Development and Evaluation of a Psychosocial Intervention for Common Mental Disorders for the British South Asians in the U.K.

A thesis submitted to the University of Manchester for the degree of Doctor of Philosophy (PhD) in the Faculty of Medical and Human Sciences

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School of Medicine
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<td>Access to high quality mental health services in Primary care</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CCBT</td>
<td>Computerized Cognitive Behavioural Therapy</td>
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<tr>
<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
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<tr>
<td>CC</td>
<td>Cultural competence</td>
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<tr>
<td>CGs</td>
<td>Caregivers</td>
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<td>CI</td>
<td>Confidence Interval</td>
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<td>CM</td>
<td>Case Management</td>
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<td>CM</td>
<td>Cultural matching</td>
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<td>CMD</td>
<td>Common Mental Disorders</td>
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<td>CORE-OM</td>
<td>Clinical outcomes in routine evaluation</td>
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<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>EBT</td>
<td>Evidence based Treatments</td>
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<td>ECGs</td>
<td>Ethno cultural groups</td>
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<tr>
<td>EQ5D</td>
<td>European Quality of Life 5 Dimensions</td>
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<tr>
<td>GAD</td>
<td>Generalised Anxiety Disorder</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>IPT</td>
<td>Interpersonal Therapy</td>
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<td>ITT</td>
<td>Intention to treat</td>
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<tr>
<td>LSE</td>
<td>London School of Economics</td>
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<tr>
<td>MeSH</td>
<td>Medical Subject Heading</td>
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<td>MRC</td>
<td>Medical Research Council</td>
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<td>NFL</td>
<td>Need for language</td>
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<td>NFCM</td>
<td>Need for cultural matching</td>
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<td>NFE</td>
<td>Need for empathy</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>PHQ</td>
<td>Patient Health Questionnaire</td>
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<td>PSI</td>
<td>Psychosocial Intervention</td>
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<td>Description</td>
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<td>REC</td>
<td>Research and ethics Committee</td>
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<td>RCT</td>
<td>Randomised Controlled Trial</td>
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<td>SD</td>
<td>Standard Deviation</td>
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<td>TAU</td>
<td>Treatment as Usual</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>U.S.A</td>
<td>United States of America</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>WSAS</td>
<td>Work and social adjustment scale</td>
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<td>Yrs</td>
<td>Years</td>
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Abstract

Background: Ethnic minorities, particularly the South Asian community, have a high prevalence of depression within the United Kingdom (UK). They suffer from poor health, social isolation and tend to not access available health services and treatment. Culturally appropriate psychosocial interventions are effective for depression however, in the UK very limited research evidence is available to date. The research study focuses on the processes involved with the aim of developing and evaluating the acceptability, adherence and effectiveness of a culturally appropriate psychosocial intervention for the South Asians in the UK.

Methods: A phased programme of research was planned to achieve the aims. In the first phase, a systematic review was conducted. The aim was to identify and synthesize the literature on effective psychosocial interventions for common mental disorders, particularly for ethnic minorities in developed countries. In the second phase, four focus groups from which three with ethnic minority service users and one with the health professionals were conducted. The purpose was to collect and understand the views of South Asian service users and providers in order to culturally adapt an intervention as part of the AMP programme. In the final phase of the study, seventeen qualitative interviews were conducted with the psychosocial intervention trial participants and the intervention provider team. The case studies were analysed to evaluate the delivery, acceptability, adherence and cultural appropriateness of the psychosocial intervention.

Findings: The systematic review provides reasonable evidence from trials and subgroup analyses from trials that ethnic minority patients could benefit from modified psychological treatments. However, there is no systematic documentation of cultural adaptations available. The participants of the focus groups and evaluation interviews identified cultural specific and universal barriers and highlighted cultural sensitive modifications for interventions which the health care providers need to respond in order to make mental health care accessible for the ethnic minorities. The qualitative studies show evidence that cultural adaptations improve acceptability and adherence in interventions. The findings highlighted empathy as the significant need.
of the participants of the well-being intervention. People make choices depending on the intensity of their need, the nature of the problem and the options available to them. The participants suggested that fulfilment of needs is vital rather than assuming that cultural matching is always necessary.

**Conclusion:** Culturally modified interventions for specific populations can improve acceptability and accessibility. Better engagement and adherence to psychosocial interventions can be achieved by overcoming culturally specific and universal barriers and by providing treatment choices to patients according to the nature and urgency of their specific need. Further research is required for developing an evidence base in respect of designing effective mental health treatments for minority patients. A systematic way of documenting all these adaptations is essential. It would enable progress by improving comparability and replication of modifications across studies.
Declaration

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The Author

Saadia Aseem completed a BSc in Statistics, Mathematics & Economics) from University of Punjab, Pakistan in 1985 and continued with a Masters in Social Sciences from Quaid-e-Azam University in Islamabad, Pakistan. Saadia completed her Master’s degree in 1988 with a distinction and receiving Quaid-e-Azam’s Gold medal award for securing the highest marks within the Department of Social Sciences in the University and Chancellors Gold Medal awards.

The author worked from 2004 to 2013 as a researcher in the Faculty of Medical and Human Sciences at The University of Manchester, Manchester UK. Before working on AMP and starting her PhD studies she worked on a variety of different research projects, such as:

- A qualitative study investigating the factors affecting antidepressant treatment concordance in primary care. It was a multi-centre collaboration project with King’s College London, Newcastle University and The University of Manchester.

- Pre- and post-natal depression in relation to infant growth and development in an on-going cohort of women of Pakistani origin in east Lancashire, U.K.

- RCT of a complex intervention for persistently depressed women of Pakistani origin in East Lancashire: The SITARA trial

Before moving to UK, the author worked from 1991-2001 as the manager of the Applied Social Research Resource Centre (ASR) Lahore, Pakistan. The ASR is a non-governmental resource centre involved in research, training, conducting academic courses, community work, starting the first feminist press in Pakistan, documentary film production, assisting theatre and art groups, and holding the first National Women Studies Conference in Pakistan. Whilst working at ASR the author managed research projects, arranged and coordinated workshops, training courses and the International Public Lecture series in 2000.
Acknowledgements

My PhD has been one of the most significant academic challenges I have ever had to face. I owe my gratitude to all those people who have made this PhD possible.

I would like to gratefully and sincerely thank Professor Linda Gask, without whom I would have never had the opportunity to start this PhD. Her mentorship, guidance, unflagging support and generous advice were paramount in encouraging me every step of the way. She has been a chief inspiring academic figure, an excellent supervisor and most of all, an invaluable friend. Special thanks for having the faith in me.

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supporting me during this time. I am also thankful to my extended family and friends who were a constant source of motivation and support.
Dedicated to

My late mother *Seema Jee* and my father *Sheikh Inam Manzur*

*And*

*Professor Linda Gask*

(*Who have been real sources of inspiration in my life. Thank you for all the love, support, guidance and motivation*).
Chapter 1: Introduction and Background

Section 1: What is the thesis about?

The purpose of the present thesis is to develop and evaluate a culturally sensitive psychosocial intervention for the South Asian community in the United Kingdom (U.K.). The author has been involved in mental health research projects for the South Asian community in Manchester for nine years. Discovering the high prevalence of depression in the South Asian community, the social isolation they experience and delay in seeking care for mental illness made the author interested to find out the reasons why South Asians in the UK do not access the required services and engage with the treatment available. The research study focuses on the processes involved in the development of a culturally sensitive psychosocial intervention for the South Asian minority suffering from anxiety and depression. The primary aim of providing this intervention was to evaluate the acceptability and adherence of culturally sensitive treatments.

The thesis reports a phased research study and is part of a larger funded National Institute for Health Research programme grant: A Research and Development programme to increase equity of Access to high quality mental health services in Primary care (AMP) (Dowrick et al., 2013). In the first phase a systematic review was conducted to identify and synthesize outcome research on effective psychosocial interventions for common mental disorders for ethnic minorities in developed countries. In the second phase, four focus groups three with ethnic minority service users and one with the health professionals were conducted to gather diverse views of the South Asian service users and providers in order to culturally adapt an intervention as part of the AMP programme. In the final phase, seventeen qualitative interviews were conducted with the psychosocial intervention trial participants and the intervention provider team to evaluate the delivery, acceptability, adherence and cultural appropriateness of the psychosocial intervention.
1.1: A Research and Development programme to increase equity of Access to high quality Mental Health services in Primary Care (AMP) (Dowrick et al., 2013)

The primary aim of AMP was to increase equity of access to high quality mental health services in primary care by linking knowledge about barriers to access for underserved groups and develop different ways to meet the needs of these groups. The programme was carried out over a period of five years and divided into three overlapping phases to achieve the required aims and objectives. It was conducted by primary care mental health researchers the University of Liverpool and The University of Manchester with policy makers and managers from Liverpool and Manchester Primary Care Trusts. Figure 1.1 below illustrates the three phases of AMP.
Figure 1.1: Phases of AMP

Phase 1: Understanding the problems and generating potential solutions
(Conceptual and structured scoping review, metasynthesis, dialogue with stakeholders, review of grey literature, secondary analysis of transcripts, interviews with service users and carers)

Phase 2: Testing potential solutions
Development of a multi-faceted model of three core components:
- Community engagement (Information gathering, community champions, focus groups, community working group)
- Primary Care (Knowledge transfer, system review, active linking)
- Tailored psychosocial interventions (designing a model of culturally appropriate well-being intervention, conducting an exploratory randomized trial)

Phase 3: Putting what works into practice
Implementation strategies:
- Educational
- Policy
- Service

The research findings of the project have been disseminated in the form of several papers (published and in progress), presentations at different conferences, seminars, workshops and a dedicated website. Further details of this project can be found on the website: www.amproject.org.uk
1.1.1: Where the author’s work is situated within the AMP project

Author’s contribution to the study:

a) Conducting a structured scoping review of 140 studies with Professor Peter Bower. Further to this, a systematic review which is part of this PhD thesis was conducted with the aim to identify and synthesize the findings on effective psychosocial interventions for Common Mental Disorders (CMD) initially with ethnic minorities (Waheed et al., manuscript submitted) and specifically with the South Asian minority settled in developed countries. Search strings were developed by the author with the help of a librarian. Initial data extraction was done by the author and Prof Bower. The updated search added more studies and data extraction was done by the author, Professor Gask, Professor Bower and Dr. Waheed. The initial qualitative analysis was done by the author followed by a meta-analysis by Professor Bower.

B) Focus group study: Four focus groups, three with the BME service users and one with the service providers, were arranged and conducted by the author. The initial findings were incorporated to develop a culturally appropriate psychosocial intervention. A detailed analysis of the focus group study is part of the current thesis.

c) As part of the AMP study the author recruited South Asian participants for the pilot trial and conducted the baseline and follow up assessments. As part of the current PhD research, 17 qualitative interviews were conducted with the trial participants and the intervention team in order to evaluate the acceptability, delivery, adherence and cultural appropriateness of the psychosocial intervention. A detailed analysis of these evaluation interviews and a further analysis utilizing case studies are included in the thesis.

1.2: Outline of the thesis

This thesis is composed of eight chapters.
Chapter 1 is divided into two sections. In the first section the author described the project into which the research reported in the thesis was embedded: Improving Access to Mental Health in Primary Care “AMP”, a project funded by the National Institute for Health Research. The author also described the work conducted for the research and how it relates to the AMP Project. Section 2 provides the background for the research defining the concepts of ethnic minorities specifically South Asian, common mental disorders and their treatment, culture and mental health, cultural matching, cultural sensitivity and cultural competence. Furthermore, it defines the study aims and research questions.

Chapter 2 presents the methodology of the research. It gives an explanation of the reasons for using a mixed methods approach. Moreover, it provides a description of the quantitative methods used in the systematic review and explains the qualitative methods used in the focus groups, qualitative interviews and the case studies. Furthermore, it discusses aspects of research ethics and governance.

Chapter 3 comprises a systematic review of psychosocial interventions for common mental disorders in ethnic minorities. In the latter part it focuses specifically on the studies carried out in the South Asian population.

Chapter 4 considers the cultural adaptation of the psychosocial intervention and contains findings from the focus group discussions. It consists of a detailed discussion of the emerging themes of the South Asians’ experiences of depression, seeking help and suggestions and requirements for sensitizing the psychosocial interventions of the population.

Chapter 5 describes the psychosocial intervention which was implemented in the ‘AMP Project’. It describes the model for choice of pathways of individual and group therapy and signposting. Additionally, it contains the details of the pilot trial and its procedures.

Chapter 6 presents the findings and results concerning access to and acceptability of the well-being intervention and comprises the results of the evaluation interviews.
Chapter 7 utilizes data from the individual qualitative interviews to explore in more depth the findings of the study in relation to cultural appropriateness and cultural matching of the intervention. The chapter uses case studies to discuss the choices available to the participants of the well-being intervention, their mental health needs and their decision making process.

Chapter 8 contains the discussion and considers the limitations and strengths of the study. The chapter concludes the thesis by putting forward some recommendations for policy and practice as well as recommendations for conducting future research.

Section 2: Background and conceptual review

The section sets the scene for the empirical research by considering definitions of the concepts of ethnicity and ethnic minority, in particular common mental disorders and their treatment, culture and mental health, psychosocial interventions and cultural adaptation. Moreover, prevalence of common mental disorders and depression in the ethnic minority populations and South Asian minorities in particular in the UK are also discussed with different treatment options available for common mental disorders. Finally, the author considers the arguments for cultural adaptations of interventions and methods of adaptation.

1.3 Defining Ethnicity and Ethnic minorities/South Asian minority

1.3.1 Ethnicity

Ethnicity is a hard to define multidimensional concept. Scientific studies in health use the terms ethnicity and race interchangeably (Bhopal, 2004). Ethnicity is derived from the Greek word “ethnos” meaning tribe or people, acknowledging the historical background, language, and social norms to create individual identity (Hall, 2001). In addition, it is based on physical appearance, personal identification, cultural and religious associations and stereotyping (Modood et al, 1997). Variation among the groups have a strong impact on how ‘ethnicity’ is related to other aspects of research and depends on such factors such as country of origin, immigration status and generation, degree of acculturation, socioeconomic status, gender, language, and geographic location (Waheed, 2010).
1.3.2 Ethnic Minority

Donavan (1984) described an ethnic minority as any group of people who “share a cultural heritage, are not part of the majority, and may experience varying degrees of discrimination”. (p. 665)

Definitions of ethnic minority have always been subject to much discussion. Bulmer’s (1996) definition of an ethnic group is as follows:

“An ethnic group is a collectivity within a larger population having real or putative common ancestry, memories of a shared past, and a cultural focus upon one or more symbolic elements which define the group’s identity, such as kinship, religion, language, shared territory, nationality or physical appearance”. (p. 35)

1.3.3 Ethnic minorities in the United Kingdom

Health professionals and researchers are often unclear about the right way of defining ethnicity. In the United Kingdom, the term ‘ethnic’ refers to an individual’s cultural background and racial designation (Fernando 2003). Within the UK ethnic minority populations are commonly based on a combination of categories including race, nationality (e.g. British, Asian, African) and/or regional origins and language. However, the language used to describe ethnic minority populations varies. The term ‘Black’ is commonly referring to Africans and Afro-Caribbeans, but may also signify all non-white minority populations such as Indian, Pakistani and Bangladeshi (Bhopal, 2004). However, there is a significant difference among these ethnic minority groups and a true understanding of these different ethnic groups is very essential. Defining people according to their geographic, social and cultural origins rather than racial groupings will be a better option.

1.3.4 South Asian minority

According to Gale Group (2006), South Asia consists of the nations of Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, and Sri Lanka. Approximately, 64% of the South Asia population is Hindu, 33% is Muslim, 2% is Buddhist and 1% is Christian. Table 1.1 below presents the basic characteristics of South Asian countries.
Table 1.1: Facts about South Asian Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Area</th>
<th>Population</th>
<th>Official languages</th>
<th>Religions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>144,000</td>
<td>150,448,340</td>
<td>Bengali</td>
<td>Muslim (89.8%), Hindu (9.2%), Buddhist (1.6%), Christian (1.3%), Believers in tribal faiths (0.1%)</td>
</tr>
<tr>
<td>Bhutan</td>
<td>47,000</td>
<td>672,425</td>
<td>Dzongkha</td>
<td>Buddhist (75%), Hindu (25%)</td>
</tr>
<tr>
<td>India</td>
<td>3,287,590</td>
<td>1,128,808,000</td>
<td>Hindi</td>
<td>Hindu (80.5%), Muslim (13.4%), Christian (2.3%), Sikh (1.9%), Buddhist (0.8%), Jain (0.4%), Others (0.6%)</td>
</tr>
<tr>
<td>Maldives</td>
<td>298</td>
<td>298,842</td>
<td>Dhivehi</td>
<td>Sunni Muslim (100%)</td>
</tr>
<tr>
<td>Nepal</td>
<td>147,181</td>
<td>28,901,790</td>
<td>Nepali</td>
<td>Hindu (80.6%), Buddhist (10.7%), Muslim (4.2%), Kirat (3.6%)</td>
</tr>
<tr>
<td>Pakistan</td>
<td>880,940</td>
<td>162,423,000</td>
<td>Urdu</td>
<td>Muslim (96.28%), Hindu (1.85%), Christian (1.59%), Ahmadi (0.22%)</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>65,610</td>
<td>19,668,000</td>
<td>Sinhala</td>
<td>Theravada Buddhist (70.42%), Hindu (10.89%), Muslim (8.78%), Catholic (7.77%), Other Christian (1.96%), Other (0.13%)</td>
</tr>
</tbody>
</table>

Adapted from “Indian Subcontinent” (Gale Group), 2006

South Asian minorities in the United Kingdom

In British English, the word “Asian” is often used to refer to those of South Asian ancestry, particularly Indian, Sri Lankans, Pakistanis and Bangladeshis. The term generally excludes people of East Asia (such as Chinese, Korean or Japanese) or Southeast Asian origin. British Asians are British citizens of South Asian descent, also known as South Asians in the United Kingdom (ONS: Census, 2011).

According to the 2011 UK Census, there were approximately 4,214,000 Asians in England and Wales representing around 7.5% of the population. The figure was 2,331,423 for South Asians in the 2001 census. Those of Indian origin comprised 2.5% of the population with those people of Pakistani origin comprising 2.0%. Around 0.75% were of Bangladeshi origin with around 1.4% were other Asian. The Lancashire County has a population of 5.3% of South Asians and Greater
Manchester has a South Asian population of 5.6%. Figure 1.2 below presents the breakdown of ethnic populations according to the Office of National statistics. (ONS: Census, 2011).
Figure 1.2: Ethnicity rates, England and Wales (UK Census, 2011)
1.3.5 Common mental disorders

Goldberg & Huxley (1980) used the term “common mental disorders” to describe depression, anxiety and related common psychiatric disorders. NICE (2011) used the term ‘common mental health disorders’ to include depression, generalized anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety disorder. When considered together these disorders have combined community prevalence in the UK of about 15% (Singleton, Bumpstead, O’Brien, Lee, & Meltzer, 2001). Common mental disorders (CMD) are the only largest contributors to years lived with disability in adults across the world (WHO, 1995). It has been expected that depression will be the second leading cause of morbidity by the year 2020 (Murray & Lopez 1996; WHO 2000).

Prevalence of common mental disorders in ethnic minorities in the United Kingdom

There is high prevalence of mental illness in ethnic minorities as compared to native populations (Nazroo, 1997). Ethnic minorities are at greater risk of depression due to a range of negative experiences such as reduced opportunities for employment, higher rates of poverty, prejudice and racial discrimination, and a greater likelihood of physical illness (Plant & Sachs-Ericsson 2004). Epidemiological studies in the United States (U.S.) show that Spanish-speaking migrants from Latin America, in particular women, have a higher prevalence of depression (Wilson & MacCarthy, 1994).

In Britain, the weekly prevalence of depressive disorders in white males is 2.7% and white females is 4.8% as compared to Irish at the respective rates of 5.8% and 6.8%, African –Caribbeans 5.6% and 6.4%, Indians 2.5% and 3.2%, Pakistanis 3.8% and 2.9% and for Bangladeshi 1.6% and 2.2 % respectively (Nazroo, 1997). However, according to Nazroo (1997) those who are fluent in English reported the same prevalence rates as the white population. Data from the empiric study focusing on main ethnic groups in Britain showed that common mental disorders were more prevalent in women as compared to men among Indian and Pakistani population
groups. However, Irish groups had the highest prevalence of common mental disorders (Sproston & Nazroo, 2002). There is evidence that depressive disorders are more persistent in Pakistanis over 50 years of age and are more common in Pakistani women (Gater et al., 2009).

Bhugra & Ahmad (2007) considered that despite the high prevalence of depression it is still an under recognized condition and limited importance is given to its diagnosis in primary care in ethnic minority populations. Variation in culturally related understanding of the disease may be one of the most important factors leading to the wrong diagnosis of depression especially in an ethnically diverse population (Comino et al., 2001). It is very important to recognize the influence of culture on the perception and presentation of symptoms and illnesses as culture may be the most influential factor in the prevalence of depression (Hussain & Cochrane, 2002).

Cochrane (1992) suggested that the higher prevalence for depression in ethnic minority groups has been based on treated cases, which do not represent the actual prevalence. Reasons could be accuracy in defining depression, variability and inconsistent diagnosis procedures (Piccinelli, Homen & Tansella, 1997). At least one third of people accessing primary care are likely to have a mental health problem, general practitioners, besides having time constraints, may also lack the appropriate training skills to make accurate diagnosis of mental health illness (Tyrer, 2009).

The symptoms of illness among ethnic minorities are persistent for longer periods (Gater et al., 2010; Miranda et al., 2003; Netto, Gaag & Thanki, 2006; Waheed et al., 2012, Submitted; Wilson & McCarthy, 1994). Reluctance to seek treatment, insufficient service provisions and low adherence in these groups are cited as the main factors contributing to persistence of symptoms (Gask et al., 2009). It has been reported that ethnic minorities use mental health services less, and when services are accessed they may not meet their cultural and religious needs. These factors in combinations with lower referral rates to specialist mental health care services are important barriers (Bernal & Sharron-del-Rio, 2001). Research evidence highlights that the minority group lacks treatment options, lack in help seeking treatment and adherence to treatment, which leads to the non-resolution of symptoms and a higher prevalence and higher disease burden (Blanco et al., 2007).
1.3.6 Treatment for common mental disorders

Since 2004, NICE has produced a series of guidelines on the care and treatment of common mental health disorders. These guidelines focus on improving access to primary care services. It is seen that 90% of depressive and anxiety disorders are diagnosed and treated in primary care but they often go undiagnosed as individuals do not seek treatment (Nice 2011, clinical guideline 123). Different treatment options are available for common mental disorders including psychotherapy, medication and psychosocial interventions. A (2011) report published by LSE on the economic case for mental health promotion and mental illness prevention concluded that: "Many interventions are outstandingly good value for money, low in cost and often become self-financing over time, saving public expenditure" (LSE, 2011).

1.3.6.1 Psychotherapy

Turkington, Dudley, Warman and Beck (2006) refer to psychotherapy as a general term referring to therapeutic interaction or treatment contracted between a trained professional and a client, patient, family, couple or group. Psychological issues are addressed and can vary in terms of their impact, causes, triggers and possible solutions. Psychotherapy is one of the available treatments for mental disorders. It includes cognitive behavioural therapy (CBT), psychoanalytically informed psychodynamic psychotherapy, systemic therapy or family therapy (See Table 1.2 below). Psychological therapies can be cost effective as they may encourage treatment in the community, reduce hospital admissions and relapses (Turkington, Dudley, Warman & Beck 2006).
Table 1.2: Psychological Interventions Specified in the UK Department of Health Review of Psychological Therapies (Department of Health, 2001)

<table>
<thead>
<tr>
<th>Psychological Interventions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive behavioural therapy (CBT)</td>
<td>It refers to the combination of both concepts and techniques from cognitive and behaviour therapies, common in clinical practice.</td>
</tr>
<tr>
<td>Psychoanalytic therapies</td>
<td>A long term developmental process of allowing inner conflicts and relationship issues exploring with the therapist through interpretation and motivation.</td>
</tr>
<tr>
<td>Systemic therapy</td>
<td>The therapists identifies and explores different patterns of belief and enable individuals to decide where change would be desirable and facilitates the process of establishing new desirable and useful patterns.</td>
</tr>
<tr>
<td>Eclectic therapies</td>
<td>It is a mix of techniques from more than one therapeutic approach. The therapy which is more practical and tailored to the individual needs is selected.</td>
</tr>
<tr>
<td>Integrative therapy</td>
<td>It is a formal theoretical and methodological incorporation of behavioural, cognitive, humanistic or psychodynamic approaches.</td>
</tr>
<tr>
<td>Other psychotherapies</td>
<td>It includes humanistic, client-centred, feminist, personally conceptualised, art therapy, drama therapy, transactional analysis and group analysis.</td>
</tr>
</tbody>
</table>

Adapted from Department of Health (2001)

1.3.6.2 Medication

Psychiatric medication is a treatment option available for many mental disorders. Antidepressants are used for the treatment of clinical depression as well as different common mental disorders, such as anxiety and panic disorder. Anxiolytics (including sedatives) are used for anxiety disorders and related problems, such as insomnia.
1.3.6.3 Psychosocial interventions

Ruddy & House (2005) defined psychosocial intervention as “any intervention that emphasizes psychological or social factors rather than biological factors”. Sobel (1994) described psychosocial interventions as:

“ones which include education through brochures, videos, classes, self-help groups and/or individual counselling sessions are accompanied by strategies that increase confidence and reduce social isolation and encourage patients to play an active role in their own health care” (p. 794)

The term psychosocial includes psychological interventions as described above and interventions such as social skills training, befriending and packages of interventions that have a psychosocial element. There has been considerable research in the field of psychosocial interventions in the last decade and an increasing number of research studies identify the need to take into account cultural and contextual aspects in psychosocial interventions (Bernal & Sharron-del-Rio, 2001). However, one needs to understand that much of the research upon which this is based was not carried out in ethnic minority populations. Ethnic minority groups are under represented among patients receiving evidence based interventions in the UK (Lloyd & Moodley, 1992; Sashidharan, 2001) and there is evidence that they have poorer access to, and outcomes from, evidence based psychosocial interventions (Rathod et al., 2009). Some possible reasons may be that ethnic minorities are poorly diagnosed by clinicians, have insufficient knowledge of healthcare systems, stigma attached to mental health, culturally inappropriate services and high rates of forced admissions.

Over the last 30 years a growing evidence base has developed for the use of psychological interventions in depression and anxiety (Roth & Fonagy, 1996). NICE Clinical Guideline 123 and current clinical guidelines for anxiety and depression strongly advocate the use of psychological interventions. NICE recommends a stepped-care model is used to organize the provision of services and to help people with common mental health disorders, their families, carers and healthcare professionals to choose the most effective interventions. The model provides initially a less intensive intervention but the person can step up or down the pathway
according to changing needs and in response to treatment (Nice, 2011, clinical Guideline 123). Psychological therapies and psychotherapy should be adapted in culturally sensitive and appropriate ways to meet the needs of culturally and ethnically diverse populations (DH, 2001).

There is a need to understand that access to psychosocial interventions is essential, particularly in milder cases of depression. However, data collected between 1993-2004 in the U.S. reveals that psychotherapy visits significantly decreased from 2.4% to 1.3% in Hispanics, whereas they remained constant (2.5%) in non-Hispanics (Blanco et al., 2007). In the UK, ethnic minorities are less aware of psychosocial interventions (Netto, Gaag & Thanki, 2006) and consequently less likely to access them than the host population (Bhugra & Bhui, 1998). This may reflect that the current treatments are not sensitive to the needs and choices of ethnic minority patients.

