participants also felt that formalised working had the beneficial impact of building clinicians’ knowledge of Sylheti culture, the experience of this community migrating the UK matters; as well as their relation to Islam was something that clinicians thought to be valuable (e.g. formal training session). Thus, enabling participants to have a greater understanding of the Bangladeshi population who were regularly using the service. Jordan reflects on this: *“When I first started, we had some the Cultural consultants team doing a presentation on Islamic psychology, and I think it became clear quite early doors that, you know, we were going to have to really be able to adapt our work at times to meet the families understanding of their difficulties”.*

A mutual learning experience

Participants observe that working with Cultural consultants has enabled them to learn a great deal. In addition to this though, the participants also describe observing a phenomenon whereby the embedded cultural consultants have been developing in their therapeutic skills from working with clinicians over time. Thus, observing a possible mutual development taking place over time which has been taking place over time spent working together as a team. Mal speaks to this: *“with the Cultural consultants …they’re clinically trained through*

seeing a lot of our work...they're not clinically trained when they came to the job, but when [they] start work, that's how you learn".

Connection to the local community

The analysis found that participants felt that working with embedded cultural consultants raised the importance of making the service accessible to the local community. As well as this, participant felt that working Cultural consultants supported clinicians in having a deeper knowledge of the local community, as well as stoke a desire to build upon existing ways of working in order to have more contact with the community that the service is situated in.

Greater sense of urgency in having an accessible service

Participants are led to reflect on the experiences of their Bangladeshi service users and consider the challenges that they might have/or continue to face in other public services. As Alex describes:

"*They [service user] had, unfortunately experienced a lot of being shunned, and not being taken seriously, partly because people didn't understand the mental health implications, also a language barrier, and the difficulties mom had gone through.… But she just felt more comfortable expressing herself in her own mother tongue. And it helped…It helped her to contain the young person"*. Similarly, Morgan shared that*: "I feel like DNA rates are much less when you've had [embedded cultural consultation] support from the beginning"* .

This extract was reflective of a sense amongst participants of feeling moved by the injustices experienced by service users and the work of embedded cultural consultants being a means through which to tackle these injustices. It was noted that a number of the participants had begun to reflect on previous work places and the efforts (or lack thereof)

made to include cultural and religious perspectives on the care and overall experience of service users. Some of these participants felt that the attention paid to cultural needs and cultural/ethnic/racial difference had been minimal in other services; despite working amongst a culturally diverse population or staff team. Jordan:

"I worked in a variety of settings, not for any great length of time. But I worked in [a team]. And I remember going in to have lunch one day and there was an enormous room full of police officers…and it was a predominantly white police group, but the population of those who were coming through the doors, where not white. And I don't there wasn't ever really reflective spaces at all... I don't know if there were ever any [space] to think about what we're bringing to that, and how, what those experiences were like [for staff and service users]".

A desire for further expansion of the embedded cultural consultants resource

Most participants reported that working with cultural consultants created a desire to have embedded cultural consultation be even more embedded in the team's practice than it currently is. The reasons for this were because their skill and cultural knowledge applied in other professional contexts would enhance: service users' care plans; service user formulations; and encourage opportunities to reflect on cultural and religious factors pertinent to clinicians' cultural competence, amongst other points. As Aisha explains:

"It could be helpful also if not joining regular MDTs, maybe having a regular presentation…because I think it's relatively clear, particularly, with the experience that they've had [Cultural consultants], the things that one clinician might pick up anecdotally from working with the cultural consultants; is probably a tiny fraction of what the cultural consultants recognizes over their longer period of practice or in general…So, it might be

helpful to have that every now and again, a bit of a teaching or training session from the cultural consultants just to keep clinicians informed and culturally aware"

There was also a shared sense that Cultural consultants' presence in the multidisciplinary team, would enhance the possibility for cultural and religious perspectives to remain held in the mind of the clinicians; and as such, there was a shared sense that Cultural consultants having an increased presence in team working would enhance this. Tristan explains:

"To actually ask [Cultural consultants] to attend regular meetings would be such a demand on their time But in terms of just the [pathway] meetings …it is so helpful to have their [Cultural consultants] representation, to help case discussions. Because we bring into those meetings complex cases where we're stuck. And we're wanting that multidisciplinary thinking around the case. But often what we're missing is cultural perspective on cases where we might be having [a] blind spot".

As participants reflected on the work of Cultural consultants, a number of participants described a feeling of wanting to do more to in the community and wanting to develop innovative ideas to see this come to fruition. The participants' desire for avenues through which to deepen their relationships with their clients extended to engaging the broader community. As Taylor reflects, described "we have an expertise with cultural advocacy that could help us to engage other populations… but yeah, there's also a lot more we could do. We could expand our, kind of, set methods to help us deliver an equal quality of care to other populations".

It was evident from the analysis that Cultural consultants had been either meeting a desire amongst professionals to engage better with the Sylheti culture; or stoking a desire to engage better with the local community. Morgan said *"how do you make sure all those*

people's needs are being met? But it also wouldn't be realistic to be like, we have one cultural consultant for every single culture. And I think that's what it's highlighted to me is, this has such an important role" (page 157).

Lou *"So maybe [the team] being more active in, not necessarily in the local community, but kind of in the local culture. I don't know.. but let me tell you what I'm thinking anyway… So like, when we have socials, we always go to the pub…but like it might be nice to go to do like a different activity or something to be more inclusive. And I think maybe kind of doing things like that might be a different way of, influencing practice…a bit of embedding the local culture a little bit more*".

Discussion

The aims of the study were to explore how clinicians experience embedded cultural consultation in the context of the 'clinical encounter'. Namely, how do they experience co-working with embedded cultural consultants in CAMHS services and describe the impact on their clinical practice; and understanding of working with clients from different cultures.

Findings suggest that participants experienced working with embedded cultural consultants as a means by which to engage service users and the local community better. In keeping with the theoretical framework outlined by Owiti et al. (2014), working with embedded cultural consultants invites participants to reflect upon the various hybrid habitus that are interacting (Lo & Stacey, 2008; Owiti et al., 2014).

The participants reflected on the impact of co-working with embedded cultural consultants in varying contexts in their working lives - beyond the clinical encounter. This is also interesting to consider given the diverse mix of ethnicity and professional disciplines represented in this study; in that this form of consultation enables more cultural reflections for clinicians from diverse backgrounds (professionally and personally). They suggest that

this work is fulfilling an emotional or value-led component of supporting to rectify the injustices of minority groups who experience poor outcomes in mental healthcare. The participants report an emotional sense of fulfilment as engaging in this work with cultural consultants enabled them to meet a need that might not have been met otherwise (e.g., granting service users an opportunity to freely express themselves). This in turn, enabled participants to feel more developed in their cultural competence over time as trust and working relationships with cultural consultants grew. Results also suggest that over time participants' experience of cultural embedded consultation strengthened their relationships with cultural groups in their local community and enhanced their confidence in the effectiveness of therapeutic work for these groups.

The embedded cultural consultation approach appeared to raise the awareness of culture, not just of their client population, but the clinicians' cultural norms., This enabled clinicians to use these reflections to make treatment more effective for their service users. The internal validity of the study is supported by similar studies (although not researching embedded cultural consultation) where findings support the beneficial impact of cultural consultation on perceived cultural competence, treatment plans and therapeutic engagement (Kirmayer et al., 2003; Bhui et al., 2012).

Kirmayer et al. (2003)'s work evaluating the impact of an external cultural consultation service, also reported findings of improvements in therapeutic alliance. Bhui et al. (2012) also reported that the external CCS service supported clinicians to make considerable improvements to service user treatment plans. However, unlike the challenges that were reported in these studies (Kirmayer et al., 2003; Bhui et al., 2012), the present study suggests that an embedded consultation approach model offers similar benefits to an external model but without limitations such as the inappropriateness of recommended

resources, concerns about competence and supporting the management of complex cases (Kirmayer et al., 2003; Bhui et al., 2012).

The participants in the study were pleased with the support that embedded cultural consultants provide, with the most consistent suggestion for improvement of the resource was that to have more cultural consultation; and to have it more deeply embedded within the CAMHS team functions (e.g., attending meetings).