Psychosocial interventions may play a part not only in treatment but in preventing the development of depression. Beck (2005) suggests that psychological interventions are effective for the treatment of depression, anxiety disorders and pain management, etc. Collaborative care is more effective than standard care at improving depression outcomes over both the short and long term (Gilbody, Bower, Fletcher , Richards & Sutton , 2006). The use of CBT for anxiety disorders has significantly improved the symptom control for generalized anxiety disorder and other forms of anxiety. Significant improvements have also been observed in explanatory style, feeling of hopelessness and dysfunctional attitudes (Bienvenu & Ginsburg, 2007; Seligman, Schulman, Derubeis & Hollon, 1999). In addition, other interventions such as parental inhibition reduction, behaviourism, parental modelling, problem-solving and communication skills have shown significant results (Bienvenu & Ginsburg, 2007). One study of sub-threshold depression found that patients who received minimal-contact psychotherapy had an incidence of 12% for a major depressive disorder one year later, as compared to 18% in the control group (Smit et al., 2006; Willemsen, Smit, Cuijpers & Tiemens, 2004). The intervention was also shown to be cost-effective (Smit et al., 2006). In another study of older patients aged 75 or above, a stepped-care intervention achieved a 50% lower incidence rate (Van’t et al., 2009).
1.3.6.4 Access to psychosocial interventions in ethnic minorities

People from some socially excluded groups are less likely to visit their GP, receive a diagnosis of a common mental health disorder and receive treatment (National Collaborating Centre for Mental Health, 2011). The National Audit of Psychological Therapies for Anxiety and Depression: National Report (2011) found that 70% of service-users who had high intensity therapy received less than the minimum number of treatment sessions that NICE recommends. Furthermore, it mentions that the commissioners and their partners should pay particular attention to the needs of the minority ethnic groups, including people who do not speak English as their first language.

The growing population of ethnic minorities in developing countries along with increasing demands for equality and fair treatment has meant that the problem of treating ethnic minority groups with conventional psychological approaches and the need for adapting treatments has received more attention in the literature (Bernal, Bonilla, & Bellido,. 1995; Bernal & Sa´ez-Santiago, 2005; 2006; Betancourt & Lo´pez, 1993; Casas,, 1995; Comas-Dri´az & Griffith, 1988; Pendersen 2003). Ward (2007) suggested that pharmacological, psychological and social interventions are likely to be as effective in ethnic minorities as in the host population. However, other researchers have suggested that psychosocial treatment needs to be tailored according to the needs of the minority population (Miranda, Siddique, Belin & Kohn-Wood, 2005). Recently, there has been growing interest in the development of culturally adapted psychosocial interventions for these groups (Gater et al., 2010; Miranda et al., 2003a). However they may require additional training, leading to additional costs, which may paradoxically reduce access for ethnic minority patients.

It is essential to gather more evidence on the effectiveness of psychosocial interventions in ethnic minorities. Particularly to examine whether modifications to existing interventions to make them culturally sensitive or the development of new culturally appropriate interventions leads to greater access, effectiveness and acceptability. A systematic review on psychosocial interventions for CMD for ethnic minorities has been conducted as part of the thesis and is reported in Chapter 3.
1.4 Culture and mental health

‘Culture’ refers to the world views and ways of life pertinent to a group of people (Baldwin & Lindsley, 1994). The word ‘culture’ traditionally referred to a combination of an individual’s behaviour and cognition arising from common beliefs, feelings and adaptations (Leighton & Hughes, 1967). The understanding of the term ‘culture’ has changed considerably in the last few years. Culture can no longer be pragmatic to a closed system composed of traditional beliefs and practices, rather it consists of a more flexible and dynamic system of values and worldviews that has been continuously developing (Fernando, 2003). The new concept of culture is described by Findley & Rothney (2006) as ‘being understood as systems of symbols and meanings that even their creators contest, that lack fixed boundaries, that are constantly in flux, and that interact and compete with one another’.

Understanding cultures refers to the awareness of the individuals’ norms “collectively being created in the here-and-now, in the context of the here-and-now” (Fernando, 2003).

Barnouw (1985) describes culture as what societies learn and pass down generations and it plays an important role in defining the complexity of specific symptoms. Culture cannot be simply defined as a collective set of attitudes, values, beliefs and behaviours shared by a group of people because it also includes ‘culture related experiences of being an ethnic minority’ (Hwang et al., 2008).

Fernando & Keating (2009) identify that mental health varies significantly across cultures and is strongly related to the ways of life, values and worldviews. Psychiatric disorders are more prevalent in ethnic minorities as compared to the host populations (Waheed, 2010). Many factors are associated with it, but ‘expectations’ and ‘attitudes’ play an important role in defining illness. However, a thorough understanding of the role of culture is needed to recognise the interaction between social and biological factors as they can influence the development and expression of illness, as well as affect help seeking behaviours (Barnes et al., 2002; Hwang et al., 2008; Piccinelli et al., 1997; Wilson, 2001).
1.5 What do we mean by Cultural sensitivity, Cultural adaptation and Cultural competence?

Culture has been considered in research methodology by different terms such as ‘cultural sensitivity’, ‘culturally appropriate’, ‘cultural adaptation’ and ‘cultural competence’. The common denominator of which is that all of these consider language and culture-related issues in any psychosocial interventions (Bernal & Saez-Santiago, 2006). Pederson (1997) first described this term as “culturally centred” which was afterwards used in the Guidelines on Multicultural Education, Training, Research, Practice and organizational change for Psychologists (APA, 2003).

Zayas (1996) described culturally sensitive interventions having the following dimensions:

- Awareness of culture
- Acquisition of knowledge about cultural aspects (Such as norms, customs, language, lifestyles, etc.)
- Capacity to distinguish between culture and pathology
- Capacity to integrate all the above mentioned dimensions in the intervention

Marin (1990) defined culturally appropriate interventions as strategies for behavioural change meeting three basic criteria:

- The intervention or treatment should be based on cultural values of the group or groups of interest
- The strategies that comprise the treatment should be compatible with the subjective culture of the particular ethnic group
- The components that are part of the strategies be based on the expectations of the behavioural preferences of the ethnic or minority groups

Culturally sensitive research necessitates referring to cultural context across the various phases of the scientific process: pretesting and planning, the investigation, translation of instruments, collection of data, and data analysis. (Malgady, Rogler, & Constantino, 1990; Rogler, Malgady & Rodriguez, 1989)
Bernal et al. (2009) defined cultural adaptations as:

“The systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client’s cultural patterns, meanings, and values” (Bernal et al., 2009).

1.5.1 The need for cultural sensitivity/adaptation

The U.S. Department of Health and Human Services (2001) specifies how culture influences different aspects of mental illness such as expression of symptoms, coping styles, social support, willingness to seek treatment and diagnosis, treatment and service delivery. Consideration of cultural and social processes in treatment, prevention and mental health service delivery is obligatory (Marin & Marin, 1991; Burlew, Bernal, Trimble & Leong, 2003). A large number of writers have emphasised the need to consider cultural and contextual aspects in psychosocial interventions (Bernal, et al., 1995; Bernal & Scharron-del-Río, 2001; Nagayama-Hall, 2001). Pendersen (2003) pointed out that all behaviour is learned and demonstrates within a cultural context, and, therefore, an effective intervention requires attention to the patient’s cultural context. There is little evidence of developing, adaptation and evaluation of treatments in diverse populations (Bernal & Scharro’n-del-Ri’o, 2001). Achieving the right equilibrium between choices available and needs is challenging when tailoring interventions to ethnic diverse populations. The problem of having to “fit” existing Evidence Based Treatments to their patients is not possible for the clinicians and administrators as there is no proper guidance for adaptation for culture, language, and context (Bernal et al., 2009).

The problem with cultural adaptations arises when clinicians try to apply evidence based treatments (EBTs) to a dissimilar group to those who have not participated in the original research conducted to provide evidence for the efficacy of the intervention (Barrera & Gonza’lez-Castro, 2006). Different studies on service utilization and treatment preferences including health beliefs have highlighted that ethnic minorities respond differently to treatments as compared to host population (Arroyo, Westerberg, & Tonigan, 1998; Aldous, 1994; McMiller & Weiz, 1996).
Evidence from several research studies support that psychotherapy is a cultural phenomenon and it plays an important role in treatment. For example, studies on service utilization (Arroyo, et al., 1998; Snowden & Cheung, 1990; Flasketurud & Liu, 1991), treatment preferences (Aldous, 1994; Constantino, Malgady, & Roger, 1994) and health beliefs (McMiller & Weiz, 1996; Penn et al., 1995) have reported that ethnic minorities tend to respond differently to treatment than the host population because of the cultural differences.

In order to decrease inequality in mental health services and provide effective psychosocial interventions there is a need for more research studies which can contribute to the knowledge base of what works and how it works. Ethnic minorities experience poverty and lack of access to resources and it is important to understand how culture, cultural values, ethnicity, discrimination and community resources impact these individuals and their families (Bernal & Saez-Santiago, 2006).

1.5.2 Evidence for and against cultural adaptations of interventions

Lloyd Rogler called attention to issues of cultural sensitivity (1989) and notifies that cultural insensitivity is prevalent in research. He proposed that in order to carry out culturally sensitive research, careful attention should be paid to the methodological issues that include adaptations and modifications considering culture (Rogler, 1989). The research process from the planning and design to instrumentation, analysis and results all need to be considered in the light of changing cultural backgrounds (Rogler, 1989). Washington and McLoyd (1982) suggested that cultural, interpretative, population, ecological and construct validity of the intervention are important in ensuring external validity in research specifically involving minorities. Cultural validity means the identification of specific “rules” that influence the behaviours of individuals, groups and larger systems. Interpretative validity refers to how the subject’s motivations, backgrounds, goals, and methods of goal achievement affect his/her actions. Population validity is defined as the degree to which one can generalize from a specific sample to the population or other populations. Ecological validity is defined as the agreement between the subject’s and the investigators...
respective perception of environment. Construct validity integrates the ecological, population, interpretative and cultural validities (Bernal, 2006).

Bernal and Sa’ez-Santiago (2006) believes that all these issues are part of psychosocial treatment research today. One of the important issues in this debate of ‘generalization’ can be dealt by the development and testing of culturally adapted treatments within a set of clinical trials on specific ethnic minority groups (Bernal & Sa’ez-Santiago, 2006). The NICE guidelines for depression (2009) recommend the development and implementation of culturally appropriate evidence based treatments in recognition that ethnic minority communities have different explanatory models of illness.

The ‘ecological validity’ argument suggests the need to increase similarity between the ethnicity of the client and the treatment provided. The methods aim to increase this similarity are described as instances of cultural sensitivity by Bernal and his colleagues (1995). Research on most of evidence based treatments cannot be generalized to all ethnic groups as it has been conducted mostly using white middle class patients. Therefore, the external validity of the treatments is unknown. Lau (2006) mentions that there is evidence for the poor response of some racial and ethnic groups to evidence based treatments which affect the recruitment and attrition rates of participants in treatment.

The cultural compatibility hypothesis was initially formulated by Tharp (1991). He emphasized that “a treatment is more effective when compatible with client culture patterns” (p.802). The null hypothesis formulated by him followed a universalistic view that the same set of procedures should be followed for treatments for all ethnic minority groups (Tharp, 1991). Sue (1998) emphasised differentiating between focusing on an individual and generalizing across a cultural group. Miranda et al. (2003) indicates about theoretical and empirical problems with race and ethnicity. The universalistic hypothesis in this case is supported by default because of the lack of conducting feasibility studies in order to find what is best for whom (Bernal et al., 2009).
The ‘specificity argument’ suggests that an important aspect of treatments is people’s subjectivity and their culture (Bernal et al., 2009). They argued that subjective cultural needs are very important aspect of ethnic minority individuals and should be given importance when treating clients from different cultural backgrounds. In addition, they highlighted that treatments should be made specific to group culture (Bernas, Bonilla & Bellido, 1995). Hall (2001) defined culturally sensitive treatments as involving “the tailoring of psychotherapy to specific cultural contexts” (p. 502). According to him interdependence, spirituality and discrimination were the key resources in adapting treatments to ethnic minority groups (Hall, 2001).

The ‘evidentiary’ argument refers to consideration of culture, race and ethnicity and is common in literature (Bernal et al., 1995; Canino et al., 2008; Hall, 2001; Miranda et al., 2005; Sue, 1998; Trimble & Mohatt, 2002). Cauce et al. (2002) uses the growing evidence of adapting evidence based treatments for ethno cultural groups to stress the need to culturally adapt treatment strategies. An evidence-based cultural adaptation can modify treatments in a systematic manner considering cultural background of different groups. Hwang (2009) and Nicolas (2009) described their procedures for cultural adaptation and collaboration with community members that are systematic and culturally consistent with Chinese Americans and Haitian American adolescents. Sue (1998) linked cultural matching between the patient and provider to positive outcomes. Griner & Smith (2006) in a meta-analysis of culturally adapted mental health interventions found an effect size of 0.45 suggesting a moderate benefit of culturally adapted interventions. The benefits of providing the interventions in patient’s native language were proved with the evidence that linguistically matched interventions were twice as effective as interventions delivered in English (Griner & Smith, 2006).

Arguments in favour of cultural adaptation have been criticized on the grounds of feasibility. Bernal et al. (2009) mentions that cultural adaptations being relatively new, researchers are engaging ethnic groups to test cultural adaptation in efficacy trials. The argument presented is that gathering a critical mass of evidence for the use of adapted treatments for ethno cultural groups (ECGs) via trials is not practical as there are no resources available for such studies (Bernal, 2009). This approach is viewed as “crassly empirical” and not feasible by Bernal and colleagues (2009).
Pauls’ (1967) question of ‘what works with whom’ is impractical to answer as the number of available treatments by disorders "would require more than 100,000 studies" (Kazdin, 2000, p. 830).

Furthermore, there are practical issues in investigating the relevance of cultural adaptations as documentation on using evidence based treatments (EBTs) is becoming a requirement by some agencies. Using EBTs for groups which were not developed specifically for ethnic minorities could result in ineffectiveness of interventions (Lau, 2006). Elliot & Mihalic (2004) argued that in order to maintain fidelity of the intervention too many adaptations may not be possible to make it culturally sensitive. Some researchers have also argued the development of cultural adaptations (Castro et al., 2010). Culture is a complex concept and it is difficult to culturally adapt an evidence based treatment in different ways.

1.5.3 Methods for culturally adapting psychosocial intervention for common mental health disorders

Different models of culturally adapting interventions have been developed by different researchers. These models provide a systematic way to make cultural adaptations and describe processes that could be followed in the designing, implementation and evaluation of cultural adaptations of treatments. These overlapping models for cultural adaptation provide a framework on how to adapt the treatments. The section below discusses some of the models of cultural adaptation in the literature.


Bernal et al.’s (1995) model proposed eight dimensions to be considered when culturally adapting a psychosocial intervention for Latino Americans. It consists of interventions language, persons, metaphors, content, concepts, goals, methods and context. Table 1.3 below summarises the eight dimensions.
Table 1.3: Dimensions for Culturally Adapting Psychosocial Interventions for Hispanics (Bernal et al., 1995)

<table>
<thead>
<tr>
<th>Dimensions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language</td>
<td>Using culturally appropriate language</td>
</tr>
<tr>
<td>Persons</td>
<td>Determining a therapeutic relationship by highlighting the ethnic differences and similarities between the participant and the therapist</td>
</tr>
<tr>
<td>Metaphors</td>
<td>using culturally appropriate concepts</td>
</tr>
<tr>
<td>Content</td>
<td>Emphasising cultural distinctiveness by using culturally appropriate content</td>
</tr>
<tr>
<td>Concepts</td>
<td>Treatment concepts should be compatible with the cultural perceptions</td>
</tr>
<tr>
<td>Goals</td>
<td>Setting treatment goals within the cultural context</td>
</tr>
<tr>
<td>Methods</td>
<td>Consideration of the cultural sensitivity of all methods and procedures</td>
</tr>
<tr>
<td>Context</td>
<td>Consideration of the social, psychological, political and/or economic circumstances of the participants</td>
</tr>
</tbody>
</table>

Considering the dimension of language according to Bernal’s (1995) model, Barona & Santos de Barona (2003) advised not only translation, but the integration of cultural norms such as emotional expression and dialect. Jerrell (1995) and Ying and Hu (1994) have shown participant-clinician ethnic matching can improve engagement but not always treatment outcomes. Ziguras et al., (2003) replicated this finding in non-English speakers living in Australia and among ethnic Norwegians (Mollersen et al., 2009). Comparison was also made by Farsimadan et al., (2007) in the UK between matched and non-matched South Asian, Black African, Black Caribbean and Middle Eastern clients’ and clinicians. The model has been used to adapt parent-child interaction therapy with Puerto Rican children and families (Matos, Torres, Santiago, Jurado & Rodriguez, 2006). The results of this project showed that culturally adapted parent-child interaction therapy was acceptable to both parents and practitioners.

The model was expanded from the “ecological validity model” and utilizes Rogers (2000) model for modifications and improvements. This cultural adaptation process model is focused on three phases and ten specific target areas as described in the Table 1.4 below. Each phase comprised of a systematic process of evaluation, revision and re-invention as proposed by Domenech- Rodriguez & Weiling (2004).

Table 1.4: Three Phased Process Model of Cultural Adaptation (Domenech-Rodriguez & Weiling, 2004)

<table>
<thead>
<tr>
<th>First Phase</th>
<th>Revision: Gathering information on needs and interests of the target population and establishing a two-way relationship between the researcher and the community leaders which keeps scientific integrity besides provision of acceptable and appropriate community needs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second phase</td>
<td>Evaluation: Adaptation process should include evaluation measures.</td>
</tr>
<tr>
<td>Third Phase</td>
<td>Re-invention: Developing a new intervention by combining the observations and data collected in the previous phase to make them applicable generally.</td>
</tr>
</tbody>
</table>

The practicality of this process model was tested by Domenech Rodriguez (2008). A parent management training-Oregon model intervention was culturally adapted for Mexican American families. The eight dimensions proposed by the ecological validity model were followed while collecting the data from the focus group discussions. The challenges faced by Mexican American families were addressed in this intervention. The main findings showed reasonable retention of parents and positive improvement in child outcomes in the intervention group.

Barrera and Castro (2006) Frameworks of cultural adaptation within treatment trials

Barrera and Castro (2006) recommended an intervention trial designed to measure the effect of cultural adaptations upon participant engagement and outcomes. Figure 1.3 below shows an example of an intervention targeting supportive parenting to reduce depression.
Engagement in the intervention is reflected by pathways A-D. The effect of adaptation on outcome is presented by pathways V-Z. The figure shows additional distress because of migration that has been addressed by additional cultural adaptation. Consideration of each adaptation is done separately in order to stress the need for further research of adaptations. The outcomes affected by these adaptations include patient satisfaction, self-esteem or caregiver burden (Lau, 2006).

Barrera and Castro (2006) also proposed a specific order of investigation when adapting an intervention presented below in Table 1.5. Besides this order they have also highlighted the need of cultural competence of the service provider.
Table 1.5: Order of Investigations in Cultural Adaptations by Barrera and Castro (2006)

<table>
<thead>
<tr>
<th>Order of investigation</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information gathering</td>
<td>Conducting extensive literature reviews and focus groups</td>
</tr>
<tr>
<td>Preliminary adaptation</td>
<td>Information gathered in the previous stage will provide initial basis for modifying the intervention</td>
</tr>
<tr>
<td>Testing the adapted intervention</td>
<td>Pilot trial</td>
</tr>
<tr>
<td>Refinement of adaptations</td>
<td>Both qualitative and quantitative evaluation of the adapted intervention.</td>
</tr>
</tbody>
</table>

A four stage adapted intervention for maternal depression was conducted by D’Angelo et al. (2009) using this model. The adaptations in the intervention showed promising results: the intervention was deemed helpful and stress free by the family members. The families reported an encouraging therapeutic relationship with the therapists. D’Angelo et al. (2009) also made adaptations in a depressive intervention for Latina families using this model and Barrera et al. (2010) also applied this framework for adult Latinas with diabetes. The findings of this pilot study were encouraging and the study attained systematic feedback from the participants and the intervention providers. A similar framework for cultural adaptation of a psychosocial intervention was followed in the AMP project and is reported in the forthcoming chapters of the thesis.

1.5.4 Issues in cultural adaptations and some recommended solutions

One needs to differentiate between issues of efficacy and effectiveness while culturally adapting interventions. Where efficacy measures how well an intervention works when tested within the controlled conditions under which it was designed, effectiveness, on the contrary, measures how well the intervention works in a practical setting (Flay et al., 2005; Kellam & Langevin, 2003). Table 1.6 below illustrates the four issues of cultural adaptation mentioned by Castro and colleagues (2010) and solutions recommended for these issues.
Table 1.6: Issues and Recommended Solutions in Cultural Adaptation Raised by Castro and Colleagues (2010)

<table>
<thead>
<tr>
<th>Issues in cultural adaptations</th>
<th>Recommended solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How can one justify cultural adaptations which are developed from original EBIs?</td>
<td>The cultural adaptation of an original EBI can be justified if they fall under any of the following conditions: (1) if clinical engagement is ineffective, (2) exceptional cases of risk, (3) exceptionally different symptoms of a common disorder, and (4) evidence showing non-significant intervention efficacy for a specific sub-cultural group.</td>
</tr>
<tr>
<td>What set of rules and procedures do the intervention developers need to follow for conducting a cultural adaptation?</td>
<td>A simplified framework suggested by Barrera &amp; Castro (2006) consisting of; (1) information gathering, (2) develop recruitment strategies and modify the intervention based on information gathered in the first step, (3) pilot test the modified recruitment, intervention, and assessment procedures, (4) Evaluating quantitative and qualitative results</td>
</tr>
<tr>
<td>Is there any evidence available for effectiveness of cultural adaptations?</td>
<td>Systematic reviews done by Griner and Smith (2006) and Huey and Polo (2008) provide some evidence about the effectiveness of culturally adapted interventions. Evidence from these two studies indicates that adaptations are typically effective in general. They are often, but not always, as effective as the original EBI and usually reveal greater relevance to the needs of a targeted sub-cultural group.</td>
</tr>
<tr>
<td>How can one tackle the issue of within-group cultural variation in cultural adaptation?</td>
<td>Identification of similar subpopulation groups with same needs and preferences and develop adaptive intervention protocols that match the individual’s or sub-cultural group’s needs and preferences.</td>
</tr>
</tbody>
</table>

Adapted from Castro et al., 2010
1.5.5 Culturally sensitizing a psychosocial intervention for the South Asian community in the UK

Section 1.4.2 above presented methods to provide a framework for conducting cultural adaptations for ethnic minorities. Different frameworks mentioned above are useful in guiding cultural modifications and adaptations but one framework cannot be suitable for all. It is important to know what procedures to follow in order to put these frameworks in practice and make interventions acceptable and suitable for different ethnic minorities like the South Asian community living in the UK.

Gater (2010) was the first study investigating a complex intervention for depressed British Pakistan women living in the UK in order to help improve their social difficulties, social isolation and access to primary care. The research team developed and piloted a manual to train staff to deliver a group intervention emphasizing empathy, confidentiality and engagement. The social intervention consisted of a group intervention and was compared in a randomised controlled trial with a protocol-based antidepressant intervention on its own and with a combination of both. In order to deal with stigma culturally appropriate venues were selected for group intervention and the groups were facilitated by culturally matched bilingual trained facilitators. A transport facility was provided in the form of a group taxi along with a female Pakistani facilitator. Child care facilities were also provided keeping in view cultural sensitivity. The cultural adaptations of this study are discussed in detail in Chapter 3.

Considering Bernal’s (1995) model mentioned above, it seems that Gater (2010) attended to the dimensions of language, persons, content and concept in culturally adapting the intervention for the Pakistani women residing in the UK. The results of this trial showed no significant difference in improvement in depression in the social intervention group and the combined treatment group compared with those receiving an antidepressant. Social functioning in the social intervention and combined treatment groups showed greater improvement than in the antidepressant group at both three and nine months (Gater, 2010). The randomized trial demonstrates procedures for culturally adapting interventions and it is essential for the researchers
to know the extent to which interventions could be modified culturally in order to cater to the needs of specific groups.

Another study Jacob (2003) prepared an educational leaflet for British Asians which was available in English, Urdu and Hindi. The leaflet described symptoms of depression and anxiety, how it becomes an illness and different treatment options available for it. This could be comparable to culturally adapting the two dimensions of language and content according to Bernal’s (1995) model of cultural adaptation. The intervention group received the patient information leaflet and the control group did not. The findings show that 43% of patients who received education recovered, compared with 20% of controls, whereas there was no effect on the explanatory model of depression, or on recognition by the GP, help seeking or treatments (Jacob, 2003).

**Conclusion**

Cultural sensitivity, cultural appropriateness and cultural adaptation are challenging concepts for researchers. Access to potentially effective interventions may be poor due to individual traditional beliefs and attitudes and the stigma attached to mental illness. Cultural adaptations to interventions may improve acceptability and engagement and could prove to be effective if provided according to the needs of specific groups. The procedures of cultural adaptation should be clearly outlined by researchers and more qualitative evaluation in the pilot phases should be done in order to differentiate between what is acceptable to specific cultural groups on the one hand and universally acceptable on the other hand.

The literature reviewed above makes an argument in favour of cultural adaptations. Different models and frameworks discussed above are useful in guiding cultural adaptations but one model or framework cannot be suitable for all. It is possible to provide effective psychotherapies for ethnic minorities, by adaptations according to their cultural values, language, socio-economic status, gender, and choices. The next question is what procedures to follow in order to put these frameworks in practice and to make interventions suitable for ethnic minority groups. It also needed to explore how to improve engagement and acceptability with these therapies. The
proposed project is aimed at finding answers to these research questions in the coming chapters.

**Research questions:**

1. What is the evidence for the effectiveness of psychosocial interventions in ethnic minority populations?
2. What are the barriers in accessing mental health care services specifically for the South Asians in the UK?
3. What are the patient’s experience of engagement and acceptability of the sensitized psychosocial intervention?
4. What modifications are required to culturally sensitize a psychosocial intervention for South Asians living in the UK?
5. What does this tell us about the specific need for cultural sensitization and adaptation of psychosocial interventions for this population?

**1.6 Summary**

- The thesis is about developing and evaluating a culturally sensitive psychosocial intervention for the South Asian community in the United Kingdom (UK). It reports a phased research study and is part of a larger funded programme grant AMP (Dowrick et al., 2013). It consists of conducting a systematic review in the first phase, a study of focus groups in the second phase and a study of in-depth interviews and case studies in the final phase.

- Ethnic minorities experience poverty and lack of access to resources and are less likely to contact health care providers and receive treatment. Despite the high prevalence of depression in ethnic minorities it is still an under recognized condition and limited importance is given to its diagnosis in primary care. Different treatment options are available for common mental disorders including psychotherapy, medication and psychosocial interventions.
• Culture has been considered in research methodology by different terms such as ‘cultural sensitivity’, ‘culturally appropriateness’, ‘cultural adaptation’ and ‘cultural competence’. There is an emerging interest in the development of culturally adapted psychosocial interventions for ethnic minorities.

• Different models of culturally adapting interventions have been developed by different researchers. These models provide a systematic way to make cultural adaptations in interventions and describe processes that could be followed in designing, implementation and evaluation of cultural adaptations of treatments. These models provide a framework on how to adapt and modify the treatments.

• Barrera & Castro (2006) suggested a simplified framework of information gathering, developing recruitment strategies and modifying the intervention based on information gathered in first step, pilot test the modified recruitment, intervention and assessment procedures, and evaluating quantitative and qualitative results of the pilot study and modifying the intervention. Similar framework procedures for conducting cultural adaptations were followed by the AMP psychosocial intervention developers.

• The evidence in the literature highlights the need for cultural adaptations of evidence-based treatments. Most of the research evidence suggests that psychosocial interventions are likely to be effective in ethnic minorities when tailored according to the needs of the minority population. Systematic reviews done by Griner & Smith (2006) and Huey & Polo (2008) provide some evidence for the effectiveness of culturally adapted interventions.

• Cultural adaptation of interventions has been criticised on the basis of feasibility as it becomes very difficult to know what works for whom. There is also lack of resources for conducting trials for different ethnic groups as it becomes impractical to gather evidence for many different groups using different treatments options.
• One model or framework of cultural adaptation cannot be suitable for all. It is important to know what procedures to follow in order to make interventions acceptable and suitable for different ethnic minorities like the South Asian community living in the UK. Gater (2010) in a randomized trial demonstrates procedures for culturally adapting interventions and it is essential for the researchers to know the extent to which interventions could be modified culturally in order to cater to the needs of specific groups.

• The procedures of cultural adaptation should be clearly outlined by researchers and more qualitative evaluation in the pilot phases should be done in order to differentiate between what is acceptable to specific cultural groups on the one hand and universally acceptable on the other hand as access to some apparently effective interventions may have reduced impact in a population due to individual beliefs and attitudes and stigma attached to mental illness. Cultural adaptations to interventions may improve acceptability and engagement and could prove to be effective if provided according to the needs of specific groups.
Chapter 2: Methodology and Methods

The first section of the chapter begins by briefly recapping the context in which the study took place. Then, it goes on to discuss why a mixed methods research methodology was chosen. The following section focuses on describing the methods of the quantitative study followed by the methods of the qualitative studies. The method of data analysis employed and ethical considerations are also discussed.

2.1 Background to study

The study in the thesis draws upon data collected whilst the author was working in a team carrying out a large five-year National Institute for Health Research programme grant on Accessing Mental Health in Primary Care (AMP) (Dowrick et al., 2013). The present research study being part of, and expanding upon, the AMP Project was conducted in three phases spanning over a period of three years. It is composed of three sub-studies:

1. A Systematic Review: Psychosocial Interventions for Common Mental Disorders in Ethnic Minorities
2. Development of a Culturally Appropriate Psychosocial Intervention: A Qualitative Focus Group Study
3. Evaluation of a Culturally Appropriate Psychosocial Intervention:
   a) A study of In-depth Interviews
   b) An analysis of Case Studies

2.2 Mixed methods research

The concept of mixed methods research was introduced during 1960’s however it became more commonly used in the 1980’s (Tashakkori & Teddlie, 1998). It has gained popularity in many disciplines including Education, Psychology, Nursing and Sociology (Leech & Onwuebbuzie, 2009). Furthermore, there has been a growing increase in the number of mixed methods research studies and the published ones have been utilized to answer questions that could not be answered by conducting
single studies. In recognition of mixed methods research a handbook of mixed methods has been published by Tashakkori and Teddlie (2003a).

Mixed methods research is a research design that amalgamates qualitative and quantitative approaches (Creswell et al., 2007a). Leech & Onwuebbuzie (2009) describe mixed methods research as one which represents research that involves collecting, analysing and interpreting quantitative and qualitative data in a single study or a series of studies investigating the same phenomenon. The case for conducting mixed methods research, as well as the debate supporting each individual quantitative and qualitative paradigms, has been discussed extensively in the literature by researchers (Borkan, 2004; Creswell & Tashakkori, 2007b; Tashakkori et al., 2009). Drawing together quantitative and qualitative data would result in more theoretically informed studies. A key advantage of using mixed methods research is its ability to combine several methods in a way that best answers the research question (Johnson & Onwuegbuzie, 2004). Table 2.1 below describes the different methods used to answer the research questions of the thesis.

Table 2.1: Methods Employed to Answer the Research Questions

<table>
<thead>
<tr>
<th>Method</th>
<th>Research Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic Review</td>
<td>What is the evidence for the effectiveness of psychosocial interventions?</td>
</tr>
</tbody>
</table>
| Focus Groups      | What are the barriers in accessing mental health care services specifically for the South Asian minority in the UK?  
                    | What modifications are required to culturally sensitize a psychosocial intervention for South Asians living in the UK? |
| In-depth Interviews| What are the patient’s experience of engagement and acceptability of the sensitized psychosocial intervention? |
| Case studies      | What does this tell us about cultural sensitization and adaptation of psychosocial interventions, for this population? |

Senne and Rikkard (2002) has conceptualized the available research designs and presented a three dimensional typology of mixed methods designs (Figure 2.1). Once
a study combines qualitative and quantitative techniques to any level the study is either using a fully mixed methods design or a partially mixed methods design. Strauss and Corbin (1990) suggests that qualitative methods allow for more individualised, in-depth and studies with rich data whereas, quantitative studies do not contextualise participants within their settings and do not give ‘voices’ to the participants.

Figure 2.1: Typology of Mixed Methods Research (Senne & Rikkard, 2002)

The author used a partially mixed quantitative and a qualitative methods design to find relevant answers to the outlined research questions. This method design involves conducting research sequentially with the quantitative and qualitative studies having equal weight. This design was considered more suitable for the research study and justifiable by the following rationale outlined below.

- The quantitative systematic review will identify all the research conducted on psychosocial interventions which have been tested and proved effective for common
Supporting this, the focus group study will provide an insight into the barriers and facilitators of accessing mental health care. This data besides the results of the review will obtain opinions of the personal experiences of (current and potential) mental health service users and providers. This would assist in the development of a culturally sensitive psychosocial intervention for this group by inculcating the facilitators and overcoming the barriers present in the findings.

The second qualitative study will give in-depth information on acceptability, adherence and engagement in the psychosocial intervention enlightening the features which could overcome barriers and improve access for the South Asian minority in future research. This study will also discuss case studies that will highlight their mental health needs, the choices available in the well-being intervention and how these impact upon the decision making of potential service users.

2.3 Quantitative study: Psychosocial interventions for common mental disorders in ethnic minorities: Systematic review

2.3.1 Systematic review

This work forms part of a paper already submitted by Waheed et al. (submitted)

Chalmers and Altman (1995) have outlined a number of terms used to describe the process of systematic reviewing and synthesising research evidence, including “systematic review”, “meta-analysis”, “research synthesis”, “overview” and “pooling”. It is defined as, ‘A systematic review is a review that has been prepared using systematic approaches to reduce bias and random errors. Meta-analysis and statistical analysis may or may not be part of the results which aim to report treatment effects’ (Chalmers & Altman, 1995). It is considered important to appreciate the difference between a systematic review and meta-analysis as appropriate reviewing and data synthesis may be misrepresentative due to statistically pooled results of different studies (O’Rourke & Detsky, 1989).
2.3.2 Methods

Preferred reporting items in systematic reviews and meta-analysis PRISMA (Moher et al., 2009) were followed in conducting and reporting this review.

Inclusion and exclusion criteria:

Population

The inclusion criterion for the population was: adults from ethnic minority populations aged 18 or over with symptoms of depression, anxiety or stress. However, patients with bi-polar disorders were excluded. All the interventions that were included had to be offered in primary care or a community setting.

Ethnic minority

This included minority subgroups of the general population who migrated from outside the residing country and maintained their own social and cultural identity.

Interventions

The interventions included were: psychosocial interventions, informal counselling, formal psychological therapy, case management or other supportive interventions were included. Studies of pharmacological treatments were excluded, but if medication was part of any other treatment then these cases were included. Both individual and group treatments were included, and a variety of delivery mechanisms (written, audio and web based interventions, face-to-face and telephone delivery) were part of the inclusion criteria in the review.

Study designs

1. All Randomised Controlled Trials (RCTs) comparing a psychosocial intervention (as defined in Chapter 1) with a control or alternative intervention in patients from ethnic minority groups were included.
2. Any subgroup analysis of randomised controlled trials, where the effects of a psychosocial intervention were examined on ethnic minority subgroups within the trial was included in the review.

Outcomes

The primary outcomes of the review were measures of clinical effectiveness of interventions on symptoms of anxiety and depression. Secondary outcomes included measures of social function and quality of life while outlining specific needs for cultural sensitization and description of adaptations of psychosocial interventions for ethnic minorities (Relevant to this thesis).

Search strategy

The search strategy of this review was part of the broader AMP Project scoping review carried out with the purpose of gathering information for the development of the intervention. The search strategy was refined and special search strings were developed for the ethnic minority groups. Previous search strategies used for the BME group in different reviews were considered in depth and with assistance of a librarian. Furthermore, specific search strategies were developed for each database (Medline, Cinahl, Psychinfo and the Cochrane Library) using a combination of text terms and subject headings.

The searches were conducted in two stages. Four databases (Medline, Psychinfo, Cinahl and the Cochrane library) identified a very high number of studies in both stages. Mental health filters and time limits (1990 till June, 2009) were used to reduce the numbers of hits to practical levels. The first search identified systematic reviews of psychosocial interventions in primary care and community settings in the four databases. The studies included in these reviews and their reference lists were then checked to identify studies meeting the inclusion criteria. An example of Medline search strings of the first stage is given below.
Medline first stage search strings

- 1. primary health care/
- 2. family practice/
- 3. (family adj2 pract$).mp.
- 4. (general adj2 pract$).mp.
- 5. (Primary adj2 care).mp.
- 6. or/1-5
- 7. mental health/
- 10. exp anxiety disorders/
- 12. exp somatoform disorders/
- 13. or/7-12
- 14. 6 and 13
- 16. 14 and 15
- 17. limit 16 to yr="1990 - 2009"

A lot of effort and time was put in developing specific search strings in the second search for the ethnic minority group. At this stage the searches of Medline, Psychinfo, Embase and Cinahl identified a very large number of studies; the mental health filter and date limits were used to reduce the numbers to practical levels. An example of Medline search strategy in the second stage is presented below. The full search strategy is presented in the appendix (See Appendix 2.1). The searches were last updated in June, 2011.

BME Medline Search Strings

1. exp ethnic groups/
2. exp culture/
3. Transcultural nursing/
4. bengali.ti,ab.
5. cantonese.ti,ab.
6. creole.ti,ab.
7. farsi.ti,ab.
8. french.ti,ab.
9. gaelic.ti,ab.
10. hindi.ti,ab.
11. kashmiri.ti,ab.
12. korean.ti,ab.
13. kurdish.ti,ab.
14. mandarin.ti,ab.
15. nepali.ti,ab.
16. pashto.ti,ab.
17. polish.ti,ab.
18. punjabi.ti,ab.
19. somali.ti,ab.
20. spanish.ti,ab.
21. sylheti.ti,ab.
22. tamil.ti,ab.
23. turkish.ti,ab.
24. urdu.ti,ab.
25. vietnamese.ti,ab.
26. welsh.ti,ab.
27. yoruba$t$.ti,ab.
28. africa$t$.ti,ab.
29. african-american.ti,ab.
30. afro-caribbean.ti,ab.
31. african-caribbean.ti,ab.
32. anti-racist.ti,ab.
33. anti-racism.ti,ab.
34. asian.ti,ab.
35. caribbean$t$.ti,ab.
36. blacks.ti,ab.
37. Cross cultural.ti,ab.
38. diversity.ti,ab.
39. Equal opportunity$t$.ti,ab.
40. equality.ti,ab.
41. (ethnic$ adj3 minorit$).ab,ti.
42. Ethnic$.ti,ab.
43. ethnology.ti,ab.
44. gypsy.ti,ab.
45. immigration.ti,ab.
46. emmigrants.ti,ab.
47. indian.ti,ab.
48. jamaica$.ti,ab.
49. Minorit$3.ti,ab.
50. Migrant$.ab,ti.
51. mixed race.ti,ab.
52. multi racial.ti,ab.
53. multi cultural.ti,ab.
54. multi ethnic.ti,ab.
55. multi lingual.ti,ab.
56. pakistan$.ti,ab.
57. race.ti,ab.
58. racism.ti,ab.
59. (Religion or religious).ti,ab.
60. romany.ti,ab.
61. trans cultural.ti,ab.
62. transcultural.ti,ab.
63. transracial.ti,ab.
64. traveller.ti,ab.
65. exp mental health/
66. exp depression/
67. Randomized controlled trial.pt.
68. Random$.tw.
69. Control$.tw.
70. Intervention? tw.
71. Evaluat$.tw.
72. or/1-64
73. 66 or 65
Data Extraction

After the searches were completed, an initial screening was carried out by reviewing the title and the abstract in order to validate the relevance of the articles to the subject, a process that was repeated by other reviewers (Linda Gask, Waqas Waheed & Peter Bower) for verification purposes. Any disagreements were resolved when all the three reviewers read the full papers and mutually agreed on their relevance. Following discussions with the project supervisor, a standardized format was developed and data was extracted in the form of tables. The data extraction was done exclusively by the author and another reviewer. Any discrepancies were resolved after detailed discussion between the two reviewers and going through the papers together. When the search was updated in June 2011, some new studies were added to the review. At that point the same procedures were repeated for data extraction by two reviewers.

Data extraction on populations (country, population type, sex, age, education and baseline depression), interventions (type, intensity, therapist, delivery mechanism, adherence, and cultural modifications) and study quality was carried out by the author and three independent reviewers. The discrepancies were resolved via discussions. The studies included were coded according to design, intervention, comparison and population.

(a) Design: randomised trials of interventions in ethnic minority patients and subgroup analysis of ethnic minority patients in randomised trials were included.

(b) Intervention: The interventions were categorised into: (i) cognitive behaviour therapy; (ii) interpersonal therapy; (iii) collaborative care; (iv) educational interventions; (v) other interventions. Conventional psychological therapies were differentiated from culturally modified interventions.
(c) Comparison: Studies comparing psychological intervention with usual care, waiting list or other non-treatment control, and comparisons on a psychological intervention with a comparator were included. Chapter 3 includes a report on those assessing effectiveness compared to usual care, waiting list or other non-treatment control.

(d) Population: Patients recruited were distinguished on the basis of current diagnosed depression with significant symptoms and also those recruited on the basis of being considered ‘at risk’ of common mental disorders (CMD).

Study quality

The quality assessment for randomised controlled trials was based on five elements: assessment of concealment (Schulz & Grimes, 2002) of allocation, sample size (Hollis & Campbell, 1999), power calculation, intent to treat analysis, and level of attrition (Borenstein et al., 2005). The quality analysis was marked at three levels: randomised controlled trial quality was rated ‘high’ if allocation was adequately concealed and at least 80% follow-up reported, ‘medium’ if one of these criterions was met and ‘low’ in absence of both criteria.

Subgroup analyses of randomised controlled trials were assessed in the same way as the main RCT, although additional code was used in relation to whether the analysis of the subgroup was appropriate (i.e. statistical test of the interaction between the subgroup and the intervention) or inappropriate (no statistical test, or separate analysis of subgroups).

Outcomes

Qualitative analysis of the results was conducted and a meta-analysis was carried out by Professor Bower. Some results from the meta-analysis, in full acknowledgement that it was not conducted by the author, are also presented in Chapter 3 and Chapter 8 due to their relevance to this study.
2.4 Development of a Culturally Appropriate Psychosocial Intervention: Focus Group Study

The aim of conducting focus groups was to explore the views and experiences of service users and providers regarding certain topics. These included their perception of mental health in the South Asian community, in addition to barriers and facilitators in accessing mental health care services which would help in development of a culturally appropriate psychosocial intervention for mental health for the South Asian community living in the UK.

2.4.1 Method

Elliot, Fischer and Ronnie (1999) mentioned that, ‘‘qualitative research methods lend themselves to understanding participants’ perspectives, to defining phenomena in terms of experienced meanings and observed variations, and developing theory for field work.’’ (p.216)

Focus groups are a commonly used method to effectively explore individuals’ views and beliefs about key topics with the aim of understanding and explaining the factors in those beliefs and cultures that influence the feelings, attitudes and behaviours of individuals (Hennink & Diamond, 1999). The rationale for selecting a focus group method for data collection in this research was the ability to highlight the respondents’ attitudes, perceptions, priorities and understandings which could not be accessible in other forms of research methods (Albrecht, Johnson & Walter 1993; Kitzinger, 2000). Exploring people’s views and beliefs about key topics involves focussing on the life world of the subjects and encouraging them to be open about their experiences and beliefs (Kvale, 1996). Essed (1994) noted that the study of a selected sample is useful as a methodology for the analysis of multiple dimensions of experience, and allows a discussion that would be difficult to uncover using other methods of research.

Participants in this type of research are selected using socio-demographic characteristics, and for the reason that they would have something to say on the topic.
and would be comfortable sharing this within the group and the interviewer (Richardson & Rabiee, 2001). The members of the group should feel at ease with each other and engage in discussion (Krueger & Casey, 2000). Krug (1994) advocates same groups and suggests that members of such a group would get engaged and produces rich data. Kitzinger (1994) on the other hand advocates using pre-existing groups for exploring personal and sensitive issues.

Besides selection of the group, the role of a skilful facilitator is vital in encouraging and engaging participants to facilitate exchange of views, ideas and feelings about the discussion topic (Kruger, 1994; Burrows & Kendal, 1997). Observation of non-verbal interactions, documentation of the general content of discussion, and identification of statements made by particular participants will supplement the text and promote a thorough analysis (Kitzinger, 1994; 1995). Kruger and Casey (2000) suggested an ideal size of a focus group should be between six to ten participants. Several authors have suggested a total number of three to four focus groups to achieve a full discussion of the research topic (Burrows & Kendall, 1997).

The aim of conducting the focus groups was to explore the difficulties, cultures and beliefs the ethnic minority service users have in accessing mental health care from their perspective, as well as the service providers' perspective. They would also highlight factors and uncover essential understanding of developing an intervention that is culturally sensitive and acceptable to the South Asian community. The concepts of cultural sensitivity, cultural matching and cultural competence have been discussed in Chapter 1.

**Setting**

All the empirical research work in this thesis was carried out in Longsight, Manchester. Longsight is a residential suburb situated less than three miles south of Manchester City Centre on the "A6 corridor" route, which stretches from the City Centre through Ardwick to Longsight. The main shopping centre is near the corner of Stockport Road and Dickenson Road, and contains a library, a supermarket and many other smaller shops. There are a large number of takeaway food shops and restaurants, in addition to providers of a very wide variety of fresh fruit, vegetables
and other supplies that cater for the interests of the various immigrant communities in the area.

http://en.wikipedia.org/wiki/Longsight)
Longsight has a very ethnically diverse population. The religious affiliation of Longsight residents is approximately one-third Muslim and one-third Christian. The area is home to a number of mosques, a few temples and a Gurdwara plus several other churches of varying denominations (http://en.wikipedia.org/wiki/Longsight). Table 2.2 below presents the population characteristics according to census 2011 and 2001.

Table 2.2: Longsight Census Table

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>2011 Percentage</th>
<th>2001 Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White: British</td>
<td>21.5%</td>
<td>39.9%</td>
</tr>
<tr>
<td>White: Irish</td>
<td>2.0%</td>
<td>4.3%</td>
</tr>
<tr>
<td>White: Gypsy or Irish Traveller</td>
<td>0.5%</td>
<td>n/a</td>
</tr>
<tr>
<td>White: Other White</td>
<td>3.1%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Mixed: White and Black Caribbean</td>
<td>1.5%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Mixed: White and Black African</td>
<td>0.6%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Mixed: White and Asian</td>
<td>1.3%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Mixed: Other Mixed</td>
<td>0.8%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Asian: Indian</td>
<td>2.9%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Asian: Pakistani</td>
<td>35.7%</td>
<td>24.6%</td>
</tr>
<tr>
<td>Asian: Bangladeshi</td>
<td>11.4%</td>
<td>7.2%</td>
</tr>
<tr>
<td>Asian: Chinese</td>
<td>1.9%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Asian: Other Asian</td>
<td>3.4%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Black: African</td>
<td>5.1%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Black: Caribbean</td>
<td>2.7%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Black: Other Black</td>
<td>1.9%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Other: Arab</td>
<td>1.8%</td>
<td>n/a</td>
</tr>
<tr>
<td>Other: Any Other Ethnic Group</td>
<td>1.9%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

2.4.2 Recruitment

Recruiting participants for these focus groups was carried out by contacting all the community organisations, Primary Care Trusts (PCTs), social and mental health care services, and religious organisations, such as mosques in the Longsight community. Good rapport for this research group was established within this community as a result of previous work, as well as through the establishment of the community engagement strand of the AMP project which was working in parallel within the community. People working with existing groups were contacted with the aim to organize these groups. It was decided to have separate men and women service users group due to the cultural obligations related to the South Asian community. The service providers group was a mix of both genders. The main reason for getting a good number of participants in all the four groups was the influence of bilingual staff which had a previous relationship within the community. Furthermore, trying to provide flexible meeting times and convenient locations also had a positive effect.

2.4.3 Data Collection

Four focus groups were conducted between October 2009 and January 2010 in Longsight, inner city Manchester. In order to obtain a wide range of opinions four consultations meetings were held.

• **Group A: Ethnic minority participants** (17 women aged between 24 – 65 years, mostly Pakistanis, one Bangladeshi and two Indians). This was convened by the author, a bilingual researcher, assisted by three colleagues as the number of participants was greater than ideal. It lasted for an hour and the discussions occurred in Urdu/Hindi, Punjabi and English. Observers were present to take notes.

• **Group B: Bangladeshi women participants** (14 women aged between 22 – 55 years, all Bangladeshi). This was convened by the author and a Bangladeshi facilitator. The Bangladeshi facilitator had a strong relationship of trust within this group. A Bangladeshi interpreter was also there to facilitate communication. It lasted for an hour and a half. The discussions were in Bengali, Syhleti and English.
• **Group C: Men participants** (9 men aged between 35 -65 years, the majority with Pakistani background and two Indians). This was convened by the author with assistance from a colleague. It lasted for an hour and the discussions were in Urdu and English.

• **Group D: Healthcare providers** with 17 service care providers. Both men and women were part of this group. The group was conducted by the author, a colleague and the study supervisor. It lasted for an hour and a half. The discussions were in English.

**Location**

The selection of venues took into account the choice and convenience of the participants. Meetings with groups A & C were conducted at the local community centre in Longsight called Roby Church. The participants were people who were already attending social groups there. The Roby Church is not associated with people of any specific ethnicity or religion, rather it is a multicultural centre which is involved in providing diverse social services and was already running men and women mental health groups. The meeting with group B was conducted at Sure start for Bangladeshi women in Longsight. The community speaks Sylheti or Bangla only and most do not understand English or any other language. Sure start provides a range of social services in the Longsight area. Shalpa and Blossom were the two social support groups convened for the Bangladeshi community in Longsight. Group D was for service providers and the meeting was held at The University of Manchester. As the service providers from all over Manchester were invited, this seemed to be the most popular and easy to find venue.

**Topic Guide**

The facilitator in each group began by giving a brief introduction about the study and a topic guide was designed and followed in order to facilitate focus group discussions (See Appendix 2.2). The topic guide included a range of different, open ended questions beginning with some general questions and leading to more specific ones about the topic of discussion. The areas of discussion in this topic guide include barriers to service access, ways to overcome these barriers, and views about what
should be the format and content of the culturally sensitive interventions for the South Asian population.

Facilitators
The author was culturally matched to the participants in three of the focus groups. The Bangladeshi group was run with the help of an interpreter and a Bangladeshi community worker. The author had existing relationships with some of the participants due to previous work in the community. Furthermore, being bilingual allowed the participants to feel comfortable and offered the opportunity to engage with them in the discussion. The Pakistani women focus group was convened by the author and a bilingual researcher with assistance of by three colleagues, one of whom was culturally matched. The focus group with the Bangladeshi women was also convened by the author and a Bangladeshi facilitator. The Bangladeshi facilitator had good rapport within the Bangla community in the area, which helped in getting a good number of attendees. In addition, the author convened the focus group with the men service users’ with assistance from a British white male colleague. It was quite difficult initially to get the men to engage in the discussion as they were not ready to reveal their mental health issues in front of a female, which may be considered something against their ‘ego’ or may have stigma attached. It was difficult to gain the trust of the participants and would undoubtedly have been more acceptable and culturally appropriate if it was conducted by a male facilitator. Unfortunately, that was not possible at the time. The author started the initial conversation by stressing the importance of mental health and how they could manage their mental health issues. The ice broke as one of them began to talk about his mental health suffering and how he had improved by getting engaged with the local mental health care.

The service providers group was chaired by Professor Gask and convened by the author and one other white British colleague. Observations regarding moods and behaviours of all the participants were recorded as field notes which were incorporated into the analysis.

Transcription
All the audio recordings were transcribed and translated where required. Group A and C were conducted in Urdu and were translated and transcribed by the author.
Group B was conducted mostly in Bangla and it was transcribed by the Bangladeshi interpreter who was also part of that group. Due to time limitations the transcription of the health professionals’ focus group D conducted in English was carried by an administrative assistant. Quality checks were carried out on the translated data. Three paragraphs were randomly chosen from each of the translated record transcripts, translated back in their original language and then re-translated (Rahman et al., 2003). After all the transcripts were ready, each one was read by the author in order to address any problems referring back to the field notes and amend anything that was missed.

2.4.4 Framework Analysis

The data was analysed according to the principles of Framework Analysis which provides systematic and visible stages to the analysis process. Framework Analysis is inductive which allows for the inclusion of priori as well as emergent concepts (Ritchie & Spencer, 1994). The method has five distinct phases which are linked to each other to form a rigorous framework. These phases enable understanding and interpretation of data, and progressing from descriptive accounts to a conceptual explanation of what is happening as suggested by the data from the participants in the study (Furber, 2010). The five key stages of the framework analysis are described in Figure 2.2.

*Figure 2.2: Five Key Stages of Framework Analysis (Lacey & Luff, 2007)*

- Familiarization: The stage involves transcribing and reading the transcripts repeatedly in order to get an understanding of the main ideas.
- Identifying a thematic framework: Similar themes are grouped together under a main theme as identified in the familiarization stage.
- Indexing: Applying different codes to data, commonly referred to as “coding”.
- Charting: Creating thematic or case charts across the data set.
- Mapping and interpretation: Synthesizing the data by merging and re-emerging of themes in the charts and making sense of the data (Lacey & Luff, 2007).

The author used framework Analysis because besides influencing policy, it provides a systematic way for combining results and coding from multiple researchers and potentially different datasets. It’s a good way to get an overview of the results and the distribution of themes within and across groups ‘to eyeball the data’. It allows you to map back themes to all the data and check the theme you developed is really representative and not just following the ‘juicy quote’. It is epistemologically neutral i.e. it does intrinsically take a stance on ‘what can be known and how it can be known’. Framework method is quite good for taking fairly open questioning and directing it towards particular research question like the author used it for getting the views and experiences of service users and providers in the focus groups and Dickson woods (2005) process model of access as the framework for analysing the qualitative interviews.

2.4.4.1 Data Analysis

Transcripts were imported to the qualitative data analysis software MAXQDA10 (www.maxqda.com) for coding, which allows the results to be exported to matrixes (in Microsoft word or excel) for framework analysis.

The analysis was carried out via the package MAXQDA10, professional software used for qualitative and mixed methods data analysis. Released in 1989, it includes powerful, innovative and easy to use analytical methods, while it can also help with systematic analysis and interpretation of text. The main focus is qualitative analysis: it is possible to import files, organise them in document groups, develop a system of categories, code segments of documents, write and organise memos and take advantage of various search functions (www.maxqda.com). The following is an example of the four window screen shot of Maxqda.
The transcribed data along with the field notes taken during the discussions were organized and coded. Different themes emerged from the research questions being asked in the discussions and the shared experiences of the participants.