Limitations

The study focused on the experience of NHS clinicians working with embedded cultural consultants; the experience of service users and carers have not been explored as part of this research. For the purposes of consultation, attempts were made to have some input from service users and family members to review the research procedure (e.g., interview schedule), as well as describing what the experience of working with an embedded cultural consultant is like from their perspective. However, it was not possible to receive support from the appropriate channels to make contact with service users possible.

Participants may have found it more difficult to express criticism and suggestions for improvement, compared to participants in studies exploring work with external cultural consultants (e.g. (Kirmayer et al., 2003; Bhui et al., 2012)), ; the embedded cultural consultants were colleagues that worked alongside the clinicians in this study. Therefore, it is possible that there may be a bias to speak about their experiences of embedded cultural consultation with less criticism. The study attempted to minimise potential bias, by making efforts to maintain confidentiality as much as possible, which was explained to participants prior to the start of the interview (see Information sheet, Appendix E).

Impact of the Covid-19 pandemic and the introduction of 'hybrid' working

It is noteworthy in considering the findings of this study that historically (up until March 2020), staff members in this CAMHS service mostly operated out of a single building. The working space had facilities for therapeutic work with young people, carers and family working. This building is still in regular use; however, it's use changed following the COVID-19 pandemic announcement in March 2020. The CAMHS service worked remotely for a period, which meant a transition to having appointments via telephone or video call. More recently, the service began to adopt a 'hybrid' model. This hybrid model of working involves professionals partially working remotely, typically away from the main site; and partially doing 'face-to-face' work with service users, on the main site or visiting clients' homes. This is noteworthy is this is likely to have meant that participants who are newer employees of the staff team (< two years) are likely to have had a different experience of working with embedded cultural consultation compared to other participants. Since the style of working with the consultants is likely to have taken a different form since March 2020. This difference may not be significant, but it is worthy of note.

Implications for clinical practice

Unlike other comparable studies. the findings of this research share the impact of embedded cultural consultation on the clinician, as well as the perceived benefits that clinicians observe from working in this way. It is recommended that such an embedded cultural consultation ought to be considered by mental health services as a means to more effectively work with diverse populations. Should such an approach be implemented a service, in addition to basing this on make-up of the local population, the perspectives and readiness of the clinicians working in the service ought to be considered too. This study explores the experience of an embedded consultation resource that has been operation for 20 years, and the participants in the study have been employed in the service more considerably less time than the Cultural consultants have done. As such their process of adjusting to

working alongside cultural consultants may look different when compared an established service starting to adopt an embedded cultural consultation approach. Despite this, as indicated by the participants in the study, clinicians who chose to adopt this way of working may find it to be satisfying decision.

Recommendations for future research

This study was unable to include the perspectives of service users and carers, as it related to how they might have experienced embedded cultural consultants impacting upon the clinical encounter. Future research could consider the role of exploring how service users and carers experience embedded cultural consultant and how this might expand our theoretical understanding of cultural competence also.

Given the lack of research in the area of embedded cultural consultation, future research could include a study evaluating mental health outcomes in services with embedded cultural consultation, when compared with a mental health service that does not have embedded cultural consultation (as a control group). It is noteworthy that for such a study, both services would need to be a location which has similarly diverse population. A randomised control trial could be attempted for such a study as this, however, there may be some significant ethical and practical factors to be considered.

Conclusion

The findings from the study suggests that working embedded cultural consultants enables clinicians to reflect further on their personal culture and its interaction with other cultures in the clinical encounter and in other contexts. That the deepened understanding gain, leads to more fulfilling work for clinicians and increasing confidence in their ability to effectively work with clients from different cultural backgrounds.

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Appendices

Appendix A: Group experiential themes

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Appendix B:

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Appendix C: Transcript, Exploratory Notes, Experiential Statements

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Appendix D: Interview Schedule

Interview Schedule

The interview will be semi-structured, aiming to elicit participants' experiences of cultural consultant co-working. The questions will aim to follow the participants' line of thinking and may not be asked in the exact order of the 'core questions' listed below.

Please note: Not all 'core questions' are expected to be answered by the end of the interview.

Introduction

- Introduction of the researcher
- Confirm that the participant has read the information sheet and ask if participant has any questions it.
- overview of the research.
- Work through the consent form, reminding the participant about withdrawal
- Confirm contact details
- Give opportunity for participant to ask questions

Consent form & demographic questionnaire

- All suitable participants who have agreed to take part in the study will be asked to complete their consent form online as part of the pre-screening for gaining consent. This will be sent to them at least 24 hours before their scheduled interview. They will be asked to indicate their willingness to attend as well as answer the following demographic questions:

- Demographic information will be gathered prior to the recording at the same time as consent (at least 24 hours prior to interview):
    1. How would you describe your gender?
    2. How would you describe your religious or spiritual affiliation?
    3. How would you describe your ethnicity?
    4. What is your profession?
    5. How long have you been working in this profession?
    6. How long have you been working in this service?
    7. How long have you worked with a cultural consultant (in the form of MDT discussion, individual or group contexts)? Please indicate the frequency of contact.

Core questions:

1. When did you first think that you might need (something like) cultural consultation?
    a. Why? b. What did that feel like?

2. Do you remember the first time you used/accessed cultural consultation in your work? This can include experiences of cultural consultation before you joined this service. Could you tell me the story of how that came about?
    a. What did it mean for you?

3. Could you tell me a more recent time that you sought consultation from the cultural consultants/bilingual co-worker?
    a. (If the model is different what is in the current service) What kind of model was presented for this? (i.e., external consultation; informal; family or friends; etc .)
    b. How does the embedded co-working model, compare to your previous experience of seeking cultural consultation?

4. Tell me the story about how you sought support from the cultural consultants/bilingual co-worker? What was it like doing this? Prompts:
    a. How did you feel about that?
    b. How did you make sense of that?
    c. What was it like?

5. Have you changed the ways you make use of cultural consultation over time? How so?

6. If at all, how have you found that co-working with cultural consultant has influenced your practice/thinking?

    a. In your opinion, how could the work of cultural consultation be even more influential to your practice?

7. Is there anything that you would like other professionals to know about this model of co-working with cultural consultants?

Examples of other general prompts

- Can you tell me more about that?
- Why is that?
- What are your thoughts/feelings about that?
- What was that like?
- How so?
- How did you make sense of that?
- How did you feel about that?

Ending

- Thank participant for their time and contribution
- Offer a debrief
- Let participant know next stages of the process
- For participants who would like to be involved, explain that I will be in touch regarding the results of the research. Ask if they would like to comment on a summary of the findings

Appendix E: Information sheet

Salomons Centre for Applied Psychology,
Canterbury Christ Church University
1 Meadow Road, Tunbridge Wells, Kent, TN1 2YG

Information about the research

Exploring the experiences of clinical professionals co-working with cultural consultants in CAMHS services

Hello. My name is [Redacted[and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide whether to take part, it is important that you understand why the research is being done and what it would involve for you.

What is the purpose of the study?
The purpose of the study is to explore how NHS CAMHS professionals experience co-working with cultural consultants and how they experience cultural consultation on their clinical practice. Given that there is little research in this area at present, it is hoped that this research could aid other services in similar contexts who wish to make use of cultural consultation in their practice.

Why have I been invited?
As you are a clinical staff member working in a CAMHS service that has cultural consultants embedded within the team

Do I have to take part?
It is up to you to decide whether to join the study. If you agree to take part, I will then ask you to sign a consent form (please see page 3). You are free to withdraw at any time, without giving a reason. If you choose to withdraw from the study, you can do so with no disadvantage to yourself. If you are interested in taking part in the study, I will arrange a convenient time to contact you before arranging an interview to ensure you have an opportunity to ask any questions.

What will I be asked to do?
You will be asked to take part in a 60-minute interview which will take place over the phone or using a video calling service (e.g., Zoom, Microsoft Teams), whichever is preferred by you. You will be asked questions about your experiences of working alongside cultural consultants in your context, your experiences of receiving the consultation along with your perspective on its wider benefits and challenges. You will also be asked to complete a brief online demographics questionnaire which asks to you to write down your demographics, such as your profession, length of time in the service, ethnicity, amongst others.

What will happen to my data if I take part?
Your personal details will be anonymised. The interview will be audio-recorded then transferred to a secure encrypted device that only I will have access to.

During the interview I may ask you to share information about your clinical practice and you will be free to share as much or as little as you feel comfortable. I will ask that you try to keep information as anonymous as possible. However, I understand that this is not always easy to do so I will anonymise any data before discussing it in supervision. To support with anonymity, you may wish to take part in a private area or a private space at your home. Any quotes used in the write up of my thesis and subsequent publications will also be anonymised. I will also keep any information discussed in the interviews confidential.

What you say will be shared with my supervisors [redacted], but they would **not** know who you are.

Expenses and payments
There will be no payment for taking part in this study.

What are the possible disadvantages and risks of taking part?
It is not anticipated that there would be any risks to taking part. However, you are invited to only share what you feel comfortable to express. If you feel as though something has been brought up that is particularly challenging, you are welcome to take a break.

There may be points where you find that discussing your experience of co-working with cultural consultants is uncomfortable. I will make every effort to create a safe and comfortable space within the interviews to discuss your professional experiences. You are welcome to take a break, ask to move on to a new topic or to stop the interview at any time.

As one of the supervisors on this project currently works as a clinical psychologist in a CAMHS service that has cultural consultants in the team, there is a chance that they will be able to recognise participants. I will make every effort to anonymise data before discussing it in supervision so as to reduce this risk. Also, Supervisors will have limited access to the (anonymised) transcripts. Dr Nasrin will only see short excerpts from transcripts.

What are the possible benefits of taking part?
There are no direct benefits to you for taking part, but your participation will be contributing to research which is hoped to improve NHS and mental health services. It is hoped that the research will contribute to a greater understanding of clinicians' experience of cultural consultation. Engaging in research about this unique approach to cultural consultation might draw the attention of other services who may be considering a form of cultural consultation and provide them with research that can inform their decision making. Ultimately, it is hoped that this research will better equip services to support staff and service users from diverse backgrounds. There is no directly intended benefit to you, but you may find your involvement in the research rewarding.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to me, and I will do my best to address your concerns. You can contact me by leaving a message on the 24-hour voicemail phone number [redacted]. Please leave a contact number and say that the message is for me, [Redacted], and I will get back to you as soon as possible.

Alternatively, you can email me on: [Redacted]

If you remain dissatisfied and wish to complain formally, you can do this by contacting [Contact details redacted]

Will information from or about me taking part in the study be kept confidential?
Yes, everything will be kept confidential unless it arises that you say something that leads me to believe there is risk of serious harm to yourself or others, in which case your supervisor and appropriate authority may be informed. Anonymised transcripts will be discussed and shared with my supervisor. We will follow ethical and legal practice and all information about you will be handled in confidence. Information discussed in the interview will be kept confidential, however I may have to break confidentiality something is disclosed in the interview that I am concerned about e.g., unsafe practice.

What will happen if I don't want to carry on with the study?
You can withdraw from the study, without giving a reason, within two weeks after the interview.

If you withdraw from the study, we would like to use the data collected up to your withdrawal, but only if you are happy to do so.

Will information from or about me from taking part in the study be kept confidential?
Yes. The data collected from you will be kept confidential. Only my supervisors [Redacted] and I will have access to the anonymised transcript. The audio recording will be deleted as soon as it has been transcribed. Until then, it will be stored securely on an encrypted USB.

What will happen to the results of the research study?
The initial results of the study will be written up in accordance with my university's standard for research studies. Please indicate if you would like to have access to the findings along with the final write up of the study and you are welcome to receive a copy of the final report. A brief summary of the report will be written and available for interested participants.

It is anticipated that the results of the research study will be published in a relevant academic journal. Any quotations used in the write up and publication of the results will be anonymous.
All participants will receive a summary of the results.

Data protection:

Interviews will be audio-recorded using computerised audio recording technology. No names will be stored and they will be coded with a number. Interviews will be transcribed anonymously and stored on an encrypted USB. All identifiable information (e.g., names, addresses) will be changed to protect your personal data. You will be asked to anonymise any clients that you talk about.

All anonymised data will be transferred to a password protected CD, where it will be stored at the Salomons Centre in a locked cabinet for ten years and destroyed. The researcher will keep the data in their possession on an encrypted USB for ten years after the study is completed, then will be destroyed. Data stored at the university is kept in a locked cabinet and is accessible only to the research supervisor and administrative assistant.

Who is sponsoring and funding the research?
Canterbury Christ Church University.

Who has reviewed the study?
This study has been reviewed and given approval by X NHS research ethics committee and the Health Research authority (HRA)

Further information and contact details
If you would like to speak to me and find out more about the study of have questions about it answered, please email me at [redacted] and I will get back to you as soon as possible.

Alternatively, you can leave a message for me on a 24-hour voicemail phone line at [redacted]

Please say that the message is for me, [Redacted] and leave a contact number so that I can get back to you.

Thank you for your time!

[Contact details redacted]

Appendix F: Consent form

Participant Identification number for this study: P[__]

CONSENT FORM

Title of Project: Exploring the experiences of clinical professionals co-working with cultural consultants in CAMHS services

Name of Researcher: [Redacted]

Please initial box

1. I confirm that I have read and understand the information sheet dated ….. (version1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I understand that relevant anonymised data collected during the study may be looked at by the project supervisors Dr Tamara Leeuwerik and Dr Farjana Nasrin. I give permission for these individuals to have access to my data.

4 I consent to the use of audio recording as part of my participation in the study, which will be destroyed as soon as the report has been typed up.

5. I agree that anonymous quotes from the interview and other anonymous data may be used in published reports of the study findings

6. [Optional] I agree for my anonymous data to be used in further research studies

Name of Participant____ Date______

☐ Signature (place an X in the box, to indicate an online signature)

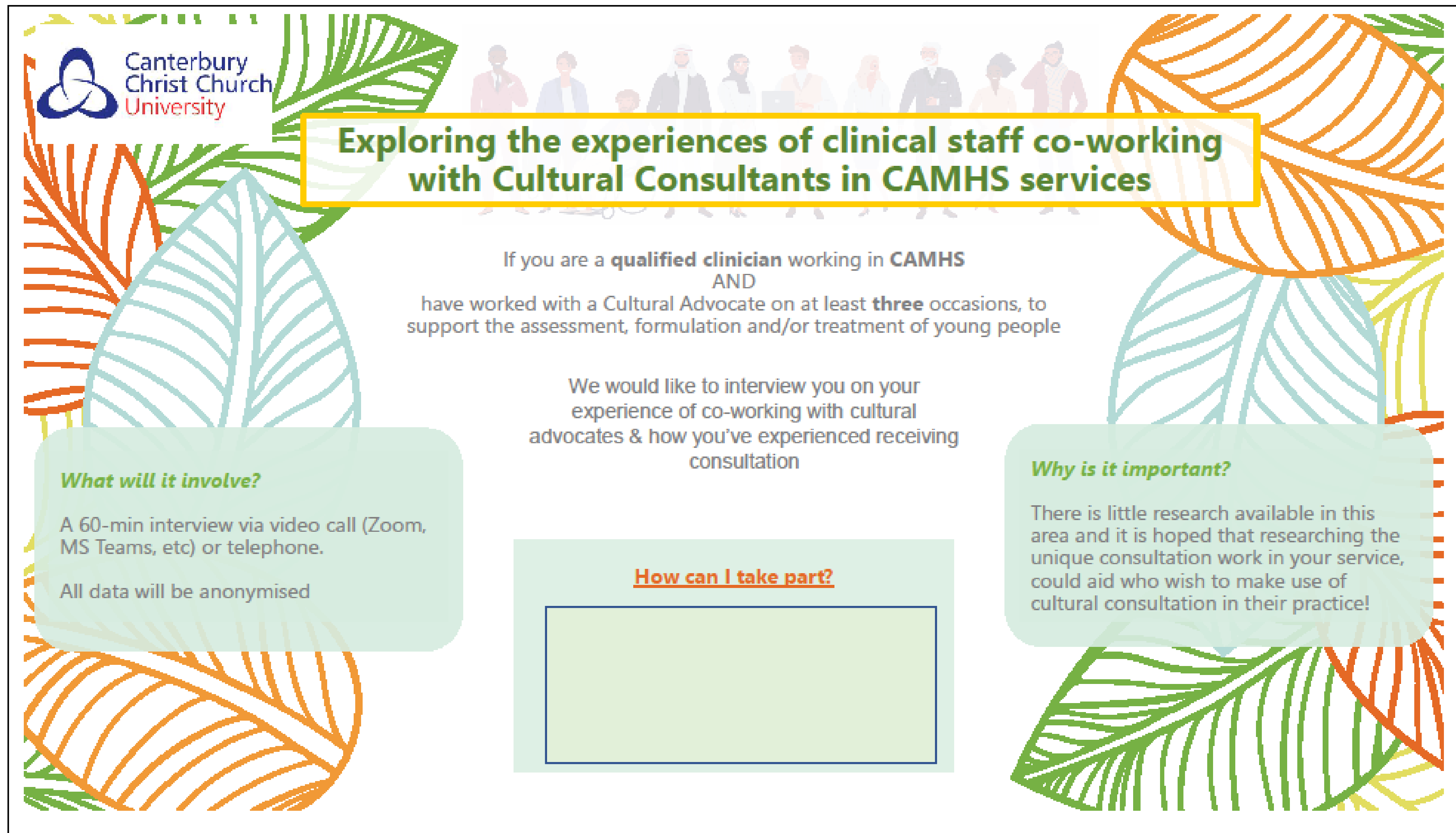
____

Name of Person taking consent _____________________________________Date_____

☐

Signature (place an X in the box, to indicate an online signature)