The analysis started with reading each transcript and writing memos with field notes in front so that the author could reflect on the actual experience. Following the familiarisation with the data, the process of coding the transcripts began. The questions in the topic guide informed the initial coding. Additional codes emerged from the data. The process of emergence and merging new codes continued to the point where:

- Individual codes were grouped into one or more themes. The major themes were used to organize the coded quotes and were then exported to Microsoft Excel as ‘frameworks’.

- The frameworks made it possible to obtain an overview of the relationships between the raw data, the interpretations, and the distribution of themes across different groups. Spencer et al. (2003) explained it in terms of the descriptive
summaries in the charts becoming incorporated into explanatory accounts that clarify the data.

- The author discussed the analysis at each stage with the project supervisor, Professor Gask. When the final coding was completed, a number of overarching themes emerged which were again discussed with Professor Gask. The interpretation of the data was shared between the author and Professor Gask, while the findings were discussed to conceptualize the emerging themes.

The excel spread sheet was verified against the original transcripts in order to agree the final framework from which the results presented in Chapter 4, 6 and 7 were built.

### 2.4.5 Ethics and research governance

Research ethics approval was granted from the Northwest 6 REC-GM South Research Ethics Committee (REC; Application 10/H1003/38). The University of Manchester REC ratified the study on the basis of that approval. Research governance approval was sought and attained from Liverpool and Manchester Primary care Trusts (PCTs) in the Northwest region.

When participants agreed to take part in the study, they were asked to sign a consent form. The consent forms were available in English, Urdu and Bengali. All the participants signed a consent form in their preferred language. Some of the participants read and signed the forms themselves and some signed after it was read to them so that they understood it clearly. Prior to the interviews the need to audio tape the interviews was explained to the interviewees, ensuring that their names would be kept confidential and only identification numbers would be used for the dissemination of research.
2.5 Evaluation of a culturally appropriate psychosocial intervention: A study of in-depth interviews

The main aim of this study was to evaluate the delivery, adherence and acceptability of the culturally appropriate psychosocial intervention that was designed based on the previous two stages.

2.5.1 Methods

An in-depth interviewing methodology was chosen for the study to explore and interpret the experiences of the patients being part of the culturally appropriate psychosocial intervention.

In-depth Interviews

Silverman (2000) described interviewing as ‘the gold standard of qualitative research’, and it is the most commonly used qualitative method (Green et al., 2005). However, there are different methods of interviewing. Green et al. (2005) defines structured interviews as ‘a way of conversations with a specific order and a set of questions. Informal interviews are interviews which rely on the natural generation of data through unstructured interactions within the field’. Burgess (1982a & 1984) described in-depth interviews as a form of ‘conversation’. The method of in-depth interviewing was described as: ‘A conversation with a purpose’’ Webb & Webb (1932, p130) reproduces a process through which knowledge about the social world is built in interacting with humans (Rorty, 1980). Kvale (1996) has put forward two different approaches for in-depth interviewing. The first approach sees knowledge as ‘given’, whereas the alternative, ‘not given’ knowledge is created and negotiated (Kvale, 1996). According to him the ‘researcher is an active player in development of data and of meaning’.

In-depth interviewing helps the researcher to scrutinise and study the subjects in their natural settings (Denzin & Lincoln, 2000). Strauss and Corbin (1990) suggest in-depth and detailed exploring of the topic in an exploratory research. Brown (1995)
and Crotty (1998) mention that reality is socially constructed. In the context of health, it is known that individuals have their own health beliefs and concepts which are affected by their social and economic situations (Dill et al., 1995). The author adopted in-depth interviewing as the methodology for this research study due to the nature of the research questions. The author wanted to know about the beliefs and perceptions associated with mental health and how the service users respond if they are offered ‘culturally appropriate’ mental health care as defined in the previous chapter. Finally, it was also desirable to explore the experiences of the intervention providers since they could provide helpful information for future research.

**Recruitment**

Patients fulfilling two criteria were contacted and asked to participate in this study: they were previously recruited into a randomised trial of the psychosocial intervention (see Chapter 5 for further details of the trial and its results) and they had also consented for the in-depth interview. Thirteen female trial participants out of the 19 agreed to participate in the study. Appointments were made and the interviews were conducted at the patients’ homes or their preferred choice of place. Just one interview was scheduled at the patient’s surgery as she was not comfortable with a researcher going to her residence because she did not want her neighbours to know about it. Three evaluation interviews with the well-being therapists and the intervention supervisor were also scheduled at their convenience in their offices.

**Topic guide**

The original topic guides developed for the main evaluation AMP study were modified as they lacked specific questions on cultural appropriateness and its acceptability. The findings of the focus group study, in conjunction with discussions on the subject with the supervisor and the research team, resulted in adding further questions on cultural appropriateness to the original topic guides. Two interview guides were developed (see Appendix 2.3 & 2.4), one for the service users and the one for the intervention providers, with the focus on cultural appropriateness in order to explore the experiences, barriers and facilitators of receiving the psychosocial intervention and its perceived impact. In order to explore the relevant topic, the
guides included open ended questions so that it was convenient to probe and ask more questions that will prompt the interviewees to narrate their views and experiences. Green et al. (2005) suggests that a comfortable rapport can be built between the interviewer and the interviewee by asking open-ended and non-controversial questions. This type of questioning also promotes the respondent to talk descriptively, thereby aiding in the collection of detailed data (Patton, 2002).

**Interview process**

The interviews began by thanking participants for agreeing to take part in the study. Confidentiality issues were discussed in detail and the participants were given a chance to ask any questions they had in mind. Each participant was given an information sheet (see Appendix 2.5) explaining the purpose of the interview. The patient information sheet was available in three languages English, Urdu and Bangladeshi. Each participant was given time to read it, or if they preferred it was read and explained by the author. A total of 17 interviews were conducted, 13 with the patients and four with the psychosocial intervention providers.

**Transcription**

All the interviews were transcribed. Six of the interviews conducted in Urdu were translated and transcribed by the author. Five of the audio recorded Bangladeshi interviews and the two Bangladeshi interviews were not recorded but detailed notes were taken. All were translated and transcribed by the Bangladeshi interpreter. Due to time limitations, four of the intervention provider interviews conducted in English were transcribed by an administrative assistant. After all the transcripts were ready, each one was checked in order to edit any problems, focusing primarily on the ones which were not transcribed by the author. This was done by referring back to the field notes in which the author had written all the observations and any relevant, missing information was added. The author also carried out the quality checks by selecting two paragraphs from three interviews each conducted in Urdu and Bangladeshi, ensuring they were translated back into their original language and then translated again (Rahman et al., 2003).
Data Analysis
The data was analysed according to the principles of framework analysis (Ritchie & Spencer, 1994). Transcripts were imported to the qualitative data analysis software MAXQDA10 (www.maxqda.com) for coding, which allows the results to be exported to matrixes (in Microsoft word or excel) for framework analysis. Details of this are mentioned in section 2.4.4. The data was analysed utilising Dixon-Woods (2005) Process Model of Access to inform the framework (Figure 2.4) which will be discussed in detail in Chapter six.

Figure 2.4: Process Model of Access (Dixon-Woods, 2005)

The Dixon-Woods model is a theoretical model providing a structure within which the experiences and understandings of the stakeholders can be interpreted, as well as testing the fidelity of the intervention to the theories outlined. The conceptual model is rooted in understanding access as a process involving: Candidacy, Navigation, Appearance, Adjudication, Offer and Receipt/Rejection. (These concepts are defined in Chapter 6).

All the transcripts were saved in rich text format and were imported for analysis into MaxQda10. This is the same software package and framework analysis used for the focus groups detailed in section 2.4.4.
Ethics and research governance

Research ethics approval was granted from the Northwest 6 REC-GM South Research Ethics Committee (REC; Application 10/H1003/38). The University of Manchester REC ratified the study on the basis of approval. Research governance approval was sought and attained from Liverpool and Manchester Primary Care Trusts (PCTs) in the Northwest region. When the participants agreed to take part in the study, they were asked to sign a consent form. These forms were available in English, Urdu and Bengali (See Appendix 2.6). Some of the participants read and signed the forms themselves and some signed after it was read to them in order to ensure they understood it clearly. Prior to the interviews, the need to audio tape the interviews was explained to the interviewees, emphasising that their names would be kept confidential and identification numbers would be used for the dissemination of research. All interviews except two were digitally recorded and lasted between 45 and 60 minutes. Detailed notes were taken for the two interviews of the Bangladeshi participants who were not comfortable and did not consent for the audio recording of their interviews. The interviews lasted from an hour and a half to two hours.

2.6 Cultural matching or Cultural competence: Qualitative case studies

The main aim of the study was to explore the decision making process of the participants according to their mental health needs and the available choices while not assuming that only cultural matching was essential.

2.6.1 Method

A case study methodology was used for this study. Description of different case studies will highlight the mental health needs of the participants of the well-being intervention, the available choices and the reasons behind their decision making. Four case studies, two Pakistani participants and two Bangladeshi participants, were selected. The purpose of this selection was that these case studies would provide an insight on different needs and requirements of the participants arising from both cultural specific and universal issues. The two Pakistani participants had therapy
from culturally matched therapists and two Bangladeshi participants had therapy from white British, culturally competent therapists with an interpreter. Analysis of these four case studies would allow comparisons and visualise what was considered best from the patients’ perspective in terms of fulfilling their mental health needs according to the choices available.

Case Study

Case studies are tailor-made for exploring new processes or behaviours or ones that are little understood (Hartley, 1994). The approach is particularly useful for tackling the ‘how and why’ questions about a contemporary set of events (Leonard-Barton, 1990). Gummersson (1988) argues that an important advantage of case study research is the opportunity for a complete view of the process as he mentions:

“The detailed observations entailed in the case study method enable us to study many different aspects, examine them in relation to each other, view the process within its total environment and also use the researchers’ capacity for ‘verstehen’.” (p. 76)

According to Yin (2003) a case study design should be considered when: (a) the focus of the study is to answer ‘how’ and ‘why’ questions; (b) you cannot manipulate the behaviour of those involved in the study; (c) you want to cover contextual conditions because you believe they are relevant to the phenomenon under study; or (d) the boundaries are not clear between the phenomenon and context.

Several authors including Yin (2003) and Stake (1995) have suggested that placing boundaries on a case can prevent this explosion from occurring. Suggestions on how to bind a case include: (a) by time and place (Creswell, 2003) (b) time and activity (Stake, 1995) and (c) by definition and context (Miles & Huberman, 1994). It is important to bind a case in order to keep it in a reasonable scope. Yin (2003) categorizes case studies as explanatory, exploratory, or descriptive.

The rationale behind using the case study approach was to determine the types of decisions made by the participants of the well-being intervention according to their
specific mental health needs, the choices available and the factors that influenced their decision making. According to Yin, (2003) a multiple case study enables the researcher to explore differences within and between cases. The goal is to replicate findings across cases because comparisons will be drawn, it is imperative that the cases are chosen carefully.

This method allowed the author to study different participants in depth, identify their mental health needs, the different choices available and their decisions made in relation to their needs and choices. In multiple case studies the researcher can predict similar results across cases, or predict contrasting results based on a theory (Yin, 2003). The case studies were selected from the study of in-depth evaluation interview discussed in Chapter six. For details on recruitment, interview process and transcription see section 2.5.

Summary

- All the empirical research work in this thesis was carried out on South Asians in Longsight, Manchester. Longsight is a residential suburb situated less than three miles south of Manchester City Centre having a very ethnically diverse population. The religious affiliation of Longsight residents is approximately one-third Muslim and one-third Christian. The area is home to a number of mosques, a few temples and a Gurdwara plus several other churches of varying denominations.

- The author used a partially mixed quantitative and qualitative method to find relevant answers to the outlined research questions. This method design involves conducting research sequentially with the quantitative and qualitative studies having equal weight.

- The quantitative systematic review method was used to identify all the research conducted on psychosocial interventions which has been tested and proved effective for common mental disorders for ethnic minorities and South Asians in developed countries and would highlight areas where further research is required. Preferred
Reporting items in systematic reviews and Meta-Analysis were followed in conducting and reporting this review.

- The focus groups method was used to highlight factors and uncover essential understanding of developing an intervention that is culturally sensitive and acceptable to the South Asian community. The reason for selecting a focus group method for data collection in this project was the ability of this method to highlight the respondents’ attitudes, perceptions, priorities and understanding of the general subject, which could not be accessed by other forms of research methods.

- An in-depth interviewing methodology was chosen to explore and interpret the experiences of the patients being part of the culturally appropriate psychosocial intervention. The author wanted to know about beliefs and perceptions on mental health and how the service users respond if they are offered ‘culturally appropriate’ or ‘culturally competent’ mental health care.

- A case study methodology was used to highlight the mental health needs of the participants of the well-being intervention, the choices available to them and the reasons for their decision making. The rationale behind using the case study approach was to determine the types of decisions made by the participants of the well-being intervention according to their specific mental health needs, the choices available and the factors that influenced their decision making.

- The data of the qualitative studies was analysed according to the principles of Framework Analysis which provides systematic and visible stages to the analysis process that include Familiarization, identifying a thematic framework, Indexing, Charting, Mapping and interpretation.

- The data from the in-depth interviews was analysed utilising the Dixon Woods (1999) Process Model of Access to inform the framework. The conceptual model is rooted in understanding access as a process involving: Candidacy, Navigation, Appearance, Adjudication, Offer and Receipt/Rejection.
The analysis of the focus group study and the study of in-depth interviews was carried out using the software package MAXQDA10, professional software for qualitative and mixed methods data analysis.
Chapter 3: Effectiveness of Psychosocial Interventions for Patients from Ethnic Minority Groups with Common Mental Disorders: A Systematic Review

Note: This work forms part of a paper already submitted by Waheed et al.,

There has been very limited research and evidence on the effectiveness of psychosocial interventions in ethnic minorities. However, there is growing awareness of the need to modify existing interventions or develop culturally sensitive psychosocial interventions for different minority ethnic groups. The evaluation of culturally sensitized or modified interventions is important in order to identify their acceptability and effectiveness. The systematic review on effectiveness of psychosocial interventions for the ethnic groups with common mental disorders in developed countries will help provide more knowledge about the topic and get the information required for culturally modifying an existing or developing a new culturally sensitive psychosocial intervention.

Aim

The aim of the systematic review is to identify and evaluate outcome research on effective psychosocial interventions in improving depression for patients from ethnic minority groups. Quantitative analysis (Questions 2, 3 & 4 required for AMP, was done by Professor Bower) and qualitative analysis (Question 1 relevant to this thesis was done by the author) were conducted to answer the following research questions.

1. What does the available evidence tell us about cultural sensitization and adaptation of psychosocial interventions for ethnic minorities in general and the UK specifically?
2. Are psychosocial interventions effective in improving depression in ethnic minority patients compared to usual care, wait list or no treatment?
3. Are adapted psychosocial interventions more effective than non-adapted interventions in improving depression ethnic minority patients compared to usual care, wait list or no treatment?
4. Are psychosocial interventions more or less effective in ethnic minority patients than white patients in improving depression compared to usual care, wait list or no treatment?

3.1 Methods

The review was planned and reported according to the guidelines of Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) (Moher et al., 2009) were followed in conducting and reporting this review. The detailed methodology of the systematic review is outlined in Chapter 2.

3.2 Results

3.2.1 Description of included studies

Following the combined searches, 764 abstracts were checked and 281 studies were initially considered eligible. After the removal of duplicates, 133 studies were considered eligible out of which 32 were studies which included an ethnic minority. One study (Beeber, 2004) was excluded after data extraction as it was difficult to analyze the results because the sample was a mix of White and African Americans. Figure 3.1 below presents the flow chart of the selection process.
3.2.2 Summary of sample characteristics

This review included a total of 31 trials. Out of those studies 26 (84%) included in the review were conducted in the U.S.A., 3 (10%) in the U.K. and 2 (6%) in the Netherlands. Total sample size of studies included was of 7271 participants. The sample in all the studies showed a higher percentage of female participation. 25 trials were conducted in ethnic minority populations, while 6 presented data on ethnic minority subgroups within larger trials. Full data on sample characteristics is presented.
Table 3.1: Sample Characteristics

<table>
<thead>
<tr>
<th>Authors</th>
<th>Country</th>
<th>Ethnic Population</th>
<th>Diagnosis</th>
<th>Female gender %</th>
<th>Mean age</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afuwape, 2010</td>
<td>UK</td>
<td>Black</td>
<td>CMD</td>
<td>75 intervention</td>
<td>42.7 yrs intervention</td>
<td>Not given</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>60 control</td>
<td>32.8 yrs control</td>
<td></td>
</tr>
<tr>
<td>Arean, 2005</td>
<td>USA</td>
<td>Black, Latino and others</td>
<td>Depression Dysthymia</td>
<td>65 (69 black, 47 Latino)</td>
<td>71.2 yrs (68.9 black, 70.6 Latino)</td>
<td>81% high school 59% black, 64% Latino</td>
</tr>
<tr>
<td>Beeber, 2010</td>
<td>USA</td>
<td>Latino</td>
<td>Depression</td>
<td>100</td>
<td>26.2 yrs intervention, 26.5 yrs TAU</td>
<td>8.3 yrs intervention 9.1 yrs TAU</td>
</tr>
<tr>
<td>Belle, 2006</td>
<td>USA</td>
<td>Latino/Hispanics, Blacks/Afro American</td>
<td>Depression</td>
<td>Latino 80.5 intervention 83.7 control</td>
<td>Blacks 60.1 yrs Hispanic 59.8 yrs White 65.2 yrs</td>
<td>Below high school Latino: 34.1 % intervention, 44.2% control, Blacks: 10.8 % intervention 5.9% Control</td>
</tr>
<tr>
<td>Lee, 2009</td>
<td>USA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blom, 2010</td>
<td>Netherlands</td>
<td>Mixed (Surinam, Turkey, Morocco)</td>
<td>Depression</td>
<td>57.1 ethnic, 66 whites</td>
<td>34.3 yrs ethnic 41.2 yrs whites</td>
<td>Lower education level in ethnic group</td>
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<tr>
<td>Brown, 1999</td>
<td>USA</td>
<td>African American</td>
<td>Depression</td>
<td>80 white 84 African American</td>
<td>37.4 yrs (37 yrs African American)</td>
<td>78% &gt; high school (87% Afro Americans)</td>
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<td>Author(s)</td>
<td>Country</td>
<td>Ethnicity</td>
<td>Disorder</td>
<td>Mean/Range</td>
<td>Mean/Range Appearance</td>
<td>Mean/Range Controls</td>
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<td>------------</td>
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<tr>
<td>Burgio, 2003</td>
<td>USA</td>
<td>Blacks</td>
<td>Depression</td>
<td>33.9</td>
<td>57.6 yrs African</td>
<td>13 yrs Afro</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td>African Americans</td>
<td>6 yrs whites</td>
<td>Americans 13.5 yrs</td>
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<td>44.0 white</td>
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<td>Whites</td>
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<td>Comas-Diaz, 1981</td>
<td>USA</td>
<td>Puerto Ricans</td>
<td>Depression</td>
<td>100</td>
<td>38 yrs</td>
<td>6 yrs</td>
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<td>Cowell 2009</td>
<td>USA</td>
<td>Mexican</td>
<td>Depression</td>
<td>100</td>
<td>35.9 yrs</td>
<td>47%&lt; 6th grade</td>
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<td>Dai 1999</td>
<td>USA</td>
<td>Chinese</td>
<td>Depression</td>
<td>60</td>
<td>71.9 to 75.6 yrs</td>
<td>13 yrs</td>
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<td>Dwight-Johnson 2010</td>
<td>USA</td>
<td>Latinos</td>
<td>Depression</td>
<td>78</td>
<td>39.8 yrs</td>
<td>27% 0-6 years</td>
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<td></td>
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<td>50% 6-11 years</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>14% High school</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9% College or Higher</td>
</tr>
<tr>
<td>Fox 1998</td>
<td>USA</td>
<td>Vietnamese and Cambodian</td>
<td>Depression Anxiety</td>
<td>100</td>
<td>42 yrs</td>
<td>5 yrs</td>
</tr>
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<td>Gallagher 2001</td>
<td>USA</td>
<td>Hispanic/Latino</td>
<td>Depression</td>
<td>94</td>
<td>50 yrs</td>
<td>3.7 yrs controls</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>4.8 yrs intervention</td>
</tr>
<tr>
<td>Gallagher 2003</td>
<td>USA</td>
<td>Latino</td>
<td>Depression</td>
<td>100</td>
<td>55.7 yrs ESG</td>
<td>12.8 yrs ESG</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>58.6 yrs CWC</td>
<td>12.0 yrs CWC</td>
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<td>Disorder</td>
<td>Sample Size</td>
<td>Mean Age</td>
<td>Treatment Details</td>
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<td>-----------------</td>
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<td>USA</td>
<td>Chinese</td>
<td>Depression</td>
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<td>57.8 yrs TSC 60.9 yrs in IHBM</td>
<td>13.6 yrs in TSC 13.2 yrs IHBM</td>
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<td>Chinese</td>
<td>Depression</td>
<td>93.3 SKDVD 91.1 EDDVD</td>
<td>59.7 yrs SKDVD 57.8 yrs EDDVD</td>
<td>13.5 yrs SKDVD 13.3 yrs EDDVD</td>
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<td>Gater 2010</td>
<td>UK</td>
<td>Pakistani</td>
<td>Depression</td>
<td>100</td>
<td>41 yrs antidepressant &amp; social intervention group 42 yrs in combined group</td>
<td>11 yrs or more: 28% antidepressant, 27% social group, 26% combined group</td>
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<td>USA</td>
<td>African American</td>
<td>Depression</td>
<td>100</td>
<td>24.3 yrs EIPT 24.7 yrs EUC</td>
<td>77% had high school degree, GED, Vocational training or college education</td>
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<td>Jacob 2002</td>
<td>UK</td>
<td>Indian</td>
<td>CMD</td>
<td>100</td>
<td>47.4 - 48.3 yrs</td>
<td>formal schooling 82.9% intervention, 80% controls</td>
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<td>Joo 2009</td>
<td>USA</td>
<td>African American</td>
<td>Depression</td>
<td>82 Afro American 67 white</td>
<td>70.6 yrs Afro Americans, 71.9 yrs white</td>
<td>12 yrs Afro American, 13.4 yrs whites</td>
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<td>Year</td>
<td>Location</td>
<td>Race/Ethnicity</td>
<td>Condition</td>
<td>Sample Size</td>
<td>Age</td>
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<td>Joseph</td>
<td>2009</td>
<td>USA</td>
<td>African American</td>
<td>Depression</td>
<td>100</td>
<td>24.6 yrs</td>
</tr>
<tr>
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<td>2010</td>
<td>USA</td>
<td>African American</td>
<td>Depression</td>
<td>100</td>
<td>34.7 yrs</td>
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<td>Kohn</td>
<td>2002</td>
<td>USA</td>
<td>African American</td>
<td>Depression</td>
<td>100</td>
<td>47 yrs</td>
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<td>Lapidus</td>
<td>2001</td>
<td>USA</td>
<td>Korean</td>
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<tr>
<td>Le</td>
<td>2011</td>
<td>USA</td>
<td>Central American</td>
<td>depression</td>
<td>100</td>
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<tr>
<td>Miranda</td>
<td>1994</td>
<td>USA</td>
<td>African American, Asian, Latino and others</td>
<td>Depression</td>
<td>62</td>
<td>52.5 yrs</td>
</tr>
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<td>Ethnicity</td>
<td>Outcome</td>
<td>Details</td>
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<tr>
<td>Miranda 2003a</td>
<td>USA</td>
<td>Latino, African American</td>
<td>Depression</td>
<td>72.2 Latinos, 79.8 African American, 68.9 white</td>
<td>40.8 yrs Latinos, 41.9 yrs Afro Americans, 45.6 yrs whites.</td>
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</tr>
<tr>
<td>Miranda 2003b</td>
<td>USA</td>
<td>Spanish speaking Afro American, Asian, American Indian</td>
<td>Depression</td>
<td>86 Spanish CBT 74 Spanish CBT+CM, 62 English speakers in CBT &amp; 56 in CBT+CM</td>
<td>48.5 yrs (Spanish CBT) 49.7 yrs (Spanish CBT+CM) 49.6 yrs (English in CBT) 49.0 yrs (English in CBT+CM)</td>
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<tr>
<td>Miranda 2006</td>
<td>USA</td>
<td>Black Latino</td>
<td>Depression</td>
<td>44 (African American), 6 (White), 50% Latino</td>
<td>29.3 yrs</td>
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<tr>
<td>Reijneveld 2003</td>
<td>Netherlands</td>
<td>Turkish</td>
<td>Mental health &amp; wellbeing</td>
<td>75</td>
<td>54.8 yrs intervention) 54.2 yrs control</td>
<td>Below primary school 58% intervention 53% controls</td>
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<tr>
<td>Miranda 2003b</td>
<td>USA</td>
<td>Spanish speaking Afro American, Asian, American Indian</td>
<td>Depression</td>
<td>86 Spanish CBT 74 Spanish CBT+CM, 62 English speakers in CBT &amp; 56 in CBT+CM</td>
<td>48.5 yrs (Spanish CBT) 49.7 yrs (Spanish CBT+CM) 49.6 yrs (English in CBT) 49.0 yrs (English in CBT+CM)</td>
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<tr>
<td>Reijneveld 2003</td>
<td>Netherlands</td>
<td>Turkish</td>
<td>Mental health &amp; wellbeing</td>
<td>75</td>
<td>54.8 yrs intervention) 54.2 yrs control</td>
<td>Below primary school 58% intervention 53% controls</td>
</tr>
<tr>
<td>Shellman 2009</td>
<td>USA</td>
<td>African American</td>
<td>Depression</td>
<td>77</td>
<td>72.6 yrs</td>
<td>42% high school graduates</td>
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3.2.3 Summary of study quality

Quality assessment for the randomised controlled trials was based on the following elements: assessment of concealment (Schulz & Grimes, 2002) of allocation, sample size (Hollis & Campbell, 1999), power calculation, intent to treat analysis and level of attrition (Borenstein et al., 2005). Details of the rating criteria of study quality of randomised controlled trials and sub-group analysis have been described in Chapter 2. Three studies included in the review were rated as ‘high’ quality, 11 were rated ‘medium’ and 17 were rated ‘low’. Table 3.2 below summarizes the study quality for each study.
Table 3.2: Summary of Study Quality