Appendix G: Promotional flyer for research



Appendix H: Application of NICE quality appraisal tool for quantitative studies

	Checklist item
1	**Population**
	1.1 Is the population or source area well described?
	1.2 Is the eligible population or area representative of the source population or area?
	1.3 Do the selected participants or areas represent the eligible population or area?
2	**Method of selection of exposure (or comparison) group**
	2.1 Selection of exposure (and comparison) group. How was selection bias minimised?
	2.2 Was the selection of explanatory variables based on a sound theoretical basis?
	2.3 Was the contamination acceptably low?
	2.4 How well were likely confounding factors identified and controlled?
	2.5 Is the setting applicable to the UK?
3	**Outcomes**
	3.1 Were the outcome measures and procedures reliable?
	3.2 Were the outcome measurements complete?
	3.3 Were all the important outcomes assessed?
	3.4 Was there a similar follow-up time in exposure and comparison groups?
	3.5 Was follow-up time meaningful?
4	**Analyses**
	4.1 Was the study sufficiently powered to detect an intervention effect (if one exists)?

	4.2 Were multiple explanatory variables considered in the analyses?
	4.3 Were the analytical methods appropriate?
	4.4 Was the precision of association given or calculable? Is association meaningful?
5	**Summary**
	5.1 Are the study results internally valid (i.e. unbiased)?
	5.2 Are the findings generalisable to the source population (i.e. externally valid)?

Study	Study 1	Study 2	Study 3	Study 4	Study 5	Study 6	Study 7	Study 8	Study 9	Study 10
	Chaudhry et al (2009)	**Owiti et al (2014)**	**Gault et al (2019)**	**Edge et al 2018**	**McEvoy et al (2017)**	**O'Shaughnessy et al (2012)**	**Lovell et al (2014)**	**Khan et al (2019)**	**Perry et al (2018)**	**Mir et al (2014)**
Section 1: Population										
1.1 Is the source population or source area well described?										
Was the country (e.g. developed or non-developed, type of healthcare system), setting (primary schools, community centres etc.), location (urban, rural),	Developed. Manchester based, Invited local Pakistani women - it's not clear how this came about.	UK	Yes	Manchester, UK	Yes	Yes	Yes - NW of England	Yes - Manchester	East London	Yes

population demographics etc. adequately described?										
1.2 Is the eligible population or area representative of the source population or area?	Unclear, whether all Pakistani women able to be a part of this group?	Yes	Yes	Yes, diverse, populated city (typical environment where many ethnic minorities live)	yes	Yes	Yes, but it’s unclear what they mean by/ why they were recruited 4 'disadvantaged localities'.	Yes	yes	Yes
Was the recruitment of individuals, clusters or areas well defined (e.g. advertisement, birth register)?	Yes. Gathered from existing population study of depression in people from Pakistani 'family origin'	Yes	Yes	Yes, 2 mental health trusts in NW England.	yes	yes	"We recruited older adults and ethnic minority participants (South Asians and Somalis) in two Primary Care Trusts in the Northwest of England. Core inclusion criteria for both elders and ethnic minority participants included being registered with one of 16 primary care practices in the two Primary Care Trusts and scoring 10 or more on the PHQ-9 and/or the GAD-7 (threshold for moderate depression and anxiety respectively)."		Yes "Referrals were received via the City and Hackney mental health network (City and Hackney MIND), from GPs, other local authorities or self-referral, and group participants were randomly selected from Derman’s mental health waiting list. Clients identified as appropriate were offered the option of attending the ACT group. Those who agreed were jointly assessed for suitability by the BME Access Service clinical psychologist and mental health coordinator from Derman."	

Was the eligible population representative of the source? Were important groups under-represented?	inclusion/Exclusion could be clearer - immigrant impact is mentioned in the intro, but not clear how many participants are immigrants Vs 2nd gens.	Yes	Yes	Yes, but those who did not have access to their biological families participated by working with FSMs	yes, no important groups were represented for this	not quite 'Due to limited resources and the need at the time, a decision was made to target one cultural group: West African women. This is a limitation of this study, however, we believe with cultural adaptation women from other cultures could benefit from a similar approach.'	Yes.		Yes
1.3 Do the selected participants or areas represent the eligible population or area?	Yes	Yes		Yes	yes	Yes	Yes		Yes
Was the method of selection of participants from the eligible population well described?	No (don't know how the comm group came to be)	Yes		A 'convenience' sample was recruited, assuming the people that were asked were those that belong to the trusts. Unclear on how they gathered them though (e.g. flyers, or asking	Service evaluation, so they just offered it. However, GPs refers their clients to the service	Yes 'recruitment was to proceed via referrals of women attending maternity units, asylum screening centers and mental health services who were screened and a service was offered to those most at risk by clinical	Yes		Yes

						assessment measures such as the Hospital Anxiety Scale (Zigmond and Snaith, 1983) and the Impact of Events Scale (Weiss and Marmar, 1997)'			
What % of selected individuals or clusters agreed to participate? Were there any sources of bias?	18 out of 55. No clear bias source	Was rolled out across 4 CMHTs. 94 clinicians were 'expected and invited' to participate. Across the different strands: 30 attended 15 training sessions; 67 out of 94 completed the TACCT questionnaire at baseline, 28 at follow up, 16 completed evaluation forms	unclear	30 out 290 total service users, but only 150 estimated thought to be eligible (due to exclusion criteria & current health) therefore of those who were eligible. So 20% from that perspective. They report that this would be enough for a feasibility study, but no literature is included to back home. It's noteworthy that research including those diagnosed with schizophrenia is challenging (due to dropout and health related issues).	whoever was referred.	21 group sessions, ranging from 4 - 12 mothers and babies at any given time. Reasons for drop out included "immigration detention, obtaining refugee status, sufficient family support in Liverpool, and fear of gossip in the community"	unclear	unclear	
Were the inclusion or exclusion criteria explicit and appropriate?	inclusion/Exclusion could be clearer - immigrant impact is mentioned in the intro, but how many participants are immigrants? Vs 2nd gens?	Yes	Yes	Yes, reasonable, clear.	Specifically for members of the Jewish community	yes, more exclusion was given that originally intended, this was largely due to limitations in what would be capable in the service. The exclusion, leads to a deviation from what the study aims to research though. Particularly as the included	Yes, threshold PHQ or GAD, 10 or more		Yes

						group with some (although not much) shared characteristics - all being West African.			
Section 2: Method of allocation to intervention (or comparison)									
2.1 Allocation to intervention (or comparison). How was selection bias minimised?	Names taken of folks in alphabetical order	n/a			at the discretion of the GP, this was challenging as the GPs choice not to refer needs reviewing.	By choosing refugees from a specific part of the African continent	"In the ethnic minorities group, 39 patients were referred" (Figure 4). Of these 20 (51%) were referred by GPs, 8 (20%) were self-referrals 2 (5%) by primary care mental health teams, 5 (12%) by voluntary organisations and 4 (10%) by others. Twenty (51%) were randomised. At 20 weeks, 16 (80 per cent) completed follow-up (79% in the intervention group and 83% in the control).		n/a
Was allocation to exposure and comparison randomised? Was it truly random ++ or pseudo-randomised + (e.g. consecutive admissions)?	No	n/a	n/a	n/a	n/a	No mention of randomisation present	Thirty seven (44%) were eligible and randomized to be allocated to either control or intervention. At 20 weeks 33 (89%) completed follow-up (96% in the intervention and 71% in the control).	n/a	n/a
If not randomised, was significant confounding	Not obviously	n/a	n/a	It's possible that those who approached/accepted are those who already had	n/a	Potentially, yes. Unclear what that might be, and why they	n/a	n/a	n/a

likely (−) or not (+)?				favourable experiences with the Mental health service, or members of the team. This is likely to be a factor in participants', engagement and maybe the outcome.		chose the West Africans also.			
If a cross-over, was order of intervention randomised?	N/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	no
2.2 Were interventions (and comparisons) well described and appropriate?	yes	n/a	n/a	yes	yes	Yes - p5 - 6	yes	n/a	no
Were interventions and comparisons described in sufficient detail (i.e. enough for study to be replicated)?	Yes	Yes	n/a	yes	yes	Yes, in line with what psychologists would be able to replicate it, given how familiar to psych work. Another discipline might got about 'time for mothers to talk..' differently though.	yes, page 3 - 4	n/a	Yes - photos and everything "The culturally adapted ACT group protocol was renamed: 'Farkındalık ve ¸Sevkatle Kabullenme' ('Acceptance with Mindfulness and Compassion'). The adaptation process also produced shared resources so that the group could be delivered in both statutory and voluntary sectors in the future to support sustainability.

									Resources included collectivist value cards specifically developed for Turkish-speaking contexts. For example, the cultural value ‘Çabalamak’ (‘Struggling’) is imbued with the qualities of courage, perseverance and strength to overcome difficulty."
Was comparisons appropriate (e.g. usual practice rather than no intervention)?	n/a	yes, baseline measures would have considered what things were like in usual practice	n/a	no	yes	n/a	Yes, TAU	n/a	n/a
2.3 Was the allocation concealed?	no	No	n/a	n/a	no	n/a	n/a	n/a	n/a
Could the person(s) determining allocation of participants or clusters to intervention or comparison groups have influenced the allocation?	n/a	No	n/a	Yes (as mentioned earlier)	yes	n/a	For the ethnic minority part: n=14 in wellbeing; n=6 in TAU	n/a	n/a
Adequate allocation concealment (++) would include centralised allocation or computerised allocation systems.	n/a	N/a	n/a	n/a	n/a	n/a		n/a	n/a
2.4 Were participants or investigators	No	No	b/a	b/a	n/a	n/a	Page 5 "Was on a 2 (intervention) to 1 (control) basis, and	b/a	n/a

blind to exposure and comparison?							carried out by an administrator who had no formal connection to the study to ensure concealment of allocation from those assessing eligibility to the study"		
Were participants and investigators – those delivering or assessing the intervention kept blind to intervention allocation? (Triple or double blinding score ++)	not clear	N.a	b/a	b/a	no	n/a	see above	b/a	n/a
If lack of blinding is likely to cause important bias, score –.	n/a	N/a	n/a	n/a	n/a	n/a	see above	n/a	n/a
2.5 Was the exposure to the intervention and comparison adequate?	yes	Yes		yes	yes	Yes	Yes, there was minimal attrition also		8 sessions, fortnightly. Attendance was above 70% for each session.
Is reduced exposure to intervention or control related to the intervention (e.g. adverse effects leading to reduced compliance) or fidelity of implementation (e.g. reduced adherence to protocol)?	n/a	N/a	n/a	There's over 9 sessions, which is adequate.	n/a	n/a	no	n/a	n/a

Was lack of exposure sufficient to cause important bias?	only if some ps new more than other ps	N/a	n/a	n/a	n/a	For participants who only attended for only a few sessions, however, they didn't clarify the no of session each p attended, and so a range cant be easily determined.	not clearly on the TAU end.	n/a	n/a
2.6 Was contamination acceptably low?	I think so	Yes	n/a	Acceptable in the sense of what might be feasible in an NHS setting. In that people were likely to be approached. This introduces researcher bias, but undoubtedly hard to minimise this. But we need to hear their justification for this	it was service eval + research, so this is more demonstrative of effectiveness as opposed to efficacy.	yes	yes	n/a	n/a
Did any in the comparison group receive the intervention or vice versa?	n/a	Same group before and after	n/a	None	n/a	n/a	no	n/a	n/a
If so, was it sufficient to cause important bias?	n/a	Only in that participants did not opt in to this, rather it was a pilot that participants were expected to engage with. Therefore, there may be some reluctance in whether people wanted to take part in this, which may skew the outcome data (evaluation forms and tacct). It may have been better to get a			a			n/a	n/a

		sense of participants' attitudes before introducing this intervention							
If a cross-over trial, was there a sufficient wash-out period between interventions?	n/a	N/a	n/a	N/a	n/a	n/a	n	n/a	n/a
2.7 Were other interventions similar in both groups?	n/a	N/a	n/a	N/a		n/a	n	n/a	n/a
Did either group receive additional interventions or have services provided in a different manner?	n/a	Not quite, it is unlikely that there was a referral system in quite the same way.	n/a	None	n/a	no, but 6 other mothers and babies attended the sessions and it is unclear why this was the case.	TAU is unclear, as which might be typical	n/a	n/an
Were the groups treated equally by researchers or other professionals?	n/a	yes (in an appropriate manner for the study)	n/a	N/A	unclear	appears so	Yes - in terms of outcome measures and recruitment.	n/a	n/a
Was this sufficient to cause important bias?	n/a	N/a	n/a	N/A	unclear. It's noteworthy that the role of rabbi's (cultural/religious leaders) in this study is likely to have considerably sway (as indicated by the author(s))/	n/a	Ni	n/a	n/a
2.8 Were all participants accounted for at study conclusion?	n/a	yes	n/a	Yes	?	unclear	only one participant dropped off	n/a	
Were those lost-to-follow-up (i.e. dropped or lost	n/a	no	n/a	Some. In acceptability, 2/52; feasibility in SU s 9/27 (30%) so not un	N/a	numbers not given	no	n/a	

pre-,during or post-intervention) acceptably low (i.e. typically <20%)?									
Did the proportion dropped differ by group? For example, were drop-outs related to the adverse effects of the intervention?	n/a		n/a	n/a	n/a	n/a	no#	n/a	
2.9 Did the setting reflect usual UK practice?	yes	Yes	yes	yes	Yes	In part.	yes	yes	yes
Did the setting in which the intervention or comparison was delivered differ significantly from usual practice in the UK? For example, did participants receive intervention (or comparison) condition in a hospital rather than a community-based setting?	Yes	no	No	no	No	no	No	no	No
Did the intervention or comparison differ significantly	No	No		No, therapists were the ones who administered the treatment.	The intervention was unique in UK practice				

from usual practice in the UK? For example, did participants receive intervention (or comparison) delivered by specialists rather than GPs? Were participants monitored more closely?							
Section 3: Outcomes							
3.1 Were outcome measures reliable?	Yes	A modified of an existing model for cross-cultural assessment was used.	n/a	The WAI, GHQ HUI and KAPI have been researched (p95)	mentioned "anonymised clinical outcome measures" and "naturally occurring data" but there's no mention of what these are.	yes - session by session evaluation (self-report), 3 x reflective groups, CARE index (more objective approach)	yes
Were outcome measures subjective or objective (e.g. biochemically validated nicotine levels ++ vs self-reported smoking –)?	Self-reported measures.	Subjective	n/a	No, all of them were self-report/	some possible objective, but most are subjective.	See above	yes
How reliable were outcome measures (e.g. inter- or intra-rater reliability scores)?	Not reported	none reported - but désirée et al (2008) reported high internal consistency.	n/a	WAI is good, GHQ is good, PCS has reliability (Renshaw, 2008),	n/a	Care index allows for a consideration of developmental or contextual (Crittenden, 2007)	phq9 and gad 7 – used in regular practice in the NHS
Was there any indication that measures had been validated (e.g. validated against a gold standard measure or assessed for content validity)?	No	Content validity done (under 'data analysis' section)	n/a	Just research	n/a	Not clearly	yes
3.2 Were all outcome measurements complete?	Yes	No - 94 did TACCT at baseline, 28 at follow up.	n/a	no, some attrition took place	n/a	Unclear, there were some dropouts though	yes
Were all or most study participants who met the defined study outcome definitions likely to have been identified?	Yes	yes	n/a	Yes, given that all the p's were from the 2 sites in Manchester.	not necessarily because of the 'informants' that made the study weren't employees of the trust	yes	yes