<table>
<thead>
<tr>
<th>Study</th>
<th>Analysis type</th>
<th>Concealment of allocation</th>
<th>Power calculation</th>
<th>Intention to Treat</th>
<th>Sample size</th>
<th>Follow-up Rate</th>
<th>Quality Code</th>
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<tbody>
<tr>
<td>Afuwape 2010</td>
<td>RCT</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>40</td>
<td>80% at 3 months</td>
<td>high</td>
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<tr>
<td>Arean 2005</td>
<td>RCT subgroup</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>413, total 1801</td>
<td>90%, 87%, 83% at 3, 6 &amp; 12 months, Black 90%, 85% and 84%, Latino 93%, 90% and 86%</td>
<td>high</td>
</tr>
<tr>
<td>Beeber 2010</td>
<td>RCT</td>
<td>Not clear</td>
<td>Yes</td>
<td>No</td>
<td>80</td>
<td>80% at 3 months</td>
<td>medium</td>
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<tr>
<td>Belle 2006, Lee 2009</td>
<td>RCT</td>
<td>Not clear</td>
<td>Yes</td>
<td>Yes</td>
<td>642</td>
<td>Not clear</td>
<td>low</td>
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<td>Blom 2011</td>
<td>RCT</td>
<td>Not clear</td>
<td>Not clear</td>
<td>Yes</td>
<td>355</td>
<td>21.1% in ethnic, 33.6% in non-ethnic</td>
<td>low</td>
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<td>Brown 1999</td>
<td>RCT subgroup</td>
<td>Not clear</td>
<td>Yes</td>
<td>Yes</td>
<td>184</td>
<td>31% IPT, 36% TAU &amp; 42% medication</td>
<td>medium</td>
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<td>Burgio 2003</td>
<td>RCT</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>118</td>
<td>80% at 6 months</td>
<td>low</td>
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<tr>
<td>Comas-Diaz 1981</td>
<td>RCT</td>
<td>Not clear</td>
<td>No</td>
<td>Not clear</td>
<td>26</td>
<td>Not clear</td>
<td>low</td>
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<td>Cowell 2009</td>
<td>RCT</td>
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<td>Yes</td>
<td>Yes</td>
<td>1004</td>
<td>Not clear</td>
<td>medium</td>
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<td>Dai 1999</td>
<td>Not clear</td>
<td>Not clear</td>
<td>No</td>
<td>Not clear</td>
<td>40</td>
<td>Not clear</td>
<td>low</td>
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<td>Study</td>
<td>Design</td>
<td>Effectiveness</td>
<td>Dropout</td>
<td>Follow-up</td>
<td>Outcomes</td>
<td>Quality</td>
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<tr>
<td>Dwight-Johnson 2010</td>
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<td>Yes</td>
<td>84% in CBT and 70% in EUC at 6 months</td>
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<td>Fox 1998</td>
<td>Cluster RCT</td>
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<td>No</td>
<td>Not clear</td>
<td>Not clear but assumed 100%</td>
<td>Low</td>
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<tr>
<td>Gallagher 2001</td>
<td>Controlled trial</td>
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<td>No</td>
<td>No</td>
<td>Not clear</td>
<td>low</td>
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<td>Gallagher 2003</td>
<td>RCT</td>
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<td>No</td>
<td>213</td>
<td>Not clear</td>
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<td>Gallagher 2007</td>
<td>RCT</td>
<td>No</td>
<td>No</td>
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<td>82% completed</td>
<td>low</td>
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<td>Gallagher 2010</td>
<td>RCT</td>
<td>Yes</td>
<td>No</td>
<td>70</td>
<td>Not clear</td>
<td>low</td>
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<td>Gater 2010</td>
<td>Clustered RCT</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>77.4% antidepressant, 94.9% social intervention, 88.1% combined group</td>
<td>high</td>
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<td>RCT</td>
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<td>No</td>
<td>53</td>
<td>92% at 3 months &amp; 87% 6 months</td>
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<td>Jacob 2002</td>
<td>RCT</td>
<td>Not clear</td>
<td>Yes</td>
<td>Yes</td>
<td>94.3%</td>
<td>medium</td>
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<td>RCT</td>
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<td>RCT</td>
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<td>Not clear</td>
<td>Yes</td>
<td>81% intervention group, 82% in TAU</td>
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<td>Kaslow 2010</td>
<td>RCT</td>
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<td>Yes</td>
<td>Yes</td>
<td>217</td>
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<td>Design Type</td>
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<td>Blinding</td>
<td>Dropout</td>
<td>Total Sample Size</td>
<td>Percentage at 6 Months</td>
<td>Percentage at 12 Months</td>
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<td>Kohn 2002</td>
<td>Controlled trial</td>
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<td>No</td>
<td>No</td>
<td>20</td>
<td>90%</td>
<td>Low</td>
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<td>RCT</td>
<td>Not clear</td>
<td>No</td>
<td>Not clear</td>
<td>40</td>
<td>100%</td>
<td>Low</td>
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<td>Le 2011</td>
<td>RCT</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>217</td>
<td>Not given</td>
<td>Medium</td>
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<td>Miranda 1994</td>
<td>RCT</td>
<td>Not clear</td>
<td>No</td>
<td>Yes</td>
<td>150</td>
<td>92% post treatment, 90% at 6 months, 92% at 12 months</td>
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<td>RCT subgroup</td>
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<td>Yes</td>
<td>Yes</td>
<td>1269</td>
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<td>RCT Subgroup</td>
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<td>Spanish speakers 40% CBT alone 17% additional case management English speakers 44% CBT alone 28% additional case management</td>
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<td>RCT</td>
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3.3 Types of interventions, cultural adaptations of interventions and Treatment Outcomes

Table 3.3: Types of Interventions

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<th>CBT</th>
<th>IPT</th>
<th>PST</th>
<th>Collaborative care</th>
<th>Educational</th>
<th>Social groups</th>
<th>Reminiscence Therapy</th>
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<tr>
<td>Belle, 2006, Lee 2010</td>
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<td>Dwight-Johnson 2010</td>
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<td>Jacob 2002</td>
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<td>Joo 2010</td>
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<td>Joseph 2007</td>
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<td>Kaslow 2010</td>
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<td>Kohn 2002</td>
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<td>Shellman 2009</td>
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</table>
Table 3.3 describes the different types of interventions used in the studies included in the review. A total of 16 studies used CBT (Afuwape et al., 2010; Belle, 2006; Burgio et al., 2003; Comas-Diaz, 1981; Dai, 1999; Dwight-Johnson, 2010; Gallagher, 2001; Gallagher, 2003; Gallagher, 2007; Gallagher-Thompson, 2010; Joseph, 2007; Kohn, 2002; Lapidus, 2001; Le, 2011; Lee, 2010; Miranda, 1994; Miranda, 2003a), while Miranda (2003b) used a combination of CBT and collaborative care and Miranda (2003c; 2006) used CBT along with educational intervention. Interpersonal therapy was used in 4 studies (Beeber, 2010; Blom, 2010; Brown, 1999; Grote, 2009) and only one study (Joo, 2010) used a combination of interpersonal therapy and collaborative care. Cowell (2009) and Fox (1998) were the two studies which used problem solving techniques while one study Arean, (2005) used problem solving techniques along with collaborative care. There were 3 studies that used education intervention on its own (Jacob, 2002; Kaslow, 2010; Reijneveld, 2003) while Shellman (2009) used educational intervention along with reminiscence therapy. Gater (2010) was the only RCT which used a social group intervention.

What does the evidence available tell us about cultural sensitization and adaptation of psychosocial interventions for ethnic minorities?

All the studies included in this review mention some level of modifications to the intervention. Table 3.4 describes different types of interventions, the level of adaptations in each intervention in relation to treatment outcome (Data has been extracted from original research papers).
Table 3.4: Types of Cultural Adaptations of Interventions and Treatment Outcomes

<table>
<thead>
<tr>
<th>No</th>
<th>Study/Site/Design/population</th>
<th>Interventions</th>
<th>Modifications</th>
<th>Intervention Providers</th>
<th>Delivery</th>
<th>Adherence</th>
<th>Results</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Afuwape, 2010 UK, RCT, Black</td>
<td>Needs led care package (practical advice, advocacy, health education, mentoring and brief psychological therapy (CBT and SFT))</td>
<td>Ethnically matched therapists and culturally matched health education culturally matched with local black community belief systems.</td>
<td>Community health workers (psychology graduates)</td>
<td>Face-to-face</td>
<td>Not reported but 80% completed the intervention.</td>
<td>At 3-month follow-up, individuals in the rapid access group showed significantly improved levels of depression (GHQ-28 adjusted pb0.05) although there was no evidence for difference in general functioning (GAF, p=0.87).</td>
</tr>
<tr>
<td></td>
<td>Study</td>
<td>Country</td>
<td>Design</td>
<td>Intervention</td>
<td>Control</td>
<td>Sample Details</td>
<td>Outcome Details</td>
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<td>2</td>
<td>Arean, 2005 USA, RCT Subgroup, Black, Latino and others</td>
<td>Collaborative care versus usual care</td>
<td>Minor changes like reference to different ethnic groups in video and educational materials are mentioned but no other details are given.</td>
<td>Nurses and psychologists, working with primary care provider &amp; supported by psychiatrist</td>
<td>Individual face to face and telephone contact</td>
<td>98% initial visit, mean of 9.2 visits and 6.1 telephone contacts, 80% on medication, 11% saw psychiatrist, 30% received PST mean 6.3 sessions</td>
<td>Overall study results showed that collaborative care increased rates of treatment, and satisfaction improved depression and functional outcomes.</td>
</tr>
<tr>
<td>3</td>
<td>Beeber, 2010 USA, RCT, Latino</td>
<td>IPT versus usual care</td>
<td>Minor cultural changes were made in the intervention delivery. Details not given. Nurses trained in cultural competence.</td>
<td>English speaking psychiatric nurses &amp; trained Spanish interpreters.</td>
<td>Individual face to face, booster sessions could be telephone.</td>
<td>87% completed the intervention</td>
<td>Results indicate that the intervention reduced depressive symptoms and, compared to previous studies in this population, retention of mothers in both intervention and control conditions was improved</td>
</tr>
<tr>
<td>4</td>
<td>Belle, 2006 Lee, 2010 USA, RCT, Latino/Hisp anics, Blacks/Afro American</td>
<td>Multi component psychosocial intervention (information, role-play, problem-solving, skills training, support, stress management.)</td>
<td>Translation of the intervention material and assessment instruments in Spanish. Use of Bilingual and Bi-cultural staff. All the staff trained in cultural competence.</td>
<td>Bachelor’s degree. English or Spanish speaking therapists.</td>
<td>Individual face-to-face, individual and group telephone.</td>
<td>60% completed all 12 sessions and 5% no sessions. Treatment dose did not differ between ethnic groups</td>
<td>Prevalence of clinical depression was lower among caregivers in the intervention group (12.6% vs. 22.7%; P 0.001). There were no statistically significant differences in institutionalization at 6 months.</td>
</tr>
<tr>
<td>5</td>
<td>Blom, 2010 Netherlands, RCT, Mixed (Surinam, Turkey, Morocco)</td>
<td>IPT alone, IPT with medication, IPT with pill-placebo or medication only.</td>
<td>None mentioned</td>
<td>Experienced therapists</td>
<td>Individual face-to-face</td>
<td>50.1% ethnic 75% Dutch completed the intervention</td>
<td>The results suggest that standard antidepressant therapy, medication, psychotherapy or both, may be effective for depressed minority patients but therapists should focus on enhancing adherence to treatment</td>
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<tr>
<td></td>
<td>Authors</td>
<td>Study Year</td>
<td>Location</td>
<td>Study Design</td>
<td>Ethnicity</td>
<td>Type of Intervention</td>
<td>Setting</td>
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<td>6</td>
<td>Brown, 1999 USA, RCT</td>
<td>Subgroup, African American</td>
<td>IPT</td>
<td>None mentioned</td>
<td>Psychologists and psychiatrists trained in IPT</td>
<td>Individual face to face</td>
<td>41% Afro Americans and 54% of whites completed therapy</td>
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<tr>
<td>7</td>
<td>Burgio, 2003, USA, RCT, Blacks</td>
<td>Skills training versus minimal support</td>
<td>Culturally modified interventions according to the needs of the African American. Details not provided</td>
<td>Trained therapists in cultural competence</td>
<td>Group and individual in home/Telephonic support</td>
<td>50% completed therapy</td>
<td>CGs in both groups reported decreased levels of problem in behaviours and appraisals and increased satisfaction with leisure activities over time.</td>
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<tr>
<td>8</td>
<td>Comas-Diaz, 1981 USA, RCT, Puerto Ricans</td>
<td>Cognitive group treatment Behaviour group treatment Waiting list</td>
<td>Culturally and language matched Therapist. Training provided to therapist for delivering the intervention</td>
<td>Trained therapist</td>
<td>Group face to face</td>
<td>Not reported</td>
<td>Results showed a significant reduction in depression for therapy groups and no significant differences between the behaviour and cognitive approaches.</td>
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<td>Cowell, 2009 USA, RCT, Mexican</td>
<td>Problem solving for mothers and their children versus no treatment</td>
<td>Cultural changes in the intervention. Details not given</td>
<td>Bilingual nurses trained in cultural competence</td>
<td>Face-to-face and group face to face</td>
<td>60% Mothers 65% children</td>
<td>Children in the intervention group showed improvement in the depressive symptoms. Mother’s mental health improved in both groups over time.</td>
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<td>10</td>
<td>Dai, 1999 USA, Chinese</td>
<td>Videotapes and CBT based on depression prevention course</td>
<td>Culturally sensitive Depression prevention course including examples related to cultural issues videotaped in Mandarin Chinese</td>
<td>Trained Psychiatrists</td>
<td>Group face to face</td>
<td>23% dropped out</td>
<td>Paired t tests indicated that the scores in the Hamilton A and D showed significant improvement over time for the experimental group. However there was no significant improvement in the control group on any of the measures.</td>
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<tr>
<td>11</td>
<td>Dwight-Johnson, 2010 USA RCT, Latinos</td>
<td>Telephone based CBT versus enhanced usual care</td>
<td>Culturally tailored CBT. Each session focused on a chapter from a patient workbook that had been translated into Spanish language. The content of examples and vignettes were modified to use Latino names and reflect situations relevant to rural Latinos.</td>
<td>Trained bilingual therapists</td>
<td>Telephone (88%) received at least one session, (54%) completed four or more sessions, and (44%) completed six or more sessions.</td>
<td>Compared with patients assigned to usual care, those in the intervention group were 21 times as likely to receive preferred treatment. Patients also indicated that individual education sessions, telephone sessions, transportation assistance, and family involvement were barrier reduction strategies that would enhance their likelihood of accepting treatment.</td>
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<td>12</td>
<td>Fox 1998, USA RCT, Vietnamese and Cambodian</td>
<td>Home visit interventions versus no treatment</td>
<td>Cultural related examples and language matched nurses and teachers delivered the intervention</td>
<td>School nurses and bilingual teachers</td>
<td>Individual face to face</td>
<td>Not clear</td>
<td>There was no significant difference in the depression scores of patients in the intervention and comparison groups at ten weeks (HSCL mean 1.5 versus 1.6, p=0.76)</td>
</tr>
<tr>
<td>13</td>
<td>Gallagher, 2001 USA, Controlled Trial, Hispanic/Latino</td>
<td>Coping with frustration, Psycho educational intervention program</td>
<td>Translation of materials, increased use of visual aids throughout the course and oral presentation of the lessons with written materials as backup. Bilingual/bicultural outreach workers, interviewers, and class leaders were employed throughout the project.</td>
<td>Bilingual/bicultural outreach workers</td>
<td>Group and individual face to face/ Individual telephone sessions</td>
<td>Not clear</td>
<td>Results indicated that caregivers in the intervention group were significantly less depressed after treatment than caregivers in the waiting list control condition Mann-Whitney test U= 296.5, p&lt;.001.</td>
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<tr>
<td>14</td>
<td>Gallagher, 2003 USA, RCT, Latino</td>
<td>Coping With Care giving psycho-educational program or in the Enhanced Support Group condition</td>
<td>All educational and intervention materials were made available in both Spanish and English. Bilingual staff delivered the intervention</td>
<td>50% of the interventionists were bilingual or bicultural Latinos. Interventions were co-led in either Spanish or English by two appropriately trained project staff.</td>
<td>Group therapy once a week for the first 10 weeks during the intensive intervention phase, then once a month during the “booster phase” for the next 8 months</td>
<td>Not clear</td>
<td>Participants in the Coping With Care giving condition reported a significant reduction in depressive symptoms, increased use of adaptive coping strategies, and a trend toward decreased use of negative coping strategies when compared with those in the Enhanced Support Group Condition.</td>
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<td>15</td>
<td>Gallagher, 2007 USA, RCT, Chinese</td>
<td>a telephone support condition (TSC) or to an in-home behavioural management program (IHBMP) for 4 months.</td>
<td>Culturally acceptable language used in the sessions. Bilingual and bi-cultural research staff used. Mandarin, Cantonese and English language options were given.</td>
<td>Bilingual and bi-cultural research staff. Unclear who provided the intervention</td>
<td>Telephone versus face to face individual sessions</td>
<td>82% completed the intervention</td>
<td>CGs with low level of self-efficacy showed little improvement in the TSC. CGs with higher self-efficacy benefited from both treatments.</td>
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<tr>
<td>16</td>
<td>Gallagher-Thompson, 2010 USA, RCT, Chinese</td>
<td>CBT skills training programme versus educational programme</td>
<td>Culturally tailored DVD sessions in preferred languages of the participants Chinese and English. Examples and role plays used were relative to their cultural issues and solutions given were culturally acceptable.</td>
<td>Bilingual staff provided phone calls</td>
<td>DVD and telephone support</td>
<td>Average of 3 calls</td>
<td>Pre post change analyses indicated that CGs did not differ on change in level of negative depressive symptoms, but positive affect was higher, and patient behaviours were appraised as less stressful and bothersome, for CGs in the CBT skill training program. They were also more satisfied with the program over all.</td>
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<tr>
<td>17</td>
<td>Gater, , 2010, UK RCT, Pakistani</td>
<td>Social groups versus antidepressant alone and in combination.</td>
<td>Participants were collected by taxi accompanied by a female transport facilitator and the groups took place in a culturally acceptable venue. Participants were addressed and greeted in a culturally appropriate way; child-care facilities were provided, selection of activities was appropriate; and food was provided after each session.</td>
<td>Bilingual Pakistani trained facilitators</td>
<td>Group face to face</td>
<td>Greater improvement in depression in the social intervention group and the combined treatment group compared with those receiving antidepressants alone. There was significantly greater improvement in social functioning in the social intervention and combined treatment groups than in the antidepressant group at both 3 and nine months.</td>
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<td>Study Details</td>
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<td>18</td>
<td>Grote, 2009 USA, RCT, African American</td>
<td>Enhanced IPT-B (engagement session, acute IPT-B, and maintenance IPT) versus enhanced usual care</td>
<td>Culturally centred metaphors and examples were used in the therapy sessions. Free bus passes, childcare, and the facilitation of access to needed social services was provided</td>
<td>Experienced Therapists trained in cultural competence</td>
<td>Individual face-to-face and individual telephone</td>
<td>68% IPT-B group compared with 7% in usual care completed the therapy. Intent-to-treat analyses showed that participants in enhanced IPT-B, compared with those in enhanced usual care, displayed significant reductions in depression diagnoses and depressive symptoms before childbirth and showed significant improvements in social functioning at six months postpartum.</td>
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<td>19</td>
<td>Jacob, 2002 UK, RCT, Indian</td>
<td>Educational leaflet versus usual care</td>
<td>The content of the educational leaflet was specific to the issues of British Asians, and was made available in Hindi, Punjabi besides English</td>
<td>Practice receptionist handed out leaflet &amp; read to illiterate patients</td>
<td>Individual</td>
<td>Not clear</td>
<td>43% of patients who received education recovered, compared with 20% of controls There was no effect on the explanatory model of depression, or on recognition by the GP, help seeking or treatments prescribed.</td>
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<tr>
<td>20</td>
<td>Joo, 2010 USA, RCT, African American</td>
<td>Collaborative care versus usual care (IPT/Medication, educational sessions)</td>
<td>None mentioned</td>
<td>Depression Care Managers: experienced social workers, nurses and psychologists.</td>
<td>Individual face to face</td>
<td>African American less likely than whites to use IPT, AOR 50.22, 95% confidence interval CI (0.06–0.80)</td>
<td>No significant improvement in both groups. Older African Americans with minor depression were less likely than whites to use psychotherapy</td>
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<tr>
<td>21</td>
<td>Joseph, 2007 USA, RCT, African American</td>
<td>Tailored counselling focused on psychosocial and behavioural risk factors for poor reproductive outcomes</td>
<td>Therapy content included culture related examples.</td>
<td>Pregnancy advisors majority master's degrees in counselling or psychology</td>
<td>Individual face to face</td>
<td>906% women attended intervention sessions</td>
<td>Women in the intervention group more resolved some or all of their risks than did women in the usual care group (odds ratio=1.61; 95% confidence interval = 1.08 2.39; P=.021).</td>
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<td>Kaslow, 2010 USA, RCT, African American</td>
<td>Psycho educational group versus treatment as usual</td>
<td>Culture related issues faced by the African American women with relevant handling techniques were part of the psycho-education</td>
<td>2 trained graduate or post-doctoral therapists</td>
<td>Group face to face</td>
<td>Participants who completed the intervention attended a mean of 9.04 (SD 1.04) groups.</td>
<td>Nia intervention showed more rapid reductions in depressive symptoms and general distress initially, and the between-group difference in depressive symptoms persisted at follow up.</td>
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<td>23</td>
<td>Kohn, 2002 USA, Controlled Trial, African American</td>
<td>Adapted CBT versus non adapted treatment</td>
<td>Limiting the group to African American women only, changes in language describing CBT, adding meditative exercises according to their rituals, Highlighting their specific issues and creating healthy relationships and spirituality.</td>
<td>Not clear</td>
<td>Group face to face</td>
<td>80% completed therapy</td>
<td>AACBT was associated with a decrease in BDI scores of 12.6 points from pre to post treatment compared with a decrease of 5.9 in the CBT group.</td>
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<td>Name</td>
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<td>Location</td>
<td>Study Design</td>
<td>Participants</td>
<td>Intervention Details</td>
<td>Attendance</td>
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<td>24</td>
<td>Lapidus</td>
<td>2001</td>
<td>USA</td>
<td>RCT</td>
<td>Korean</td>
<td>Psychological differentiation intervention vs. directed problem-solving treatment</td>
<td>Problem solving integrated with culturally relevant issues and solutions compatible with Korean culture</td>
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<tr>
<td>25</td>
<td>Le</td>
<td>2011</td>
<td>USA</td>
<td>RCT</td>
<td>Americans</td>
<td>Group CBT and individual post-partum booster sessions versus usual care.</td>
<td>Cultural modifications to structure and content. Details not mentioned.</td>
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<tr>
<td>26</td>
<td>Miranda, 1994 USA, RCT, African American, Asian, Latino and others</td>
<td>Group “Depression Prevention course” CBT based</td>
<td>The intervention was adapted for low income, minority population, by simplifying language and using culturally appropriate examples. A Spanish-language version was also prepared.</td>
<td>Doctoral level psychologists</td>
<td>Face to face group</td>
<td>62.5% attended at least half the sessions</td>
<td>Differences between groups on BDI were significant at all three follow ups. Results showed that impact on depression, somatisation and missed medical appointments moderated by baseline minor depression, with larger impact of the course on patients with sufficient symptoms to meet minor depression cut off at baseline.</td>
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</table>
Miranda, 2003a USA, RCT, Latino, African American Practice-based quality improvement. Bilingual and bicultural providers, providing all materials in Spanish, training staff to show respect and sympathy to patients, and allowing for warmer, more personalized interactions. Primary care provider, nurse specialists and psychotherapists Face to face, group and individual Not clear There was a significant interaction between intervention and minority status on rates of probable depression at 6 and 12 months, with minority groups more likely to show an intervention effect.

Miranda, 2003b USA, RCT, Subgroup, Spanish speaking Afro American, Asian, American Indian Group CBT plus clinical case management versus ‘Depression Prevention’ alone Adapted manual, bilingual and bicultural providers, Staff trained in cultural competence. Clinical psychologist or social worker, and social workers for case management Group face to face (CBT) and individual telephone (CM) 60% Spanish completed CBT and 83% of case management completed therapy There was a near significant interaction (p=0.06) between intervention and ethnicity. At both follow up points, CBT+CM was associated with reduced depression in Latino patients.
| 29 | Miranda, 2003c, 2006 USA, RCT, Subgroup, Black Latino | Education meetings followed by either antidepressant medication, group or individual CBT or referral to community services | Translated materials in Spanish, Bilingual intervention providers | Psychotherapists supervised by clinical psychologist | Face to face at | 67% of women attended educational sessions. 53% received 4+ CBT sessions, 36% received 6+ 17% received extra 8 sessions of CBT | Psychotherapy was associated with reduced depressive symptoms and social functioning. At 12 months, 51% of those assigned to antidepressants, 57% assigned to CBT, and 37% assigned to community referral were no longer clinically depressed |
|   | Reijneveld, 2003 Netherland, RCT, Turkish | ‘Healthy and Vital’ programme versus control | Health and physical education both were included in therapy session. Health education was relevant to traditional Turkish diet. Therapy was delivered by Turkish speaking persons | Peer educators, exercise instructors and course organizers | Group face to face | 61.1% attended all sessions | Participants in the intervention group showed a significant improvement in mental health (intention to treat effect size: 0.28 SD, 95% CI 0.02 to 0.54, p=0.03) but not in mental wellbeing (intention to treat effect size: 0.27 SD, 95% CI -0.03 to 0.57, p=0.08) |
|   | Shellman, 2009 USA, RCT, African American | Integartive reminiscence therapy versus health education and control | Tailored to oral cultural traditions of older African Americans remaining sensitive to stigma. Details not mentioned. | African American research assistants | Individual face-to-face | Not reported | Findings demonstrate that integrative reminiscence has a positive effect on decreasing depressive symptoms in older African Americans. The mean score for the reminiscence group was 6.8 (SD = 4.7), significantly different from the control group 14.6 (SD = 10.1) and the health education group 11.7 (SD = 7.1). |
CBT interventions (1,4,7,8,10,11,13,14,15,16,21,23,24,25,26,27,28,29) in the above Table 3.4 were modified (the level of modification was different in each) for the ethnic minorities either using culturally sensitive materials, bilingual and bi-cultural therapists or intervention providers and culturally tailored therapy for the target population. These modifications demonstrated some benefits. The level of modifications of intervention varied within each study. There was one study (study 20) in Table 3.4 that used CBT combined with collaborative care. The results of this show improved clinical outcomes and increased retention in mental health outpatient care for Spanish speaking patients. The African-American patients who received CBT without case management showed improvements in depression symptoms.

There was no significant difference in improvement in depressive symptoms between ethnic minorities and the host population in the studies within Table 3.4 (5, 6 and 20) that used IPT. The interpersonal therapy was provided by trained experienced staff but without any major cultural modifications to the intervention or use of culturally matched bilingual staff or interpreters. Another study (number 3 in Table 3.4) used trained therapists and bilingual staff for an in-home delivery treatment for Latina mothers which showed reduced depressive symptoms in the intervention group. The study also showed improvement in retention rates of mothers in both conditions as compared to previous studies with a similar population. A further study (number18 in Table 3.4) in which cultural appropriate modifications were supplemented in the intervention and the therapist were trained in cultural competence, displayed significant reductions in depression diagnoses. Depressive symptoms before childbirth (three months post baseline) and at six months postpartum showed significant improvements in social functioning at six months postpartum.

Three studies in the review (Table 3.4 number 2, 9 and 12) used problem solving techniques. Study 2 (Table 3.4) used the collaborative care model in which psychotherapy was based on problem-solving techniques. Minor modifications regarding ethnicity were made to the educational leaflets. The outcome of the intervention group showed reduced depressive symptoms and fewer health related issues in comparison to usual care. Two other studies (9 and 12) culturally modified the intervention for the specific needs of the target groups. However, there was no significant difference in the depression scores of patients in the intervention and
comparison groups. In study number nine children in the intervention group showed improvement in their depressive symptoms and the mother’s mental health improved in both groups over time.

Interventions which provided culturally appropriate educational materials as part of the intervention, either by translating the materials or tailoring them according to the specific needs and requirements for the target groups (Table 3.4, studies19, 22, 30, and 31) in the review were also associated with benefits. The content of the educational leaflet in study19 was based on issues and symptoms of common mental disorders specific to British Asians and how the symptoms persist and illness prevails. Study 22 provided culturally tailored psycho-education to an African American population. The culturally informed, empowerment focused Psycho-educational group intervention (Nia) used African proverbs, attended to African American heroines and personal positive female mentors and role models, and emphasized culturally relevant coping strategies to enhance self-awareness and connection (Hampton & Gullotta, 2006). Women receiving the intervention showed more rapid reductions in depressive symptoms and general distress initially, and the between-group difference in depressive symptoms persisted at follow-up.

Study30 (Table 3.4) culturally tailored a healthy and vital programme for Turkish immigrants. A cultural appropriate modification for physical health according to older Turks traditional diets’ were made to the educational content and the intervention was offered by a Turkish peer educator, in Turkish. The intervention group in this study showed a significant improvement in mental health (intention to treat effect size: 0.28 $SD$, 95% CI [0.02 to 0.54], $p=0.03$). The findings of educating patients show that there was reasonable evidence that culturally tailored educational intervention in which relevant ethnic modifications were made proved effective in improving mental health outcomes of the participants in the intervention group. In study 31, (Table 3.4) the reminiscence intervention was culturally modified according to the traditions of older African American populations using culturally matched research staff. The results of the study demonstrate that integrative reminiscence had a positive effect on decreasing depressive symptoms in older African Americans participants.
Table 3.5 below shows the effect sizes of different interventions included in the review. The effect sizes of all the psychological interventions show promising results for adapted interventions. The studies using CBT reported a lower effect size compared to other interventions.

Table 3.5: Effect Sizes of Different Interventions

<table>
<thead>
<tr>
<th>Interventions</th>
<th>Effect sizes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological interventions based on CBT</td>
<td>-0.23 (95% CI -0.35 to -0.11, n=13)</td>
</tr>
<tr>
<td>collaborative care</td>
<td>-0.35 (95% CI -0.57 to -0.25, n=4)</td>
</tr>
<tr>
<td>Educational Interventions</td>
<td>-0.50 (95% CI -0.78 to -0.22, n=3)</td>
</tr>
<tr>
<td>Interpersonal Therapy</td>
<td>-0.86 (95% CI -1.44 to -0.28, n=2)</td>
</tr>
<tr>
<td>Other Interventions</td>
<td>-0.53 (95% CI -0.86 to -0.19, n=4)</td>
</tr>
</tbody>
</table>

(Effect sizes calculated by Prof. Bower, details presented in Waheed et al., manuscript submitted))

Table 3.4 demonstrates reasonable evidence from trials and subgroup analyses from trials that ethnic minority patients could benefit from modified psychological treatments. The effect sizes of different interventions in Table 3.5 are also beneficial. The CBT interventions show lower effect size as compared to the other interventions.

What does the evidence available tell us about cultural sensitization and adaptation of psychosocial interventions for Ethnic minorities in the UK?

Afuwape (2010), Gater (2010) and Jacob (2002) were the only three studies conducted for ethnic minorities in the UK.

Afuwape (2010) investigated the feasibility and effectiveness of a culturally acceptable and cost-effective needs-led, community-based intervention for treating individuals from black minority ethnic (BME) groups with common mental disorders. The aim of the intervention was to improve daily living, health status and the psychosocial functioning of the group. A stepped care approach was followed and the patients were randomised to a rapid access group or to a three month waiting
list control group (standard access). The therapy was delivered by ethnically matched therapists who had two months training in cultural needs and mental health issues of the BME group. In instances of complex needs of the patients the therapist had the facility of getting help from experienced therapists and psychiatrists. The intervention group received advice and help for their social and mental health needs and brief individual therapy sessions based on the principles of CBT focusing their specific issues. Furthermore, child care was provided to the participants in order to retain engagement. No other details of cultural sensitisation were provided. The study is the first known trial to deliver a tailor made, acceptable and cost effective intervention to the BME community service users. The users found the intervention to be culturally appropriate and acceptable and there was not any significant increased cost. The study results showed that access to such interventions can significantly improve the mental health of the black ethnic minorities.

Gater (2010) developed a culturally sensitive social intervention with a selection of culturally appropriate activities for British Pakistani women living in the UK to help improve their social difficulties, social isolation and improve access to primary care. The study was the first trial of a social intervention for the BME population in the UK. The social intervention was compared to antidepressant treatment alone and to a combination of anti-depressants and social groups. The social intervention included group activities and psycho-education. The social groups took place in culturally appropriate acceptable venues, facilitated by two culturally matched bilingual trained facilitators. In order to de-stigmatize transport was provided by a taxi accompanied by a female facilitator and child care facilities were also provided keeping in view with cultural sensitivity. The cultural appropriateness of the format, content and delivery of the intervention helped in engaging participants. The results showed no significant difference in the improvement of depression in the social intervention group and the combined treatment group compared with those receiving antidepressants. However, social functioning in the social intervention and combined treatment groups showed greater improvement than in the antidepressant group at both 3 and 9 months.

Another study, Jacob (2002), prepared an educational leaflet which described common mental disorders relevant to British South Asians. The content of the leaflet
was prepared in light of the issues mentioned in a focus group study for common mental disorders for South Asians (Bhugra et al., 1998). The educational leaflets described the symptoms of anxiety and depression mentioning how anyone can suffer from them. It also indicated that persistence of these symptoms will lead to an illness. Furthermore, different treatment options are described and patients were advised to discuss the treatment options with their GP. The educational leaflet was available in English and was also translated into Urdu and Hindi. The intervention group received the patient information leaflet whilst the control group did not. The patients had the choice of selecting the questionnaires in their preferred language, which were available in English and Hindi. The findings showed that 43% of patients who received education recovered, compared with 20% of the control group, whereas there was no effect on the explanatory model of depression, or on recognition by the GP, help seeking or treatments (Jacob, 2003). The studies mentioned above demonstrate that modified culturally sensitive psychosocial interventions do have beneficial outcomes for the ethnic minorities.

Conclusion

The findings of the systematic review suggests that adaptations like collaborative care with training in cultural competence, pharmacological intervention with clinical case management, individual and group culturally tailored psychotherapies and educational interventions raising awareness about depression can result in better clinical outcomes in improving common mental disorders in ethnic minorities. The lower effect size of CBT might be due to the reason that CBT deals with thoughts and behaviours which are sensitive to cultural influence. Insufficient cultural adaptations, which are not according to specific ethnic minority needs, may contribute to this reduced effect size for CBT. There is lack of well documented and systematic way of culturally adapting interventions. The author will be further exploring the potential benefits of culturally sensitive interventions such as impact on stigma, access and engagement/retention in the interventions and lack of therapist experience and competence in the forthcoming chapters of the thesis.
Summary

- The aim of this systematic review was to identify and evaluate outcome research on effective psychosocial interventions in improving depression for patients from ethnic minority groups.

- The review included 31 trials. 84% of the studies included in the review were conducted in USA, 10% in the UK and 6% in the Netherlands. A total of 25 trials were conducted with ethnic minority populations, while six presented data on ethnic minority subgroups within larger trials. Study quality was rated high for three studies, eleven were rated ‘medium’ and seventeen were rated ‘low’.

- A total of 18 eligible comparisons from primary trials, and 8 from subgroup analysis within trials could be made. There is reasonable evidence from the trials and subgroup analyses that ethnic minority patients could benefit from modified psychological treatments within these groups.

- There were only three studies included in this review which were conducted with ethnic minorities in the UK; Afuwape (2010), Gater, (2010) and Jacob, (2003). These provided a need-led care intervention package, social group intervention and educating patients about symptoms of depression and different treatment options available respectively. The results of these three studies show that access to culturally sensitised interventions had beneficial outcomes for ethnic minorities in the UK.

- The effect sizes of the psychological interventions showed promising results for the culturally adapted interventions. The lower effect size of CBT as compared to other interventions might be because of insufficient cultural adaptations as CBT is sensitive to cultural influences. The benefits of culturally sensitive interventions relating to impact of stigma, access and engagement/retention in the interventions will be further explored by the author in the forthcoming chapters of the thesis.

- There is lack of well documented and systematic way of culturally adapting interventions.
Chapter 4: Development of a Culturally Appropriate Psychosocial Intervention: Focus Group Study

4.1 Aim

The main aim of this sub-study of the research was to gather diverse views of South Asian service users and providers in order to develop a psychosocial intervention.

Specific Goals

- To explore the views and experiences of service users and providers regarding perception of mental health in the South Asian community.
- Discuss barriers and facilitators in accessing mental health care services
- To inform the development of a culturally appropriate psychosocial intervention in mental health for the South Asian community living in the UK.

4.2 Method

A qualitative method in the form of focus group interview was selected in order to obtain diverse views about South Asian’s perceptions of mental health and access to mental health services and psychosocial interventions, from both service users and health care professionals. The details of methods are presented in the Chapter 2.

4.3 Results

The focus groups discussions were a source of obtaining insight into the experiences of help seeking, diagnosis and treatment options of service users and service providers regarding mental health. The groups discussed different barriers and facilitators in accessing mental health care services. Their views and suggestions would be a source of first-hand information in developing a culturally appropriate psychosocial intervention for mental health for the South Asian community living in the UK, keeping in view with their specific needs and requirements which would be more acceptable and help in engaging the service users. The main themes emerging from the discussions are presented below with all the direct quotations in Italics.
4.3.1. Perception and experiences of mental health

Stigma, Shame, Honour, Gossip

The participants from traditional Asian families had limited understanding of the concept of mental illness, identifying it with ‘madness’, a concept not to be discussed with others or outside the family. While some did identify depression and anxiety as mental health problems they did not want to speak about it because of the shame and stigma attached to mental illness.

“Our families are not that much aware of mental health issues and they think it is not something you need to discuss with others.” (Group A, ethnic minority women participants)

There was less openness in discussing mental illness in the men’s group as compared to the women’s groups. Most of the men were of the opinion that feeling low or stressed was something natural. They assumed that if anybody felt low in mood or stressed there was no requirement of seeking help from outside the family. Most of the men in the group were Pakistani, belonging to a patriarchal society; their primary concern was their duty as the head of the household to maintain family honour. They appeared more reluctant to accept the concept of mental illness which they thought would bring a bad name and shame for them. Furthermore, men appeared to be more concerned about their personal honour and status as being the head of the family and the decision maker. Rather than seeking help for mental health from any health professionals, they were keen to maintaining their status in society because of the cultural pressures.

‘In our culture we have a different value system. I am the head of the family and the decision maker. I would not go to the doctor for stress and put my family down.’ (Group C, ethnic minority men participants)

“Would not go to the doctor as what can he do to cheer you up? If you are feeling low and have some sort of family issues you need to solve them instead of going to the doctor”. (Group C, ethnic minority men participants)
The fear of gossip was one of the primary reasons for all the participants for not sharing their mental illness with their friends or family. Traditionally this concept ‘was’ and still ‘is’ understood as madness so people try not to relate themselves to it and like to stay ‘behind the curtain’ (Bradley et al., 2007). It was difficult to break the ice in the ethnic minority men’s group as nobody wanted to be the first one to talk about their mental illness. The discussion revealed that participants were worried by the gossip and stigma about mental illness:

“Nobody among us in the first place would like to tell about their stresses or depression and specially coming forward in a group and talking about such issues was very difficult”. (Group A, ethnic minority women participants)

Living in a small community like Longsight where ‘everyone knows everybody’ was something that made it very difficult and stigmatizing for them to indulge in activities for betterment of mental health as they feared the community would give them a bad name.

“Most people don’t talk to others about their depression because of the stigma and of the fear that it will spread out”. (Group B, Bangladeshi women participants)

Moreover, the participants felt that it was shameful and embarrassing for them to talk about their mental illness as it was considered to be against their cultural norm of keeping family issues private. For some of the participants discussing mental health issues within their own community was not considered to be a good idea because of their bitter previous experiences of breach of confidentiality. They felt that people in the community don’t keep such things to themselves and then they become widely known.

“Some of the women are quite afraid now because of stigma attached to mental health and they don’t share anything just because of the reason that people from their community will know about it and it will be shameful for them as they will make fun and will inform other people, so they avoid sharing things within their own community”. (Group A, ethnic minority women participants).

One of the women participants mentioned her particular experience:

“It has happened with me as well as once I talked about my problems and someone from our community came to me and said that ‘oh we did not know that this has
happened with you’. Then I realized that I should not have talked about it and even my children were annoyed as to why I shared it within the community. People really make fun of you if they know about such things”. (Group A, ethnic minority women participants)

Another one mentioned something similar:

“Most of us feel very embarrassed and ashamed so we try not to share our problems within our own community as people don’t keep confidentiality” (Group B, Bangladeshi Women participants).

The participants of the ethnic minority women group (Group A) talked about ‘being judged’ and sharing their problems and issues with someone not belonging to their religious background. The only Sikh participant in this group mentioned:

“Mostly women share their issues and problems with me thinking that I am not from their religion and will not think about them the way other people from their own community think”. (Group A, ethnic minority women participants)

In all the service users groups, both females and males wanted to maintain a sense of control over their depressive feelings and tried to maintain control of their lives. Initially they utilized self-coping strategies to deal with their mental illness instead of seeking help from outside. Some women felt they could discuss their problems with close family members back home in Pakistan as coping with their stress.

“I would just phone someone in my family or a relative back home and speak to them……..I said when I feel down like this and going to my doctors isn’t an option, I deal with it on my own because I feel there is nowhere to go. I sometimes call up my sister and talk and cry to her”. (Group A, ethnic minority women participants)

Men were more reluctant than women to use social coping strategies to help for mental health issues and wanted to maintain their self-control and honour of being a ‘man’. Instead they emphasized the importance of self-reliance and used coping strategies which could be kept private. They preferred to be socially isolated in situations of mental stress rather than involving outsiders.

“I would not go to the doctor as what can he do to cheer you up. If you have some sort of family issues you need to solve them instead of going to the doctor……….. Yes
I have, but it has never been severe depression. What I normally do to make myself feel better is close my eyes and try to go to sleep”. (Group C, ethnic minority men participants)

Most of the participants in the service users groups as well as in the service providers’ group were in agreement that in order to de-stigmatize mental illness the word “mental health” should be clearly defined and explained by the health care services. The message should be conveyed in a way such that people appreciate the importance of mental health as much as physical health. The service users and providers discussed that perception of “mental illness” did not exist in most of the more traditional Asian families and where a few had the idea considered it to be madness, something that brings bad name, shame and stigma.
“I think most of the Asian people don’t know what mental means and the problem starts here. They think its madness and call ‘Pagal’. I think for them the meaning should be changed in the dictionaries”. (Group D, healthcare providers)

Most of the Asian families live in extended families and an individual was not able to take any decision on their own which in, any way would affect them or bring bad name to the family.
“Don’t call them ‘mental health groups’….If it is called a depression session then our husbands or mother in laws or even children might not allow us to attend it”. (Group A, ethnic minority women participants)

Social support/isolation

The mental distress of the participants was dependent on and related to different social, political and financial pressures. Social isolation seemed to be a major contributing factor towards the onset of depressive feelings. The participants discussed their experiences and thought that depression would not persist or become chronic if they were back home in their country of origin; the reasons being the lack of social support they have in times of child birth, physical illness, bereavement, and other family issues or conflicts.
“When I had my youngest child in this country I didn’t have anyone to support me. I was not feeling very well, my chest used to feel heavy so I went to the doctor with my
problem and he turned around and said- ‘you are still young, how you would have managed if you were older?’ When he said that, I didn’t know how to respond, so I came home”. (Group A, ethnic minority women participants)

The Bangladeshi women participants (Group B) suggested that Bangladeshi women seemed to be hardest hit by the sense of isolation. As they talked about their experiences it seemed that they were burdened more with family responsibilities and appeared to be less empowered than other family members. They were more likely to suffer social isolation because they were not able to communicate in any other language than their native Bangla or Sylheti. This was also mentioned by one of the mental health care support workers:

“That lady’s sitting down at home doing all the time working, praying and watch like Bengali TV and the children and husband are also busy with work and what’s happening in her mind she doesn’t know slowly, slowly, slowly, she goes to mental health and then she feels like I don’t want to talk to anybody I don’t like to... other people sit down at home and all the pressure inside, she didn’t disclose to anybody and then what happened her husband took her to GP, GP see her for one or two sessions and then GP give her anti-depression tablets, it’s from my experiences how their depression starts”. (Group D, health care providers)

All the participants of the service users groups raised similar issues and problems regardless of being Pakistani, Indian or Bangladeshi. The participants acknowledged the social support services provided by the few voluntary organizations working in the Longsight community. The Bangladeshi women appreciated the efforts of the Shapla group run by Sure Start in Longsight which they happily joined, as language the main barrier for them, was not an issue as it was being facilitated by a Bangladeshi woman.

“I think community support is very important. We have the Shapla Group here, we also have the Bangladeshi Association nearby, they take us on outings and also have sessions on mental health etc. I feel better going there”. (Group B, Bangladeshi women participants)

The men’s and women’s focus groups appreciated the efforts of The Roby Church regarding their community services. The church was the only place in the area in
which they felt comfortable. This might have been as it is not affiliated to any ethnic background. The majority of the participants of the men’s and women’s groups run by The Roby Church were from a Pakistani background with a few from the Indian and Sikh community.

“We come here at the Roby, share our problems and sometimes find solutions as well. Enjoy, have a bit of nice time and we always look forward to come here” (Group C, ethnic minority men participants)

4.3.2 Barriers and facilitators in accessing mental healthcare services

Acculturation and Intergenerational concerns

The perceptions of and awareness about mental health and accessing mental health services were very much dependent upon the cultural and generational background of the service users. Participants seemed to have better understanding of mental health in the second generation.

“I think our second generation understands better. They don’t feel bad or stigmatized regarding mental health. My children supported me fully when I suffered from depression.” (Group A, ethnic minority women participant)

There were very few participants from all three service users groups who were fully aware of the concept of ‘mental health’. This could be that they were second generation; born and brought up in UK with more westernized concepts of health care making them appreciate the importance of mental health. The reality behind this concept was that “things were changing”.

‘Things have changed now. It’s not like as it used to be fifty years back....’ ‘I think our second generation understands better. They don’t feel bad or stigmatized regarding mental health.’ (Group A, ethnic minority women participants)

The family proved to be supportive in cases where either the individual or someone close in the family was in suffering for a long period of time. When it became
difficult to cope for that individual as well as the family, they had no other option than to seek medical treatment.

“My family was very supportive. My children knew that I was suffering from depression and I am being treated for it”. (Group D, Healthcare providers)

Another reason for difference of opinion between generations could be that the second generation being born and brought up in UK have adopted the westernized culture and value system. They have proved to be the ‘gate openers’ for the rest of the traditional sufferers of mental illness in the family.

“I think our second generation born and brought up here (UK) understands better. They don’t feel bad or stigmatized regarding mental health. My children supported me fully when I suffered from depression. (Group D, Healthcare providers)

**Cultural Competence’ or ‘Cultural Matching’**

There was a discussion within all the groups that service providers should be culturally competent, be sensitive to cultural values and family situations of the patient experiencing mental health issues. They felt it can be more beneficial and it was not necessary that the health provider was of the same ethnicity. Rather some were not interested in cultural matching due to their past and sometimes unpleasant experiences. One of the service users revealed about the unpleasant incident by saying:

“I have really had a very bad experience. The doctor was from the same ethnic background. I was very ill. I was very much stressed after going to the doctor. After that I really don’t believe going to a doctor of our own ethnic background”. (Group C, ethnic minority men participant)

One of the new things emerging from the group discussions was the concept of selection of the health provider that seemed to be very much dependent on personal choice of the participants. Their preference of seeking help from a service provider from their own culture might simply meant that they would be able to explain their cultural specific issues, symptoms of their illness and converse fluently in their native language.
“I would prefer an Asian doctor as they listen and understand you more. At the moment my doctor is Indian. He understands my issues. I can converse with him in Urdu and language is not a barrier and I can explain things easily”. (Group A ethnic minority women participant)

The participants had different opinions. The ethnicity, age and gender of the Health Care Provider was not that important for some as they were keen and wanted to have someone who could understand them, and with whom they were able to communicate fluently when they were ill.

“It really does not matter to me, age, sex or ethnic background. If the doctor or the therapist understands your problem and you can communicate to him/her then I don’t have any issues.” (Group A ethnic minority women participant)

Help seeking behaviour

Some of the participants in the group were very positive about seeking help from the health professionals regarding their mental and physical health. They thought that seeking help from the GP or the required health professionals was legitimate as well as the right decision. They were keen to contact the doctor and had faith that they were the right people to contact in times of need.

“Will first go to the doctor. Inform him about my situation. I will ask for help from him and after he has given me some options then I will choose the right one for myself.” (Group A, ethnic minority women participant).

In contrast to this there were participants specifically in the ethnic minority men’s group who gave the impression that they were not ready to consult the health professional for any mental health issues. In their view it was not legitimate and required to contact the GP or any health care provider for suffering from stress or depression.

“If you are feeling low and have some sort of family issues you need to solve them instead of going to the doctor” (Group C, ethnic minority men participant).

The health professionals group felt that the South Asian community in general was not aware of mental health issues. In their view South Asian service users accessed
healthcare services for physical illnesses and did not consider necessary seeking help for mental health issues as rightful because for them health was just ‘physical health’.

“They (South Asians) haven’t got any concept of mental health, health is physical health.” (Group D, healthcare providers)

Another reason for not accessing the services in times of need was the intricacy of healthcare systems. Participants were not pleased with the appointment system as they were not able to take appointments when required. The short consultation time given by the general practitioners often ended in dissatisfaction for the patients. Repeated failures to gain access lead to an understanding within the community that help was not available.

“We don’t get GP appointments easily... if we want to consult the doctor for more than one thing they don’t take things seriously and say that you have brought all your illnesses today so please tell us about the major one. After hearing this from the GP I got confused and I then think that who else can solve this health issue of mine and next time I feel reluctant to consult the doctor”. (Group A, ethnic minority women participant)

Trust and Confidentiality

The group discussions revealed that lack of trust and confidentiality with the health care providers restrains access to mental health services. Participants feared lack of trust in disclosing their mental health issues, as the health care providers including the practice staff, GPs, mental health care workers were part of their local community. The fear was the main factor in limiting their access. The service users talked about being betrayed by the health care providers as all the members of the family were registered with the same practice and once the illness was disclosed all the family would know about it. The health professionals group agreed with it as one of them mentioned

“I have experience of a client who has ... [she] isn’t able to trust the GP with certain information because ... that GP has disclosed information to other family members” (Group D, healthcare providers)
The service users clearly preferred not accessing the services as they did not want to talk about their family issues or disclose their mental illness in the fear that it would be gossiped about. Their past experiences of mistrust prevented them from accessing mental health services unless they were in desperate need. However, interpreters were often not available in times of need. Some participants mentioned about not getting an appointment or having a cancellation because of no availability of the interpreter.

“No, you can’t always get an interpreter when you need one”. (Group B, Bangladeshi women participants)

Previous experiences of breach of confidentiality made most of the participants reluctant to use interpreters:

“I prefer not to use an interpreter and try to explain to the doctor myself. My English is not good but it is getting better, but no I do not use an interpreter because I don’t trust them”. (Group A, ethnic minority women participant)

Participants were also not happy with the quality of interpretation as they felt that messages were lost either way. Secondly, they were given limited time for consultations and as they were not able to communicate directly which took more time to explain their symptoms which they were not able to, thus making them dissatisfied.

“Yes we have a language problem. You are right; we cannot always communicate with them properly. They don’t understand you and even when you have an interpreter, the time limit is a problem; you cannot say everything you need to say to the doctor because the interpreting takes time”. (Group A, ethnic minority women participants)

Most of the participants who used interpreters also felt a sense of awkwardness between the patient and the doctor losing the essence of the consultation. In their view the third person in-between made the consultation very formal and they were not able to communicate freely.

“I often feel embarrassed and bad talking about my problem in front of the interpreter. No I’m not happy with interpreters; an interpreter is supposed to be professional like the doctor, they should keep things confidential and not share it with anyone”. (Group B, Bangladeshi women participants)
Summary of Results

- There is considerable stigma attached to mental health and discussing mental illness with others is not considered culturally appropriate within the South Asian community.
- Participants had a fear of gossip as ‘mental’ still means ‘madness’ in the Asian culture. Masculine roles in the society and their ego forbid them for seeking help for mental health issues. They have their own styles of coping with stress and do not seek help. The language barrier leads to social isolation which is one of the causes of onset of depression.
- Lack of social support leads to stress and depression and some people suffering from it maintained self-control by using self-coping strategies and not accessing health care services or seeking support from non-ethnic voluntary organisations.
- Some participants had adopted more westernized concepts of mental illness due to their second generation who have a more westernized living style because of being born and brought up in the UK.
- There were some problems with accessing the health care systems, specifically the appointment system and the non-availability of interpreters restricted access for the participants.
- Participants had a fear of trust and confidentiality with the health care providers and interpreters because of their past experiences of mistrust thus limiting their access to services.

4.3.3 Sensitizing Psychosocial Interventions

The wider issues rose above outline participants’ understanding of mental health, depression and anxiety, including their causes and consequences. They emphasize the social contexts which bound and influenced help seeking behaviour, and the acceptability and preconditions for engaging in treatment. In addition to these more inferential findings the focus groups moved iteratively towards more direct exploration of the consequences of these for sensitizing interventions.
Social structure

The concept of mental health still isn’t really acceptable within South Asian communities due to the stigma attached; thus the groups concluded that psychosocial interventions for mental health should be culturally appropriate and acceptable for the service users and named ‘Well-being interventions or positive health programmes’. All the participants mutually agreed not to call them ‘mental health interventions’.

“Don’t call them mental health groups...If you specifically keep depression sessions many of us might not attend it because of the name attached to it. If it is called a depression session then our husbands or mother in laws or even children might not allow us to attend it”. (Group A, ethnic minority women participants)

Participants were of the opinion that the social structure of the psychosocial intervention should empower people with skills and tools that they can take away and use in their daily life even after the intervention finishes.

“Sessions should include jewellery making, art classes, exercise classes, leisure trips, and information about mental health from psychiatrists. We need to learn and enjoy both.”(Group A, ethnic minority women participant)

There was considerable keenness shown by the service users about exercise sessions to be always part of the mental health intervention as healthy living is publicized everywhere. Most participants had financial constraints and could not afford to go to a gym. The cheapest way of doing exercise for them was walking or being part of the different free exercise sessions in the local community centres.

“I would say exercise. We really want this. Definitely walk is something I really like to go for. Yes, walking in groups is better, may be for half an hour each time”. (Group A, ethnic minority women participants)

“I am always looking for exercise sessions and whenever they are near my place I make sure I join it.” (Group A, ethnic minority women participants)

The service providers in the voluntary organizations and the community centres also mentioned that the exercise sessions had always been very welcoming and very
appealing to the service users. Participants had been keen not to miss any exercise sessions.

“It’s very well received. We’ve got a six week programme happening from this Thursday which is funded by the Sports Development team and women especially really do want to get into exercise and we’ve had a group of men that wants to do exercise”. (Group D, healthcare providers)

Therapy structure

There were mixed views on the therapy structure of the well-being intervention. Some participants preferred individual therapy while some seemed more positive about group therapy. They felt group therapy would be a more effective method of de-stigmatizing mental health. Very few of the participants were aware of cognitive behavioural therapy (CBT), computerised CBT and problem solving skills. Most of the participants considered that the psychosocial intervention should cater to the individuals’ need and the person should be able join in or switch between individual therapies to group therapy when required. The health professionals proposed a flexible provision of services in psychosocial intervention for South Asians, including flexibility in time, venue and number of sessions. In their view westernized therapies were not able to cater for the needs of the South Asian mental health users.