3.3 Were all important outcomes assessed?	Yes	Yes, but it have bene helpful to have patient input	n/a	Yes, they covered al the bases that feel appropriate for this client group	The qualitative yes, but the quant is confusing.	Was there a repeat of the	yes
Were all important benefits and harms assessed?	Unclear how they assessed stuff around familial challenges around attendance (3 due to 'family commitment s' and '1 whose husband stopped attendance')	Was seen as being as an intervention that would improve patient safety (Jonstone & Kanitsake 2006, Betancourt & Green 2010). However, staff safety was not discussed as part of the research.	n/a	Ethical approval was done. Participants also noted that family outcomes could worsen e.g. (p61)	Didn't go through ethics, but was ethically proof read by an independent practitioner AFTER the study was written up. No benefits and harms clearly assessed except that which was post-hoc.	Not really as it much of is service eval	"The magnitude of difference was comparable to other psychosocial interventions in primary care [28] and will be helpful in estimating sample size for a future definitive trial. It is noteworthy that neither group demonstrated large benefits in anxiety symptoms, despite the intervention being designed to improve both anxiety and depression"
Was it possible to determine the overall balance of benefits and harms of the intervention versus comparison?	Yes in so much as the women invited had already agreed to take part in previous research.	Yes - overall the goal of improving cultural competence was considered to be great.	n/a	no, other than the outcome measures	The were some reflections	Just the benefits	The magnitude of difference was comparable to other psychosocial interventions in primary care [28] and will be helpful in estimating sample size for a future definitive trial. It is noteworthy that neither group demonstrated large benefits in anxiety symptoms, despite the intervention being designed to improve both anxiety and depression.
3.4 Were outcomes relevant?	Yes, something around family would have been available.	yeah	n/a	?	Yes	yes	Yes
Where surrogate outcome measures were used, did they measure what they set out to measure? (e.g. a study to assess impact on physical activity assesses gym membership –	N/a	yes	n/a	No, but did assess acceptability, which was an	n/a	no	no

a potentially objective outcome measure – but is it a reliable predictor of physical activity?)				important part of the work				
3.5 Were there similar follow-up times in exposure and comparison groups?	N/a	n/a	n/a	n/a	n/a	n/a	yes	
If groups are followed for different lengths of time, then more events are likely to occur in the group followed-up for longer distorting the comparison.	N/a	n/a	n/a	n/a	n/a	n/a	no	
Analyses can be adjusted to allow for differences in length of follow-up (e.g. using person-years).	yes	n/a	n/a	n/a	n/a	n/a/	n.a	
3.6 Was follow-up time meaningful?	No follow up	yes	n/a	yes, 3 months	n/a	not explained	yes	
Section 4: Analysis								
4.1 Were exposure and comparison groups similar at baseline? If not, were these adjusted?	N/a	n/a	n/a	n/a	QUAL DATA WAS SUBMITTED:	n/a	no	
			n/a					
Were there any differences between groups in important confounders at baseline?	N/a		n/a	n/a		n/a	the majority were south asian (despite recruiting for ethnic minorities)	no
If so, were these adjusted for in the analyses (e.g. multivariate analyses or stratification).	N/a	Analysed as though it is for 2 independent groups, not between (?) 'took a sample of teams at both time intervals'.	n/a	n.a		n/a	No - These results are not adjusted for any potential baseline differences.	
Were there likely to be any residual differences of relevance?	n/a		n/a	n/a		n/a		
4.2 Was intention to treat (ITT) analysis conducted?	not clear	no	n/a	Unclear		not mentioned, there's an assumption given that all info was gathered by everyone, despite mentioning that some psh had to leave the project	no need	
Were all participants (including those that dropped out or did not fully complete the intervention course) analysed in the groups (i.e. intervention or comparison) to which they were originally allocated?	not clear	no, only an aggregate was used	n/a	Unclear		?	yes	

4.3 Was the study sufficiently powered to detect an intervention effect (if one exists)?	not mentioned	No mention of power calculation - however, there appears to be a high	n/a	Not powered enough, feasibility study	not mentioned	not required, plus not stat significantly
A power of 0.8 (that is, it is likely to see an effect of a given size if one exists, 80% of the time) is the conventionally accepted standard.	not mentioned	yes	n/a	no	not mentioned	n/a
Is a power calculation presented? If not, what is the expected effect size? Is the sample size adequate?	no	No	n/a	no	no	no
4.4 Were the estimates of effect size given or calculable?	n./a			n/a	no	The results suggest that the group receiving the wellbeing intervention improved compared to the group receiving usual care. The results are plotted in Figure 5 using a standardised mean difference (effect size) measure. All results are in the direction of greater benefit in the intervention group.
Were effect estimates (e.g. relative risks, absolute risks) given or possible to calculate?	n/a	Effect sizes were given.		n/a	no	..
4.5 Were the analytical methods appropriate?	Not much mention on this	Yes, but the aggregate wa done	n/a	yes	Thematic analysis for reflective conversations, different analyses for the care-index analysis	means, qualitative analysis for evaluation
Were important differences in follow-up time and likely confounders adjusted for?	n/a	The aggregate approach, instead tracking individual changes pre and post.	n/a	n/a	n/a	no

If a cluster design, were analyses of sample size (and power), and effect size performed on clusters (and not individuals)?	n/a	n/a	n/a	n/a		n/a	no	
Were subgroup analyses pre-specified?	n/a	n/a	n/a	n/a		n/a	no	
4.6 Was the precision of intervention effects given or calculable? Were they meaningful?	unclear how they made use of the 'interview' - unsure of the qualitative measure allows for info on participants' home stuff.	n/a	n/a	it was reasonable to view that the intervention had a large influence on the outcome measure.	yes, given the qualitative nature, asking about the specifics of what the newer intervention offered also.	n/a		
Were confidence intervals or p values for effect estimates given or possible to calculate?	yes	yes p<0.02	n/a	yes these were given	n/a	none	n/a	
Were CI's wide or were they sufficiently precise to aid decision-making? If precision is lacking, is this because the study is under-powered?	Cis not given!	not given	n/a	not particularly, p106	n/a	n/a	n/a	
Section 5: Summary								
5.1 Are the study results internally valid (i.e. unbiased)?	appears so	Cultural consultants were involved in the analysis of qualitative data (thematic, followed by content analysis) they may have been involved in the quant analysis also. This is potentially problematic since it is in their interests to reports the changes in clinical stats significant.	yes	**yes**	yes	yes, but had some lacking as it included people from a similar part of the world.	yes	Yes, but mitigated with the small sample. Curious about the researchers.

How well did the study minimise sources of bias (i.e. adjusting for potential confounders)?	Could have done more to name these	Used a mixed methods approach to limit the participant bias (open evaluation forms mixed with closed questionnaires). Noteworthy also that there was a considerate decline in post data than pre data. They note, that 'it's possible that responders at the second measurement ...[could have been] those who subjectively benefitted most or always scored high' - were people informed of their tacct scores after the pre??	Unclear	Appropriately	Yes	Yes	Unclear	yes
Were there significant flaws in the study design?	Not clearly	Not factoring in the high-drop out rate with a contingency way to get more than 50% of those they started with.	no	no	no	no	Meant to be on ethnic minorities, but ended up being more for south Asian participants and some Somali groups. Maybe exploring why this is, is important	All outcomes measure were translated into Turkish & verbally administered - would have been helpful to state what the challenges with this might be.
5.2 Are the findings generalisable to the source population (i.e. externally valid)?	Not enough participants, hence the	Yes		it's a feasibility study			It may be too small for that. But maybe indicative	no

	pilot nature of it						of working with south Asians and Somalis	
Are there sufficient details given about the study to determine if the findings are generalisable to the source population? Consider: participants, interventions and comparisons, outcomes, resource and policy implications.	Yes	Yes	Not appropriate	yes	Not appropriate	Not appropriate	Yes	o - study too small

Appendix I: Application of NICE quality appraisal tool for qualitative studies

NICE (2012) quality appraisal checklist for qualitative studies

Checklist item		***Responses***	
Theoretical approach			
1	Is a qualitative approach appropriate?	Appropriate, Inappropriate, Not sure	
2	Is the study clear in what it seeks to do?	Clear, unclear, mixed	
Study design			
3	How defensible/rigorous is the research design/methodology?	Defensible, indefensible, not sure	
Data collection			
4	How well was the data collection carried out?	Appropriately, inappropriately, not sure/inadequately reported	

Trustworthiness			
5	Is the role of the researcher clearly described?	Clearly described, unclear, well described	
6	Is the context clearly described?	Clear, unclear, not sure	
7	Were the methods reliable?	Reliable, unreliable, not sure	
Analysis			
8	Is the data analysis sufficiently rigorous?	Rigorous, not rigorous, not sure/not reported	
9	Is the data 'rich'?	Rich, poor, not sure/not reported	
10	Is the analysis reliable?	Reliable, unreliable, not sure/not reported	
11	Are the findings convincing?	Convincing, not convincing, not sure	
12	Are the findings relevant to the aims of the study?	Relevant, irrelevant, partially relevant	
13	Conclusions	Adequate, inadequate, not sure	

	Study 1	**Study 2**	**Study 3**	**Study 4**	**Study 5**	**Study 6**
	Gault et al (2019)	**McEvoy et al**	**Owiti et al (2013)**	**Khan et al (2019)**	**Yasmin-Qureshi & Ledwith (2021)**	**Mir et al (2015)**
Theoretical approach						

1. Is a qualitative approach appropriate?	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings?	yes - how medication use is enabled or rejected		Yes	yes	Yes - evaluation following a number of BME related initiatives done	Yes in terms of how the BA work is being received
Could a quantitative approach better have addressed the research question?	no - it would still take on a qual approach		Not necessarily - an quantitative approach in addition might have been helpful	no	No	No
2. Is the study clear in what it seeks to do?						
Is the purpose of the study discussed – aims/objectives/research question/s?	Yes		yes	Yes	This study used semi-structured interviews to facilitate an in-depth discussion and exploration of Women's' experiences of accessing IAPT services	Yes

Is there adequate/appropriate reference to the literature?	Yes		yes	Yes - speaking in similar study (perry et al , as well as their previous study).	Yes	yes
Are underpinning values/assumptions/theory discussed?	Yes - in that the assumptions of understanding perspective on medical adherence will make professionals more effective in at S users accepting medication. Theory discussed based on Canada study.		yes - Canadi an approa ch	yes - e.g. disagreement re. disagreement between the patient and professionals' 'explanatory' models of illness	Yes - on the values part	Incorporating religious beliefs into mental health therapy is associated with positive treatment outcomes. However, evidence about faith-sensitive therapies for minority religious groups is limited
Study design						
3. How defensible/rigorous is the research design/methodology?						
For example:						
Is the design appropriate to the research question?	Yes. Interviewing BAME Service users/carers followed by analysis and a 'consensus' workshop supported by interview participants.		Yes	yes	Yes - "What aspects of the service make psychological therapy accessible for South Asian women? Second, does therapy within IAPT enable individuals to frame their experiences within their own cultural context?"	yes
Is a rationale given for using a qualitative approach?	Yes - more in-depth understanding of the BAME Service user perspective.	No		"This was a mixed-methods feasibility study. Initially qualitative interviews were conducted to explore the women's experiences of depression, their explanatory models about depression, and most appropriate help they may find acceptable."	Yes since they wanted to "explore" SA women's experiences of the IAPT model	yes

Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used?	Use, cited research on the rational for systematic coding processes (section 3.2.1). Similarly with the approach with the interview guide (3.4). Data generation (3.4) - Charmaz et al	No	yes	Yes, but could be clear about the initiatives used that they're talking about.	no
Is the selection of cases/sampling strategy theoretically justified?	Yes - 3.3. Continued sampling until saturation was reached.	No	No "Those British Pakistani mothers, who had taken part in our earlier cohort study on social stress and depression in the ante-natal and post-natal period [6], were approached for participation in this study"	Other the 4 from social media, "An additional 16 clients were identified from staff within IAPT teams and were invited to take part in the study. Of these 16, six responded and agreed to take part. A total of ten participants were recruited into the study"	Yes, but only in the feasibility study Meer et al 2012 study
Data collection					
4. How well was the data collection carried out?					

Are the data collection methods clearly described?	yes	"Data collection and analysis of the qualitative interviews Initial data was collected through in-depth interviews. The interviews topic guide was developed through discussion within the research team and the existing literature. Key areas explored were, perceived causes of maternal depression, what help women had previously received for maternal depression and the type of help they would like to receive. All interviews were digitally recorded and transcribed verbatim. Data were analysed using framework analysis, consisting of familiarisation of the data, identification of a theoretical framework, indexing, charting, mapping and interpretation. Following detailed readings of the transcripts, themes and sub-themes were identified and a thematic framework was developed."	Yes	Yes, particularly in the feasibility bit.
Were the appropriate data collected to address the research question?	yes	yes	Yes	yers
Was the data collection and record keeping systematic?	yes - hundreds of in vivo codes were produced and collected in an organised way.	The coding framework was then applied manually to the interview transcripts and then pasted to the excel spread sheets. Using the spread sheets, the study team (SK & KL) compared and contrasted various subthemes to finalise the theoretical table.	Yes	yes, Nvivo, recordings
Trustworthiness				

5. Is the role of the researcher clearly described?					
Has the relationship between the researcher and the participants been adequately considered?	Unclear who makes up the research team. Mentions 'faculty' but it's unclear who this is.		"The programme involved 12 weekly sessions facilitated by a research therapist who led the group with some training in CBT and leading depression groups using CBT skills and principles. Regular supervision was provided by a senior CBT therapist (KL) and a senior psychiatrist (NH). The sessions lasted approximately 60–90 min and involved group discussions, case scenarios, individual goal setting, and skill-based activities."	Little clarity was given about the relationship between the researcher and the participants. Comments made about the analysis though "six-phase method by the researcher. Throughout analysis a reflexive journal was maintained and an independent researcher reviewed a sample of the data set and the themes to check their credibility."	Described as being done by the GM, it is unclear who this is.
Does the paper describe how the research was explained and presented to the participants?	Not clearer outlined			Not more than the fact it was purposive and through social media	
6. Is the context clearly described?					
For example:					
Are the characteristics of the participants and settings clearly defined?	Yes		Yes	Yes, very much so (	yes
Were observations made in a sufficient variety of circumstances	Yes - there were a number of stages		yes	n/a	yes

Was context bias considered	No	Yes "the study took place in one geographical area in England; hence, these results may not be generalisable to other regions and populations. The participants were from a Pakistani background, so the results may not be applicable to the other ethnic groups. A further limitation is selection bias as the sample was selected from an earlier existing cohort of British Pakistani women who may be more motivated to participate in research compared to other women attending primary care centres."	?	its possible, it doesn't appear that there wasn't anyone double checking the coding
7. Were the methods reliable?				
For example:				
Was data collected by more than 1 method?	No, just interviews	Yes	telephone or f2f	no just interviews
Is there justification for triangulation, or for not triangulating?	n/a			n/a

Do the methods investigate what they claim to?	Yes	yes	yes	This can create room for too much variation in findings "Interviewers did not follow a structured protocol but rather followed a topic guide which drew on processes and themes developed in Study1" However the first study had 2 researchers, following Pope et al (2007)
Analysis				
8. Is the data analysis sufficiently rigorous?				
For example:				
Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results?	Yes, grounded theory was used - a literature led approach was taken (Charmaz et al) using systematic coding; used Nvivo to do this. Line-by-line transcription was done. Open coding to develop explanatory categories. A not was mentioned that the participants had challenged the researchers assumptions also.	yes	yes	Qualitative Framework Analysis was used
How systematic is the analysis, is the procedure reliable/dependable?	Yes	yes	good	Little framework used for the interview process, thus can create some problems with variation
Is it clear how the themes and concepts were derived from the data?	Yes	yes	clear. Named and then expanded upon	Religion' and 'religiona nd therapy' appears too vague, others appear okay
9. Is the data 'rich'?				
For example:		yes		