“With regards to therapy, I fully support the idea of having flexibility there as to how many group or individual sessions South Asian people could be offered because to work with the majority of South Asian communities you know they don’t understand these euro-centric models of therapy and it’s not really their concept and it takes time to build up that trusting relationship and if you’re seeing somebody who’s 40 plus you know they will have been through different episodes of distress in their lives, so having to work through each of those episodes in a qualitative manner I think is really important and therapy should be about quality and not quantity”. (Group D, Healthcare providers)

The health professionals recommended group therapy as a better option for the South Asian mental health service users as individuals would be able to develop social links, gain self-confidence and realize how others are experiencing similar problems.
Group therapy would help in gaining a better understanding of mental health and de-stigmatize the concept of mental illness.

“*I think any kind of intervention in a group setting would be the most effective method of de-stigmatizing mental health as well, and it would also serve the purpose of educating as well as providing therapy interventions for people who are not really familiar with the kind of mental health interventions and therapeutic treatment now available to them.*”(Group D, healthcare providers)

Participants, who had an experience of any kind of individual or group therapy previously, could differentiate the positive and negative effects of each. They appeared to be more assertive in getting the right therapy which seemed beneficial at times of distress and not restricting themselves to just one type of therapy.

“*I have been attending individual counselling sessions for quiet sometime. What I feel is that initially when they started I use to feel relieved, but after a month I felt that I and neither the counsellor was that enthusiastic which did not helped in improving my condition. Then I joined this group here and I realized that this was much better*”. (Group A, ethnic minority women participants)

Most of the participants were aware of counselling but very few in all three service user groups knew about CBT and CCBT. Computer-based CBT was not a popular idea because most of the service users were not fluent in English and were not computer literate as one of the service providers indicated:

“*I don’t think that they are very culturally sensitive either they are very western orientated, a lot of the examples are you know from English culture or American culture or Australian depending on where the place is from so I think there’s an issue there as well in that not a lot of examples. The majority of my clients have actually limited English so I know for them they would really struggle with computerized CBT, it just wouldn’t be appropriate for them.*”(Group D, healthcare providers)

The male participants initially seemed or wanted to be aloof of any psychosocial interventions available for mental health in their community. As discussions proceeded they became open in sharing information and talked about their experiences of different therapies. Most of them disclosed that they had been referred
for counselling by their general practitioners or by the psychiatrist when seen in secondary care. Only one of the male participants knew about CCBT as he had been offered that but preferred counselling:

“I think counselling is something really good if you are stressed and want to talk to someone and specially someone who does not know you a ‘stranger’ and can listen to you for quiet sometime whatever you feel you can say that. My counsellor was a Jew and it was good he listened well. Counselling is for satisfying your soul and machines can’t do that”. (Group C, ethnic minority men participants)

The male participants appeared to be happy being part of the group run by one of the voluntary organizations in the community. It was something they looked forward to and tried to take time for from their daily routine activities. This social meeting was a source of happiness for them as they were able to forget about their stressful life events.

“We come here to chat and share our views. This group therapy which in a way is talking therapy has been a great help. One feels better.”(Group C, ethnic minority men participants)

Help seeking: Treatment options and therapist fit

Participants in all the groups were of the opinion that referral to the psychosocial interventions should not be complex. If there was a need there could be a self-referral besides being referred by friends, family or healthcare providers. Referral by the GP was considered to be the most appropriate one. Most service users trusted their GPs in making decisions for their mental health care and thought it to be legitimate if suggested by the GP as one of the participants expressed her views:

“I will first go to the doctor. Inform him about my situation. I will ask for help from him and after he has given me some options then I will choose the right one for myself”. (Group A, ethnic minority women participants)

The majority of participants considered that people would engage in the psychosocial therapies if they were provided by people who had expertise in this area, good interpersonal and communicational skills, who were able to develop trust and confidentiality and were aware of the cultural background.
“If it’s delivered by well-known and reputable people, people will like to come and if they have trust and know that confidentiality will be kept then everybody will be happy coming for that. Some of them do and some of them don’t understand our culture and it is very important to know the sensitive issue of culture when you are treating the patients”. (Group A, ethnic minority women participants)

Two participants in the ethnic minority women group volunteered their particular experience and specific reason of engaging in group therapy as:

“The therapist is very welcoming, and gives a warm response so people like joining in here but everybody is not like that. So basically it depends on the person who is running the group. Some people are not very friendly and they are not comfortable so it’s on part of the person who is running the group to see that everyone likes the group and is comfortable.” (Group A, ethnic minority women participants)

The place where the psychosocial intervention was delivered carried more significance. Home settings were not liked both by the service users as well as service providers due to stigma. One of the service providers who had previously conducted a research project mentioned:

“Well in my research study it was the home setting rejected because of the stigma, they preferred community settings or clinics or local health centre.”(Group D, healthcare providers)

Similar views were expressed by other service users as well; one of the participants of the women service group said:

“We won’t be comfortable at home as our husbands or children will be around or mother-in-laws would be interfering which would be stressful.”(Group A, ethnic minority women participants)

Participants in all the groups seemed to prefer places that could be accessed without feeling self-conscious or embarrassed. In addition, participants were in favour of places within the community where people from different ethnicities together felt comfortable without racial issues. Places which were not specific to any ethnicities were preferred for well-being programmes.
“There are a number of community centres in the area like Sri Lankan, Bangladeshi, Pakistani and many other but we find Roby as the friendliest one. There are no politics here which some of the other centre’s do have. Most of us here are from Pakistan, India and from Bangladesh. We really don’t mind as we carry the same culture”. (Group A, ethnic minority women participants)

“Psychosocial interventions should be in community settings, should be at places which people trust. We would prefer going to a place for a therapy like The Roby Church. Places like the Pakistani Community Centre and a few more centres do have stigma and people like us avoid going there to attend anything”. (Group C, ethnic minority men participants)

Participants from the voluntary organizations in the health professionals group shared their experiences of running the men and women groups in the community. They had positive views and mentioned that people from different ethnic backgrounds together felt comfortable without any racial issues. They share and learn from each other’s experiences.

“When we come into contact with lots of families and we run a couple of groups... it sounds exactly what this lady was describing and it’s really, really positive the ladies do learn from each other and they share ideas and they don’t feel like they’re on their own so it does really work, trust is really important, but it does work in that group and it’s on going the group that we run it’s really good”. (Group D, Healthcare providers)

Views on evaluation process of psychosocial interventions

The discussion about assessment or evaluation of the intervention was more positive in the service providers’ group. The service users did not welcome the concept of filling in questionnaires or other such things as part of the evaluation. Most of them did not respond to questions about evaluation and a few responded as yes or no. Some of the health professionals mentioned their experiences of evaluating the interventions. They indicated that participants were mostly unable to read and write so it was difficult for them to complete any questionnaires. Secondly, in a group setting they are influenced by each other’s opinions hence giving ‘false’ comments.
“You know so they remember what they enjoyed about it and then at the end of the term kind of we do a whole evaluation by asking them what did they like what would they like to see happening more of and just people’s comments and I think when you start using paper like, like get a lot a lot of people can’t read or write and it’s gets very complicated and if you’re doing it as a group everybody goes off of what other people say but if it’s individual it’s so easy for them just to leave a comment on the book so you know you know what they said” (Group D, ethnic minority men participants )

The health professionals group suggested audio recording the comments of the service users as language and literacy was an issue. Moreover, they recommended using pictorial tools for patient assessment which are easy to use and the service users will enjoy doing it as part of an activity.

“Because if language is a barrier and they can’t read so it’s like they speak in any language and could record it”. (Group D, healthcare providers)

“You can also use, there’s lots of tools isn’t there that are just pictorial, they’ve got faces, I know it’s quite basic but even that’s good if somebody can’t read or write so it’s just saying tick what face. You know something basic like that so at least you’re capturing something”. (Group D, healthcare providers)

Summary of sensitising psychosocial interventions

- All four focus groups suggested naming mental health interventions as ‘well-being’ interventions or ‘positive health programmes’ in order to de-stigmatize the concept of mental illness.
- Culturally appropriate psychosocial interventions having flexibility of time, venue and number of sessions were recommended by all the groups for mental health of South Asians.
- Psychosocial interventions should include sessions to empower people with skills that they are able to use in their daily life. The intervention should include craft sessions as well as group based exercise sessions, informative sessions on health and intergenerational issues and leisure trips/days out.
• Concepts of healthy living and including exercise sessions in the therapy appealed to all the service users. The health professionals and some of the service users recommended group therapy over individual therapy to reduce stigma and confidence building.

• The suggestion of a simple referral system was recommended by all the groups. This system should include referral by health care providers, family and friends. Option of self-referral should be also provided. Referral by the GP to a mental health psychosocial intervention was considered to be the most appropriate and acceptable one. Most of the service users thought that GP was the most trusted and legitimate source of referral into mental health care.

• Delivery of the psychosocial intervention (PSI) in the home setting was rejected by the participants because of the element of stigma. Community settings, clinics or local health centres were acceptable for delivery of psychosocial interventions. Local community places not affiliated to any ethnic background were preferred for psychosocial interventions.

• Facilitators of psychosocial interventions should be trained in cultural competence. They should be able to understand the cultural aspects of the service users regarding mental health and should preferably be able to converse in the same language to avoid use of interpreters where possible.

• Evaluation could be carried out through acceptability interview/satisfaction scale or writing comments after each session or audio recording if language is a barrier or use of pictorial tools after each session.

The chapter covers work which forms part of the broader AMP project and has been submitted for publication (Lovell et al., manuscript submitted). It will describe the developmental process of the AMP wellbeing intervention, and the results of the pilot randomised trial will also be presented which explore the feasibility of the culturally sensitive intervention for the South-Asian community only (relevant to the thesis).

5.1 Development of the AMP Wellbeing Psychosocial Intervention

As mentioned in Chapter 1, the study is part of a larger funded programme AMP (Dowrick et al., 2013), and was carried out in three phases (see Figure 1.1 Phases of AMP Chapter 1). After synthesising the evidence (part of which has been presented in Chapters 3 and 4 of the thesis), the team proposed a new multi-faceted model with three core components, namely: community engagement, primary care quality and psychosocial interventions designed to improve access to primary care mental health for people from under-served communities. The Multi-Faceted model is described in Figure 5.1 below, and the details are presented in Dowrick et al., (2013). Delivery of a tailored psychosocial intervention, which is the third component of the model, is relevant to the thesis and is discussed below.
The aim of the psychosocial intervention strand of the AMP project was to develop and evaluate an evidence based, feasible, acceptable and culturally sensitive psychosocial intervention for older people and the ethnic minority community (Lovell et al., manuscript submitted). The intervention was carried out in two phases as described in Figure 5.2 below.

**Figure 5.2: AMP Well-Being Psychosocial Intervention**

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and verify the content, delivery method, acceptability and cultural sensitivity of an intervention targeting older and BME people.</td>
<td></td>
</tr>
<tr>
<td>Developing a training package for mental health workers and training them to effectively deliver the intervention protocol.</td>
<td></td>
</tr>
<tr>
<td>Piloting a study to test the intervention protocol, and explore the delivery, adherence and acceptability of the intervention.</td>
<td></td>
</tr>
<tr>
<td>Examining recruitment rates and comparing outcomes of patients in the intervention arm to those in the usual care for carrying out a trial.</td>
<td></td>
</tr>
</tbody>
</table>
5.2 Phase 1: Developing the AMP Well-Being Psychosocial Intervention

The process of developing the well-being intervention was carried out in Phase 1 of the AMP study. Chapter 3 and Chapter 4 of the thesis, consisting of a systematic review (Waheed et al., submitted) and a focus group study were part of the process of developing the well-being intervention and sensitising it to the ethnic minority population. The summary of developing the intervention is outlined in Figure 5.3 below.

*Figure 5.3: Process of Developing the Culturally Appropriate Well-Being Psychosocial Intervention*

- **Systematic reviews of access related studies and psychosocial interventions (Chapter 3)**
- **Meta-synthesis of data on patient perspectives, Dialogues with local stakeholders; Review of grey literature from statutory and voluntary service providers**
- **Outline drafted for the wellbeing intervention**
- **Key findings of the Focus groups (chapter 4) were used to add cultural Adaptations which refined the draft outline**
- **Final version of the intervention developed**

(Gask et al., 2012)
The process of gathering evidence included a systematic review of access studies, a meta-synthesis of data on patient perspectives, dialogues with local stakeholders, a review of grey literature from statutory and voluntary service providers, secondary analysis of patient transcripts from previous qualitative studies and interviews with service users and carers. The findings of this synthesis include the formulation of mental health problems and reasons of persistence of mental health problems in ethnic minorities and different reasons and issues for not accessing interventions in primary care (Dowrick et al., 2009; Dowrick et al., 2013; ; Gask et al., 2012; Kovandizic et al., 2011; Lamb et al., 2012; Waheed et al., manuscript submitted).

After the synthesis, the details of the intervention and the training materials were developed, focusing on older individuals and within the ethnic minority community. The rationale behind focusing on these particular two groups was that the local Primary Care Trusts had identified them as ‘hard to reach groups’, as they are less likely to access primary mental health care and do not receive standard care when they do access primary care (Dowrick et al., 2013).

In order to ensure the acceptability and cultural appropriateness of the intervention, eleven focus groups, with a total of one hundred and seventeen service users’ members of the community and service providers, were conducted. The details and findings of the South-Asian focus groups are presented in Chapter 4. Some of the findings of the ethnic minority focus groups integrated into the draft intervention are presented in Figure 5.4 below:
**Figure 5.4: Findings of the Ethnic Minority Focus Groups**

1. In order to de-stigmatise mental health naming the intervention as ‘wellbeing’ intervention
2. Increase mental health awareness by taking the family and religious leaders on board
3. Availability of translated materials in different languages
4. Available of audio and visual information about mental health not including too many medical terms
5. Availability of bilingual/culturally matched therapist/ culturally competent therapist
6. Flexibility of service provision of individual and group therapy
7. Provision of home visits
8. Provision of childcare and transport facilities
9. Selection of culturally appropriate venues not affiliated to any ethnicity
10. Different treatment choices available for specific and urgent mental health needs of the patients
11. Signposting to other mental health organizations and relevant organisations for dealing with social, economic and financial issues
12. Multiple routes for referral into the intervention including self-referral;
13. Empowering people with skills and tools that have utility in their daily life after the completion of the intervention.

**5.2.2 The Well-being Intervention**

The well-being intervention was based on cognitive behavioural therapy (CBT) techniques aimed at reducing anxiety and depression and challenging social isolation. The word ‘well-being’ suggested in the focus group discussions was specifically used to de-stigmatise mental health and engage more participants in the intervention. The well-being intervention is described below Figure 5.5.
The intervention started by offering an initial session to the participants with the well-being facilitator, in which they mutually decided a well-being plan on self-identified goals. After identification of these goals, the participants chose any one (or all) of the three ways mentioned in Figure 5.5 to gain support.

- **Individual Intervention:** The intervention was based on CBT techniques. A total of 8, thirty-minute sessions were spread over a period of eight weeks and were delivered by the well-being facilitator either face to face, by telephone, or by e-mail, depending on the preference of the participants.

- **Group Intervention:** The group intervention was delivered by the well-being facilitator along with the third sector volunteers as a two-hour session on a weekly basis, for ten weeks. Culturally appropriate group activities were selected to improve the mental health of the participants.

- **Signposting:** The signposting was provided three times in ten weeks, and the aim was to signpost the participants to the local mental health or social care services or any drop in centres, in order to reduce stress, anxiety, depression and social isolation.
5.2.3 The Well-Being Facilitator

Training: The well-being facilitators were provided a two-day training programme along with a handbook to assist in the delivery of each session. The programme focused on delivering the group and individual intervention, and the handbook contained a directory of all the local and third sector organisations for appropriate sign-posting. A special session on cultural competence was delivered, highlighting the needs and requirements of the older people and the BME community. Psychologists, counsellors, CBT facilitators and community support mental health workers had a role of well-being facilitators. Eight well-being facilitators were trained to deliver the intervention. A total of four facilitators (two white, English-speaking ones and two South-Asian, bilingual females) were to deliver the therapy to the South-Asian participants in Longsight, Manchester.

Role of the Well-Being Facilitator: The well-being facilitators’ role was to engage advice, provide support and follow up the participants of the PSI. One of the main responsibilities of the well-being facilitators was to keep regular contact with other health and social care professionals who were involved in the participants’ care, and particularly with the GP.

Supervision: The clinicians (a psychiatrist and CBT therapist) of the intervention team supervised the well-being facilitators either by face to face or by telephone every two weeks.

Phase 2: Results of an Exploratory Randomised Controlled Trial (RCT) and Evaluation of the Qualitative Interviews

An exploratory trial was conducted to evaluate the acceptability and adherence of the well-being intervention for the ethnic community. A number of qualitative interviews were conducted after the intervention was delivered with the participants, the well-being facilitators and the well-being intervention supervisors about the acceptability and adherence to the intervention. The qualitative evaluation of the interviews is described in Chapter 6.
5.3: Exploratory Randomised Trial of the Effectiveness and Acceptability of a Psychosocial Intervention for Common Mental Health Symptoms in Patients from Black and Ethnic Minority Groups Compared to Treatment as Usual (TAU)

NOTE: The AMP study involved two exploratory trials in BME populations (South Asian minority in Manchester and Somali minority in Liverpool) and older people. The main procedure was the same in both trials but the target populations were different. In the present thesis, the ethnic minority trial consisted entirely of South-Asian participants from Manchester, who are the one described and discussed. All baseline and follow up data in the trial was collected by the author (Details presented in Lovell et al., manuscript submitted).

Aim: The main objectives of the pilot trial were to pilot RCT procedures, estimate recruitment rates for a future large randomised controlled trial, estimate the effect size of the intervention, and explore the delivery, adherence and acceptability of the well-being intervention for common mental disorders in the BME community.

Method and design: An exploratory RCT was designed with two BME groups (South Asian and Somali groups) at two different sites, Longsight in Manchester and Picton in Liverpool, to test the feasibility and acceptability of a culturally sensitive well-being intervention with treatment as usual. Each site recruited an estimated 25 patients.

Inclusion/exclusion criteria: BME patients aged eighteen or over with symptoms of depression and/or anxiety, registered with one of the four primary care practices participating in the AMP study, and scoring 10 or more on PHQ-9 and/or the GAD-7. Patients with learning difficulties cognitive impairment, or with risk to themselves or to others, were excluded from the study.

Recruitment: Recruitment for the study took place from September, 2010 to December, 2011. The study information was available in different languages: English, Urdu and Bengali. It was made available in relevant community places,
local grocery stores and libraries, and religious places like churches, mosques and gurdwaras. Recruitment was carried out through GPs, relevant health professionals, the voluntary sector and by self-referral.

Potential participants were contacted by the research team and they were provided with detailed study information in the initial assessment. Only participants who gave written consent were recruited. The researcher, after carrying out the baseline assessments, sent the participants’ details to the administrator for randomisation. Randomisation was carried out on a 2:1 intervention/control basis by an independent statistician. A single blind method was used for the allocations of groups, where the researcher was unaware of the group allocations. Ethical approval was granted by North-West 8 Research Ethics committee (Ref: 10/H1003/38).

**Analysis/Outcome Measures:** Analysis of quantitative data was conducted in SPSS 20 (SPSS Inc., Chicago, IL, USA). Intent to treat analysis was done on the quantitative data and effect sizes calculated for meta-analysis. Analysis of the qualitative data was carried out using MaxQDA (www.maxqda.com), which is described in detail in Chapter 6. The different instruments used for specific outcomes are mentioned in Table 5.1.

**Table 5.1 Outcomes and Instruments (Dowrick et al., 2013)**

<table>
<thead>
<tr>
<th>Outcome parameter</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-being</td>
<td>CORE-OM</td>
</tr>
<tr>
<td>Depression</td>
<td>PHQ-9</td>
</tr>
<tr>
<td>Anxiety</td>
<td>GAD-7</td>
</tr>
<tr>
<td>Social Functioning</td>
<td>WSAS</td>
</tr>
<tr>
<td>Health state utilities</td>
<td>EQ-5D</td>
</tr>
</tbody>
</table>

**Results**

Table 5.2 below describes the total number of people referred and recruited in the trial. A total of thirty nine participants were referred. Twenty referrals came from the GP surgeries, two from the primary mental health care teams, five from the voluntary organisations, and eight were self-referrals. A total of twenty participants were randomised; fourteen to the well-being intervention and six to the normal care.
Thirteen participants did not meet the inclusion criteria, two refused to participate and four changed their contact details. Out of the fourteen randomised, thirteen participants received the intervention and one did not attend. A total of sixteen participants completed a five months follow-up. Drop out level at the 5-month follow-up consisted of three participants who changed address and one who refused to participate.

Table 5.2: Recruitment and Randomization

<table>
<thead>
<tr>
<th>Site</th>
<th>Focus</th>
<th>Referred</th>
<th>Randomized</th>
<th>Not randomized</th>
<th>Completed follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longsight (Manchester)</td>
<td>Pakistani/ Bangladeshi</td>
<td>30</td>
<td>19</td>
<td>11</td>
<td>16</td>
</tr>
</tbody>
</table>

Baseline socio-demographic characteristics of the BME sample are shown in Table 5.2 below. The participants recruited were female, and were either Pakistanis or Bangladeshi, with one Somali participant; their mean age was forty years. One third of the total participants were involved in some kind of community activities and the education level showed that only twenty per cent had a degree qualification. The mean CORE score was 255 and the mean PHQ score was 19, both showing a high level of distress.
Table 5.3: Socio-Demographic Characteristics of Patients Included in the AMP Feasibility Study: BME Sample (Karina et al., manuscript submitted)

<table>
<thead>
<tr>
<th></th>
<th>Wellbeing intervention n=14</th>
<th>Usual care n=6</th>
<th>Total n=20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Female</td>
<td>14 (100%)</td>
<td>6 (100%)</td>
<td>20 (100%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD) range</td>
<td>38.92 (9.29) 25-56</td>
<td>43.02 (14.50) 21-58</td>
<td>40.15 (10.87) 21-58</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistani</td>
<td>6 (42.9%)</td>
<td>4 (66.7%)</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>6 (42.9%)</td>
<td>2 (33.3%)</td>
<td>8 (40%)</td>
</tr>
<tr>
<td>Punjabi Indian</td>
<td>1 (7.1%)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td><strong>Qualifications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree or higher degree</td>
<td>3 (21.4%)</td>
<td>1 (16.7%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>8th grade</td>
<td>0 (0%)</td>
<td>1 (16.7%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>6th grade</td>
<td>1 (7.1%)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>5th grade</td>
<td>1 (7.1%)</td>
<td>1 (16.7%)</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>3rd grade</td>
<td>1 (7.1%)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>A levels</td>
<td>0 (0%)</td>
<td>2 (33.3%)</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>O levels</td>
<td>4 (28.6%)</td>
<td>0 (0%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>High School</td>
<td>1 (7.1%)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>None</td>
<td>2 (14.3%)</td>
<td>1 (16.7%)</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (7.1)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td><strong>Engaged in community activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3 (21.4%)</td>
<td>3 (50%)</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>No</td>
<td>11 (78.6%)</td>
<td>3 (50%)</td>
<td>14 (70%)</td>
</tr>
<tr>
<td><strong>Baseline measures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (sd)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ9</td>
<td>19.36 (3.20)</td>
<td>19.50 (1.76)</td>
<td>19.40 (2.80)</td>
</tr>
<tr>
<td>GAD7</td>
<td>18.07 (3.52)</td>
<td>17.83 (1.17)</td>
<td>18.00 (2.97)</td>
</tr>
<tr>
<td>WSAS</td>
<td>28.85 (8.11)</td>
<td>26.83 (8.35)</td>
<td>28.21 (8.01)</td>
</tr>
<tr>
<td>EQ5D</td>
<td>0.21 (0.36)</td>
<td>0.20 (0.49)</td>
<td>0.20 (0.39)</td>
</tr>
<tr>
<td>EQ5D Health state (0-100)</td>
<td>17.14 (12.51)</td>
<td>17.50 (11.29)</td>
<td>17.25 (11.86)</td>
</tr>
<tr>
<td>CORE-OM (mean x 10)</td>
<td>25.01 (5.86)</td>
<td>24.92 (4.56)</td>
<td>24.98 (5.38)</td>
</tr>
</tbody>
</table>

Note: Baseline assessment, demographic details and the 20 week follow-up data of the Pakistani and Bangladeshi participants of the trial were carried out by the author.
The exploratory trial was not able to meet the recruitment target because only one eligible individual of Somalian heritage was recruited details are not presented. The Somali population in Picton is smaller than the South-Asian population in Longsight, and many Somali patients were not registered with the eligible study practices.

Table 5.4 below shows the 20 week outcome data. It is important to be cautious in interpreting data from an exploratory feasibility study, as the power to detect the differences is small and the baseline differences can occur by chance (Lovell et al., manuscript submitted).

Table 5.4. Baseline and Twenty Week Outcome Data for the BME Sample (Lovell et al., manuscript submitted)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Wellbeing intervention</th>
<th>Usual care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>CORE-OM</td>
<td>20.98</td>
<td>7.40</td>
</tr>
<tr>
<td>GAD7</td>
<td>13.45</td>
<td>4.53</td>
</tr>
<tr>
<td>PHQ9</td>
<td>13.99</td>
<td>4.91</td>
</tr>
<tr>
<td>WSAS</td>
<td>22.30</td>
<td>11.93</td>
</tr>
<tr>
<td>EQ5D</td>
<td>0.35</td>
<td>0.46</td>
</tr>
</tbody>
</table>

Figure 5.7 below describes the forest plot. PHQ9 and EQ5D showed larger effects. The results shown in the figure are not adjusted for any potential baseline differences (Lovell et al., manuscript submitted).
Conclusion: The results suggest that the group receiving the well-being interventions improved compared to the group receiving usual care. The BME patients showed larger effects on PHQ9. The exploratory trial provides promising evidence of the efficacy of an intervention for BME groups experiencing anxiety and depression. Furthermore, the analysis of the quantitative data indicated that patients offered the well-being intervention showed greater improvement than those who were offered usual care, with largest effects on reduction in depressive symptoms. The acceptability and cultural appropriateness of the intervention is discussed in Chapters 6 and 7.

Summary

- The third component of the AMP model psychosocial intervention is relevant to the thesis. It was carried out in two phases. The aim of the psychosocial intervention
strand of the AMP project was to develop and evaluate evidence based, feasible, acceptable and culturally sensitive psychosocial intervention for older people and the ethnic minority community.

- Phase 1 includes the process of developing the well-being intervention. This included the synthesis of evidence which led to the drafting of the well-being intervention and the focus groups, which were conducted to refine the intervention by incorporating views on acceptability and cultural appropriateness as reported in Chapters 3 and 4.

- Phase 2 includes piloting the study to test the intervention protocol, and explore the delivery, adherence and acceptability of the intervention.

- The well-being intervention was based on CBT techniques and consisted of three arms: individual therapy, group therapy and sign-posting. It was delivered by well-being facilitators who were provided training along with a handbook to deliver each session.

- The role of the well-being facilitator was to engage, advise, provide support, follow up and keep regular contact with the participants. The well-being facilitators were provided face to face or telephonic supervision by the clinician of the intervention team every two weeks.