How well are the contexts of the data described?	It's well described in that the interview method is clear. Who the interviewers were and the location (at the 'Recovery College'), the justification being that it was environment that was well known and was likely that ps had positive associations with.			yes	
Has the diversity of perspective and content been explored?	Yes - however, it is noteworthy that the sample is small in size n = 5		yes	yes	yes - religion being a resource for mental health, but drawing upon it in therapy being a challenge for therapists (page 8); social exclusion and inclusion
How well has the detail and depth been demonstrated?	The codes have been shared and demonstrated using a diagram. In the discussion, the explanatory .. Was given and various quotes shared for the reader to make sense of the grouping of codes.		Measured over a range of outcome measures. Including exploration of service satisfaction, marital relationss, and depressive symptoms	yes	appears so
Are responses compared and contrasted across groups/sites?	n/a		n/a	no	n/a
10. Is the analysis reliable?					
For example:					
Did more than 1 researcher theme and code transcripts/data?	Yes		Not clear	more than one research, 1 x transcripts, then another researcher reviewed a sample	in the first one, yes

If so, how were differences resolved?	They used workshops, with a 'nominal group technique' recommended to establish consensus, which is supported by research. One that is commonly used in health care research (Hickey & Chambers, 2014)	n/a	Doesn't say	Unclear, but sited Pope et al (2007) as a framework
Did participants feed back on the transcripts/data if possible and relevant?	yes "participants challenged researcher's assumptions"	not clear		no, there was feedback on the intervention though
Were negative/discrepant results addressed or ignored?	Yes - 'SUs challenged researchers' intentions and assumptions about how education should be delivered and suggested that the study's target audience should be student mental health-care professionals. In doing so, they changed the process and outcomes of the study. MIND5 note that co-produced research is less likely to produce	"	yes - e.g. page 11, where there's discussion on the way cbt disregards culture	discussed in discussion section

	stigmatized findings.'			
Analysis				
8. Is the data analysis sufficiently rigorous?				
For example:				
Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results?	Yes, grounded theory was used - a literature led approach was taken (Charmaz et al) using systematic coding; used Nvivo to do this. Line-by-line transcription was done. Open coding to develop explanatory categories. A not was mentioned that the participants had challenged the researchers assumptions also.	yes	yes	Qualitative Framework Analysis was used
How systematic is the analysis, is the procedure reliable/dependable?	Yes	yes	good	Little framework used for the interview process, thus can create some problems with variation
Is it clear how the themes and concepts were derived from the data?	Yes	yes	clear. Named and then expanded upon	Religion' and 'religiona nd therapy' appears too vague, others appear okay
9. Is the data 'rich'?				
For example:		yes		
How well are the contexts of the data described?	It's well described in that the interview method is clear. Who the interviewers were and the location (at the		yes	

	'Recovery College'), the justification being that it was environment that was well known and was likely that ps had positive associations with.				
Has the diversity of perspective and content been explored?	Yes - however, it is noteworthty that the sample is small in size n = 5		yes	yes	yes - religion being a resource for mental health, but drawing upon it in therapy being a challenge for therapists (page 8); social exclusion and inclusion
How well has the detail and depth been demonstrated?	The codes have been shared and demonstrated using a diagram. In the discussion, the explanatory .. Was given and various quotes shared for the reader to make sense of the grouping of codes.		Measured over a range of outcome measures. Including exploration of service satisfaction, marital relationss, and depressive symptoms	yes	appears so
Are responses compared and contrasted across groups/sites?	n/a		n/a	no	n/a
10. Is the analysis reliable?					
For example:					
Did more than 1 researcher theme and code transcripts/data?	Yes		Not clear	more than one research, 1 x transcripts, then another researcher reviewed a sample	in the first one, yes

If so, how were differences resolved?	They used workshops, with a 'nominal group technique' recommended to establish consensus, which is supported by research. One that is commonly used in health care research (Hickey & Chambers, 2014)		n/a	Doesn't say	Unclear, but sited Pope et al (2007) as a framework
Did participants feed back on the transcripts/data if possible and relevant?	yes "participants challenged researcher's assumptions"		not clear		no, there was feedback on the intervention though
Were negative/discrepant results addressed or ignored?	Yes - 'SUs challenged researchers' intentions and assumptions about how education should be delivered and suggested that the study's target audience should be student mental health-care professionals. In doing so, they changed the process and outcomes of the study. MIND5 note that co-produced research is less likely to produce		"	yes - e.g. page 11, where there's discussion on the way cbt disregards culture	discussed in discussion section

	stigmatized findings.'				
11. Are the findings convincing?					
For example:					
Are the findings clearly presented?	Yes, clear sense	Yes clear	Yes	yes	Yes
Are the findings internally coherent?	aa	Yes	Yes	yes	yesd
Are extracts from the original data included?		Yes	Yes	yes	yeds
Are the data appropriately referenced?	yes	Yes	Yes	yes	yes
Is the reporting clear and coherent?	yes	Yes	yes	yes	yes
12. Are the findings relevant to the aims of the study?					
		Yes			yes
13. Conclusions					
For example:				Cultural competence can be defined as “the ability to understand, appreciate and interact with people from cultures or belief systems different from one’s own.” (DeAngelis, 2015).	

How clear are the links between data, interpretation and conclusions?	yes	Clear, given the links around religious/cultural messaging and engagement in treatmennt	Clear links, particularly when thinking about the relationship between pakistani service users and professionals. Futher evidenced by the minimal attrition.	there is clarity on this	yes
Are the conclusions plausible and coherent?	yes, although they are brief.	Yeah	yes	Yes - need for cultural adaptations, therapeutic relationship being the basis for cultural competence, etc	yes
Have alternative explanations been explored and discounted?	This isn't clear from what I've read		None	Yes - south asians relationship to psych therapies, may hve been impacted by cbt being limiting and institutional racism; However counselling approaches have offered some remedy to these problems	n/a
Does this enhance understanding of the research topic?	Yes, particularly the reflections on professional humility when hearing difficult feedback.	yes	Yes	Yes as it relates to IAPT and SA women, but not by much I think	yes - lacking data in this area
Are the implications of the research clearly defined?		yes	Implicatons in terms of - future research.	Yes	yes
Is there adequate discussion of any limitations encountered?	Maybe more detail about their own reflections upon receiving the findings. But they said enough.	Yes, the lack of representation from other groups within this ethnic community, limitations with staff persepectives, impacts from GPs	yes	Not quite - could have done more, just two points were made. Important points, but these were minimal.	Briefly, but the key points were made: small sample; assumption of effectiveness;
Ethics					
14. How clear and coherent is the reporting of ethics?					
For example:					

Have ethical issues been taken into consideration?	Yes	Not great	Ethical approval completed.	Ethic	the study is in line with plans to improve service user dignity and access to care.
Are they adequately discussed e.g. do they address consent and anonymity?	Yes, these are address - could have added the time frame's given for informed consent	Decided to be a n/a since it was service evaluation. Participants opted to take on the intervention though	The women were approached from October 2008 to February 2009, after obtaining written informed consent.	yes ;" After written consent was obtained, Interviews were conducted by the researcher either face-to-face or over the phone."	"consent covereddigitalrecordingoftherapysessionsandals o qualitativeinterviews" - no clear consent with regard to the staff input though - this requires some thinking about
Have the consequences of the research been considered i.e. raising expectations, changing behaviour?	Yes, SUs sharing info that might require professionals to make reporots to authorities.	yes	yes		yes
Was the study approved by an ethics committee?	Yes, approved by an NHS ethics committee and HRA	no	ye	Yes	yes
Overall assessment					
As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)		it was alright. They skimped out on not doing more ethical checks a priori.		It seems okay, some unclear parts about how participants were selected from staff members though. Some care was taken to review the analysis, but more detail could've been given.	fairly well. More discussion on limitations of the study would have been valuable.

Were there significant flaws in the study design?	Small sample size	Bias of having an intervention that people feel is already effective, could've said more about how it could expand.		Not clearly	small ps
5.2 Are the findings generalisable to the source population (i.e. externally valid)?	No, because the sample size was too small. The findings appear plausible though	I think so	"In addition, the study took place in one geographical area in England; hence, these results may not be generalisable to other regions and populations"	Unsure, but some guidance on why the uptake was so poor via social media would be good to reflect upon.	
Are there sufficient details given about the study to determine if the findings are generalisable to the source population?	yes	yes	satisfactory	unsure	

Appendix J: Abridged Bracketing interview

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Appendix K: Abridged research diary

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Appendix L: Salomons approval

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Appendix M: HRA Approval

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Appendix N: End of study report – HRA Form

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