- The main objectives of the pilot trial were to pilot RCT procedures, estimate recruitment rates for a future large randomised controlled trial estimate the effect size of the intervention and explore the delivery, adherence and acceptability of the well-being intervention for common mental disorders in the ethnic minority community.

- A total of twenty participants were randomised; fourteen were allocated to the well-being intervention and six to the normal care. Thirteen participants did not meet the inclusion criteria, two refused to participate and four changed their contact details. Out of the fourteen randomized, thirteen participants received the intervention and one did not attend. A total of sixteen participants completed five months follow-up. Three participants changed addresses and one refused to participate.

- The analysis of the quantitative data of the pilot trial indicated that patients offered the wellbeing intervention showed greater improvement than those offered usual care, with largest effects on reduction in depressive symptoms.
Chapter 6: Evaluation of a Culturally Appropriate Psychosocial Intervention: A Study of In-depth Interviews

The main aim of Chapter 6 of the thesis was to evaluate the delivery, adherence and acceptability of the psychosocial intervention. The process involved establishing that the groups who participated in the intervention were consistent with those for whom the intervention was designed and whether the key ingredients of the model were influential in improving access and adherence.

The qualitative evaluation of the intervention relied on capturing the valuations of stakeholders and some of the members of the intervention team. The novel intervention was performed with ethnic groups who experience poor access to health services and may be under-represented in service design. Therefore, evaluating the process and background from which patients engage would be key to ensuring intervention fidelity. Fidelity of the theoretical model to the interventions provided is important if the intervention is to be rolled out or further developed.

6.1 Method

An in-depth interviewing methodology was chosen for the study to explore and interpret the experiences of the patients who were part of the culturally appropriate psychosocial intervention. The details of these methods are presented in the methodology chapter (Chapter 2).

6.2 Results of the analysis

The process of delivering a culturally appropriate psychosocial intervention in terms of acceptability and adherence was evaluated through in-depth, semi-structured interviews. The responses of patients who were part of the AMP intervention identified the extent to which the culturally appropriate psychosocial intervention had been effective for South Asians in improving access. The patients discussed factors affecting their choice in accessing the services and suggestions to improve access specifically for the South Asian community. Baseline socio-demographic
characteristics of the BME sample are shown in Table 6.1. All participants were female of Pakistani and Bangladeshi origin. The mean age was approximately 40 and 20% of the participants had education up to a degree level. (Dowrick et al., 2013).

**Table 6.1:** Socio-Demographic Characteristics of Patients Included in the AMP Feasibility Study: Ethnic Minority Sample

<table>
<thead>
<tr>
<th></th>
<th>Wellbeing intervention n=14</th>
<th>Usual care n=6</th>
<th>Total n=20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Female</td>
<td>14 (100%)</td>
<td>6 (100%)</td>
<td>20 (100%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD) range</td>
<td>38.92 (9.29)</td>
<td>43.02 (14.50)</td>
<td>40.15 (10.87)</td>
</tr>
<tr>
<td>25-56</td>
<td></td>
<td>21-58</td>
<td>21-58</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistani</td>
<td>6 (42.9%)</td>
<td>4 (66.7%)</td>
<td>10 (50%)</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>6 (42.9%)</td>
<td>2 (33.3%)</td>
<td>8 (40%)</td>
</tr>
<tr>
<td>Punjabi</td>
<td>1 (7.1%)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>Indian</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Qualifications</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Degree or higher degree</td>
<td>3 (21.4%)</td>
<td>1 (16.7%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>8th grade</td>
<td>0 (0%)</td>
<td>1 (16.7%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>6th grade</td>
<td>1 (7.1%)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>5th grade</td>
<td>1 (7.1%)</td>
<td>1 (16.7%)</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>3rd grade</td>
<td>1 (7.1%)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>A levels</td>
<td>0 (0%)</td>
<td>2 (33.3%)</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>O levels</td>
<td>4 (28.6%)</td>
<td>0 (0%)</td>
<td>4 (20%)</td>
</tr>
<tr>
<td>High School</td>
<td>1 (7.1%)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td>None</td>
<td>2 (14.3%)</td>
<td>1 (16.7%)</td>
<td>3 (15%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (7.1%)</td>
<td>0 (0%)</td>
<td>1 (5%)</td>
</tr>
<tr>
<td><strong>Engaged in community activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3 (21.4%)</td>
<td>3 (50%)</td>
<td>6 (30%)</td>
</tr>
<tr>
<td>No</td>
<td>11 (78.6%)</td>
<td>3 (50%)</td>
<td>14 (70%)</td>
</tr>
</tbody>
</table>

(Dowrick et al., 2013)

The in depth interviews explored the experience of stress and depression of the patients and their difficult life events. The interviewees described their help-seeking behaviour, barriers and facilitators in accessing the mental health services (Dixon-Woods et al., 2005). The Process Model of Access to Care (Figure 6.1 below) was used as a framework to interpret the experiences and understandings of stakeholders, as well as testing the fidelity of the intervention to the theories outlined. The model is
rooted in understanding access as a process involving: Candidacy, Navigation, Appearance, Adjudication, Offer and Receipt/Rejection.

*Figure 6.1: A Process Model of Access to Care (Dixon-Woods et al., 2005)*

The findings present the route through which participants in the study gained access to the psychosocial intervention and utilises the concepts of Candidacy, Navigation, Appearance, Adjudication, Offer and Receipt/rejection which are defined below. Candidacy is defined as ‘*how people’s eligibility for health care is jointly negotiated in interaction between individuals and health services*, and as a ‘*dynamic and contingent process, constantly being defined and redefined through interactions between individuals and professionals*’ (Dixon-Woods et al., 2005).

Following determination of candidacy, an individual navigates to gain a point of entry to the health services. This involves a series of psychological and cognitive skills and resources which include self-efficacy (Bandura, 1997) and health education (Goldney et al., 2000; Nutbeam, 2008).

Dixon-Woods (2005) indicated that appearances can involve a number of different approaches, including appearing before health services through a patient’s own initiative, or through invitations (where people respond to appointments from health services) or grabs (such as compulsory hospital admissions where candidacy is not under the patient’s control).
Adjudication refers to ‘decisions made by professionals, presenting an individual for intervention or service, influenced by categorizations of patients made by professionals with reference to current services and relationships’. This leads to an offer/non-offer of a health service, which the individual may accept or reject (Dixon-Woods et al., 2005).

The findings are presented below with all supporting direct quotations in Italics. (Quotes are presented as ID numbers in order to keep anonymity and confidentiality; L001-L0019 represents patients, LR001-LR003 represent research therapist and LS001 represent the research supervisor)

6.2.1 Candidacy

The participants described their initial experiences of stress and depression as something they did not recognize as mental illness. Primarily, at this stage most of them did not think that they were one of the ‘candidates’ requiring any help or mental health care as they were not aware of the concepts of stress, depression or mental illness.

“I didn’t even know what depression was, people did not talk about it because they didn’t even know about it.” L003 Bangladeshi

“I don’t really know how it started. I used to get angry very quickly, I would take everything the wrong way. Someone would say something to me and I used to take it the wrong way even if they meant well. I used to get very upset and wanted to be in a quiet place by myself and cry.” L027 Bangladesh

“It was when I really felt low and was not able to do any house work and was not able to look after the children. I did not feel happy for a single moment and did not find pleasure in anything.” L014 Pakistan

The women talked about their difficult life events including family conflicts, domestic and financial issues and bereavement. They thought that these had been the contributing factors towards the onset and persistence of stress. At this point they felt distressed and recognized the need to seek help for this on-going suffering, as it was becoming unbearable for them trying to lead a normal life under these conditions.
Difficult Life Events

Family conflicts

Family issues including problems with husbands, in-laws and parents, seemed to be factors associated with the increased levels of the participants’ stress. One of the participants who got married and moved to the U.K. when she was 19 years old, expressed her views about the on-going mental suffering that reached an extent that made things very difficult for her. At this point she realised that she was miserable and needed help:

“I got married and came to UK by myself. All my family was back home in Pakistan. I did not get along well with my husband from the very first day. When I came to U.K. I came to know that he was a drug addict and a heavy drinker as well. He used to beat me and I got very scared. I had no social support and nobody to talk to. I did not want my family back home to know about it so kept everything inside me. It kept on building up and I felt suffocated I had no one to talk to nowhere to go to so things got building up. I felt very lonely and felt like crying all the time. I was very scared of the gossip”. L014 Pakistani,

Another participant who struggled at a very young age had migrated from India, started her own business and wanted to settle her family in UK. She had a lot of conflicts with her family and was not able to cope with certain difficult life events. She realized that her mental suffering was getting worse because she was not able to cope with the emotional stress she was under:

“Actually when I was earning and my business was good I had good terms with my family. I had money so I called my two brothers from India and settled them here. But when I had problems nobody came to help me rather when I was struggling with all these issues my father insisted me to get married to a person whom I did not like. They kept on forcing me which I suppose ended in my getting depressed. When I refused and said that I can’t do it my father stated that he disowns me. All this was difficult to bear and my mental state was getting worse. This was the reason I was not able to sleep. I had lost everything: money, friends and family even and did not find any reason to live” L018 Indian
One of the participants spoke about her bitter experiences of being caught in family conflicts where she was emotionally blackmailed by the elderly family members to do something unreasonable and against her will. She seemed to be entrapped and saw no way out as it was considered to be part of the cultural obligations with which she had to abide. The level of stress overburdened her and she was not able to cope with normal day to day activities and thought that she needed help:

“I think I was emotionally blackmailed as my mother in law was on the death bed and I did not want everyone to blame me for her death .......you do realise what I was going through...too much stress, you know how elders in our families sometimes blackmail you and then force you to obey their decision and I was the one who got caught in that fix....you can understand.......... his(husband’s) mother was very ill and he had to listen and fulfil her wishes as she was on the death bed and so on and then he said that she wants him to marry a girl of her choice as I was not the one she liked. We had love marriage. I was under too much pressure.” L006 Pakistani

Financial and domestic issues

Some of the participants mentioned that their domestic and financial issues were not the only reason of their stress, but as these issues remained unresolved, their stress prolonged and their mental state worsened. At this point most of them realized that they needed help to find a way out of these circumstances:

“I am mentally much stressed and every day issues make it worse. If there is a decrease in the everyday issues and my domestic and financial issues are resolved I will be at ease because these problems are all the time pinching me and I don’t have any solutions for them.” L014 Pakistani

“I didn’t have any housing and financial issues which I am having at the moment. Such things don’t let you do anything. They are the main reasons of stress for you.” L018 Indian

Bereavement

In five of the cases bereavement proved to be the reason for the onset of stress and depression. The loss of a close family member, such as a mother, child or husband
was unbearable, leading to stress and anxiety. Some of them did understand that they were suffering, but were not able to find any relief:

“Depression? Errmm, for some years. I think from 2003. Actually may be even before then because when I was in Bangladesh before I came here my two children died in a house fire didn’t they. So from then on I have been feeling upset, worried and anxious and then my mum passed away so it just continued.” L026 Bangladeshi

“Yes my husband passed away at that time you see, so I was completely lost. I had two small children, my youngest was only 7 months old and I didn’t know what to do or how to bring them up on my own because I had not even gone out to buy some milk for my children up until then. He used to do everything outside of the house, he would do the entire shopping etc. and when I did go out he would take me in the car so I never did anything on my own. People we know would sometimes say to him, you should get you wife to go out and do things and he would joke and say ‘no I can’t let my wife go out on her own I’m afraid she will get lost.’ L026 Bangladeshi,

One of the participants talked about her experience of having a sad childhood due to her mother passing away when she was a child. Her sadness and ‘thinking too much ‘during her childhood years prevented her from leading a happy, normal life. She realized that it was not something normal as she kept everything to herself, while her sadness turned into depression when she herself became a mother.

“One thing that I know made me very upset and I used to think a lot about, is my mum. I lost my mum when I was very young and I always have this sad feeling (depression) with me because I could never feel my mum’s love. I think it has become worse since I had my children, because every time they call me mum or do something I think I must have run around after my mum like this, my mum must have done this for me, and I just can’t stop thinking about it and thinking too much about these things”. L027 Bangladeshi,

Social Isolation

The majority of the participants mentioned having a good support system of friends and family in their country of origin. They either lived there in extended families or lived near their families and friends. The feeling of loneliness and not being able to share their stress and worries in the UK was one of the contributing factors towards
their stress and depression. Most of them talked about not having any social support here in times of distress:

“No I didn’t hide anything, what is there to hide and from whom? I have no family here who can do anything for me and my in-laws it’s not like they care about what happens to me anyway. I have no family here to worry about me, I have a mother and sister in Bangladesh who are obviously worried about me all the time and they know. Other people are my husband and a couple of friends; they know and worry about me too”. L005 Bangladeshi,

“Now (in this country) I worry about being alone in this house. I have no one or nowhere to go. If I am unwell, there is no one to take care of me.”L003 Bangladeshi

“I had nobody here and I did not know anybody no family and no friends. My mother in law was very strict and I was not allowed to do anything of my own choice. We had a lot of family issues as my husband’s sister was married to my brother. It was difficult for me to handle the issues as my mother in law created a lot of fuss and I was pressurised too much and still it is the same. That is why I think I was not able to get out of my depression state and it persisted and persisted and got worse”.L002 Pakistani,

6.2.2. Navigation/Help seeking Behaviours

Participants described their ‘help-seeking behaviours’ regarding mental health care. They mentioned different reasons about not seeking help in times of distress, like shame and stigma attached to mental health, issues of trust and confidentiality within their community, language barriers and an intricate appointment system they had experienced in accessing mental health care.

Barriers

Shame and stigma

Most participants were scared of talking about or sharing their mental illness with other members of the community and in some cases even within the family because
of the shame and stigma attached to it. The fear of being labelled kept them in isolation and prevented them from seeking help for mental health issues:

“There is a lot of bad name attached if you have mental health issues. People in our culture try not to meet you if you have depression as they think you are mad and you might harm them physically. I have heard very bad things about myself that is the reason I don’t meet anybody and do not go out. I have stopped going to the gurudwara even as people stare you so much that you feel bad. I really hate when people do this but that adds a lot to my stress and depression”. L018 Indian

Some seemed to believe that the level of shame and stigma about mental health did not differ very much between first and second generations of Asian cultures. To their disappointment the second generation being born and brought up in UK had similar ideas of shame and stigma attached to mental health as people in the first generation in the Asian culture:

“Things have not changed, even the second generation thinks in the same way so you can imagine how much effort you need to change things, rather I think stigma attached to mental health will remain as it is. One has to be really bold to stand and say that they are suffering from mental health as people will start calling him/her mad so what can we do?”L014 Pakistani

“I can’t discuss this issue of mine with anybody. If my family or neighbours know about it they will talk bad things about me. You know how our culture is, and how people give you a bad name. Feeling depressed is very stigmatizing especially in my family. I have not told anybody about you being coming here or that I am taking any help from anywhere.”L009 Pakistani

One of the well-being therapists who had experience of working with the Asian community previously, mentioned that discussing mental health is still considered stigmatising and shameful in the Asian community and that stigma is a barrier in accessing mental health care.

“The term ‘mental’ still holds a lot of stigma for the Asian community, the word ‘mental’ needs to be changed.” LR001, Well-being therapist
Trust and confidentiality

Participants appeared to have a fear of sharing their mental health issues within their friends and community and refrained from seeking any help in times of distress. Most of them thought that people in their community gossip, lacked confidentiality and couldn’t keep things to themselves:

“Sometimes yes, you know people gossip a lot and they tell each other and this is very common in our culture.” L014 Pakistani

“You know the Asian community when it’s out of your mouth then it’s everywhere and people talk rubbish about you. They think that you are mad and the society does not accept you as a normal being. You yourself then start feeling as a misfit”. L014 Pakistani

Language/Use of interpreters

Most of the participants considered that language had been a major barrier in accessing services, as they were not able to converse in English. In their view they should be able to communicate, talk about themselves and fluently express what they are going through in times of low mood and stress:

“If you can’t communicate properly specially in times of stress and anxiety there is no way you can reduce it, communicating properly is key thing and language becomes a big barrier if you are in a community where you can’t make people understand your views.” L006 Pakistani

Participants talked about being uncomfortable during different situations when accessing care. They were often not able to explain their illness to the GP because of the language barrier. Sometimes even if the doctor spoke their language the surgery staff might not and it became difficult for them to explain their illness requirements. Furthermore, it was difficult for them to make appointments as when they phoned up they most likely ended up talking to an English speaking person.

“Honestly my English is not that good and I cannot communicate well so when you cannot talk or explain things then it is better not to talk. Sometimes I want to ask
questions or explain my symptoms to the doctor but cannot and feel very reluctant because I can’t speak English. I have told my doctor that I want to explain my symptoms and what I am going through but cannot because I can’t speak English fluently. I think language is a big barrier if you don’t know it.” L018 Indian

“I would say that language has been a barrier in communicating with the doctor and the GP surgery staff as well. Things would have been better if the other person speaks the same language, it’s much easier to communicate and talk about what exactly is wrong with you. I think especially when you have mental health issues there should be someone who can understand you quickly as you are not in a state to put in any sort of effort as you don’t want to”. L014 Pakistani

The examples mentioned above show that language has been a barrier for people in accessing mental health care. Use of interpreters could be a way to handle this issue, but participants mentioned that the service providers were not able to arrange interpreters in time of need. One of the patients mentioned about an on-going problem of not able to book an appointment because of the non-availability of an interpreter, while another talked about not having an interpreter even in emergency situations.

“I could not get an appointment as they were not able to arrange an interpreter. This has been an on-going problem.” L018 Indian

“Well if I say it’s an emergency they will give me an appointment sooner but then the problem is they can’t book an interpreter in such short notice and I can’t explain anything without an interpreter”. L005 Bangladeshi

Those who had the experience of using an interpreter did not always appreciate it because they did not feel comfortable. They seemed to believe that the essence of communication was lost with the presence of an interpreter.

“Yes ..... Although I tried to talk about my problems openly I think it’s different when there is an interpreter. It would definitely be better without an interpreter.” L027 Bangladeshi

“It’s not the communication because they keep an interpreter. You cannot express yourself the way you want to.” L023 Bangladeshi
One of the AMP well-being supervisors, through her past experiences of using an interpreter, also recognized this issue of the patients being uncomfortable about using the interpreters:

“I knew that they would be the barriers but I think I didn’t really appreciate how incredibly difficult it is. I mean I’ve done a little bit of work through interpreters but it’s not just the interpretation it’s the whole cultural thing.” LS001 Well-being Supervisor

Intricate appointment system

Most of the participants mentioned the difficulty in getting an appointment in time of need, which acted as a barrier in accessing primary care. They were very dissatisfied with the appointment system. Some of them said that they had to call the surgery between certain times slots to book an appointment which was not always possible and some had to really convince the surgery staff of their need and urgency to book an appointment to see the GP.

“You see that is the main problem at my surgery. If it is 5 minutes past 8am then they won’t give you an appointment whether you live or die. That’s not their problem. There is an urgent need to change the appointment system they have to understand this....” L004 Bangladeshi

“I would have to plead with people to make me an appointment and then eventually..... I’ll get someone to make me one.” L005 Bangladeshi

6.2.3. Appearances

Participants recounted their different unhappy experiences of mental health issues and seeking help from the doctors in times of distress. Some only came to know about their depression after disclosing their symptoms to the doctor. For some, meeting the doctor and discussing their mental health issues brought temporary relief to their distress:

“It was when I really felt low and was not able to do any house work and was not able to look after the children. I did not feel happy for a single moment and did not find pleasure in anything. Then I went to see the GP. I told him that I was not able to
sleep, felt very confused and upset all the time. The doctor told me that I was suffering from depression.” L014 Pakistani

“Whenever I go to the doctors and the advice they give me makes me feel better, but only for that time. But when I come back home and I think of everything I go back to feeling worried and anxious. That tension comes all back and I can’t see things getting better.” L005 Bangladeshi

Some were hesitant about visiting their doctors themselves and did not seem to recognise that they were suffering. Their family members, recognising what they were going through had taken the initiative of taking them to the doctor:

“My husband took me to my GP and then she (GP) was the one who diagnosed that I had depression. At that time I did not know what depression was and I use to get more and more anxious.” L002 Pakistani

Some also reported seeking help from different community organisations providing social support or signposting in their locality.

“I spoke to this lady at Sure Start, she is called Miss X, I don’t know if you know her? I told her about my problems and she helped me.” L026 Bangladeshi

Cultural appropriateness and personal choice

Participants raised the role of personal choice in selection of the service provider which could include culturally appropriate services and/or cultural matching of therapist, which was not always their choice.

“Sometimes I suppose yes it matters as they do understand your culture and your cultural values and if language is a barrier then its best to talk with someone who understands and speaks the same language, but ...sometimes people may prefer someone outside their community. I think it’s a matter of personal choice.” L009 Pakistani

“May be there are some sensitive issues which are quite different in western cultures as compared to ours and they (service providers) may not understand the complexity so I don’t know. If ‘choice of both’ is available, might be a solution.” L011 Pakistani

One of the participants suffering from depression due to conflicting family issues and being emotionally blackmailed by her family due to particularities specific to the
South Asian culture, preferred to see a service provider from her own cultural background. The specific choice to consult somebody who could understand her cultural obligations seemed to fulfil her needs in this instance as she thought that anybody outside her culture would not be able to understand her sensitive culture-specific issues.

“I think our culture is very different to this English culture. The problems and issues I was going through was something very common and not against their cultural values so if I talk about it with them I don’t think they will realize my state of stress and depression and may think that I am exaggerating things. Men and women in western societies think differently about issues we are very conservative about and I don’t think they understand our family systems and issues. So it is better to talk to someone from our culture who can make out what you are going through.”

Pakistani

The issue of need and choice related to appearances is discussed in greater depth in Chapter 7.

6.2.4 Adjudication

Consultations with the health providers

Participants talked about their experiences of consultations with the health providers. In some cases the person had a trusting relationship with their health provider and did not question or negotiate their treatment. They thought that the doctor knew best about their illness and were satisfied with the treatment suggested by their GP. One of them mentioned about her experience of trusting and relying on the doctor completely for treatment.

“He just gave me medication which I took for some time and due to that I was very lethargic and the medication did not really help. So after sometime the doctor increased the dose of the antidepressants as he thought that the previous dose was not effective. I did not argue or asked any questions as trusted him a lot. After sometime when I did not recover even after taking the medication I was referred for counselling. I have been receiving counselling on and off as there is a big waiting
However, there were some participants who, although having trust in their GPs, tried negotiating a treatment which they thought would be more effective in improving their illness. One of them talked about not taking medication because of the fear of getting addicted. She was able to successfully negotiate with the doctor and choose psychological treatment which she thought would be more effective in her case:

“Initially I did but as the doctor had discussed the side effects plus I even thought that if I get addicted to medication then I won’t be able to leave it so even I myself wanted therapy or counselling. The doctor very nicely explained the benefits of counselling or therapies which were offered and she insisted that I should go for it as I was socially isolated and I do realise that I required social support at that time”.

L006 Pakistani

6.2.5 Offer

Participants reported that the AMP psychosocial intervention was offered to them by their health providers either verbally during their routine consultations or they were informed through information leaflets and invitation letters. Some of them felt that they were initially not given detailed information regarding the intervention and did not know much about it:

“I think my doctor offered me the intervention; he did not talk in detail but mentioned that he was referring me somewhere. Afterwards you contacted me and then I thought that this must be the thing the doctor was talking about.” L011 Pakistani

On the other hand, some of the patients had the feeling that they were given detailed information about the AMP intervention when they were offered to participate. Their GP had informed them about what the intervention was, how it was likely to be helpful for them and the flexibility of provision of services available in it. They knew that they would have an option of individual or group therapy and they would have culturally matched research staff.

“My GP informed me about the details of the AMP intervention and said that someone will contact me regarding counselling/therapy sessions, groups or
something similar to what I required so I was waiting for someone to contact me”. L014 Pakistani

Some, who were both on medication and on the waiting list for therapy, were offered the AMP intervention by their GP. Most of these considered the GP had provided them with the necessary details of the intervention which seemed effective for them and they trusted their GP with their mental health treatment. It appeared that the culturally appropriate way of participating in the intervention was if the participant was referred or offered a treatment by their GP.

“I thought that the intervention will be good because I trust my doctor.” L018 Indian

“Yes, I thought my doctor suggested this for me so I should try it.” L011 Pakistani

Some also mentioned consulting their family members, especially their husbands, in order to discuss the final decision to be part of the intervention;

“I’ve spoken to my husband about it. He said if that is what your doctor has recommended then go and try it. If you speak about your problems may be your mind will be ‘refreshed’ and you will feel better.” L005 Bangladeshi

**Reasons for accepting the offer**

Some participants consulted their families in deciding to take part in the intervention and made their own decision to be part of the well-being intervention. The reason behind their individual or mutual decision was essentially that they wanted to get rid of their suffering and get better.

“Yes, it was my own decision to participate as I am suffering for such a long period and I really want to get rid of it. I wanted to try anything that can help me out.” L014 Pakistani

“Yes, when you contacted me and told me about the study I decided to try it because I was suffering and the doctor had recommended it as well.” L009 Pakistani

Some decided to take part in the culturally appropriate well-being intervention as they thought it would help in getting some social support and relief from their social isolation. The participants in the group intervention indicated that being part of the
group would be a source of meeting different people, making new social contacts and reducing their social isolation.

“I was contacted by your Research therapist and she also explained everything. Initially I agreed to take part in the group intervention as I wanted to meet people and get better.” L006 Pakistani

“I am suffering for such a long period and I really want to get rid of my loneliness, I wanted to try anything that can help me out.” L014 Pakistani

“I always want to do things to make myself feel better, so if it was something that was not making me feel better and was making me feel worse I would not go.” L003 Bangladeshi

**Rejection**

Some participants did not accept the offer to be part of the well-being intervention. One participant who initially decided to take part explained that her refusal was due to the stigma attached to mental health. She did not want to disclose her mental health issues as the family would know about her suffering and ‘give her a bad name’. She was also afraid that the gossip around her neighbourhood regarding her mental illness would end up disclosing her illness issues in the community:

“You had given enough information and initially I decided to take part but I was a bit afraid of the stigma attached and all my family lives nearby and my mother will not like that I was suffering from depression and even I have a very gossipy neighbourhood. I know that they would tell my family so I was a bit reluctant.” L009 Pakistani

Another reason for rejecting the intervention was highlighted by one of the research therapists when talking about the difficulty in contacting the participants referred to the intervention. Telephone contact was difficult to make as people did not answer the phone and as the appointment letters were initially sent in English from the NHS partner team (as was apparently routine for them) and potential participants were unable to reply. Realizing the fact that language was a barrier for them, the appointment letters were subsequently translated into the specific languages of the participants by the AMP project and sent out again. Some either did not reply or
replied late and because of the time constraints were not able to be part of the well-being intervention.

“Either people weren’t in, or didn’t answer the phone, or didn’t pick up answer phone messages so a lot of the time it was kind of sending appointment letter out to them and hoping that that was convenient for them. And the language line was particularly difficult to use with people. But again that appointment letter was in English, which is something we needed to be aware of as well.” LR002, Research Therapist

6.2.6 Receipt

The participants in the study discussed the causes and experiences of their journey of stress and depression and their understanding of mental health. They talked about their help-seeking behaviours in times of mental distress. In addition to the above findings, the in-depth interviews focused on the evaluation of the culturally sensitized well-being intervention delivered by the AMP team. Furthermore, it explored the delivery, adherence and acceptability of this intervention from the participants’ perspective as well as getting feedback from well-being therapists and the supervisor.

Appropriateness of therapy

The participants felt that the well-being intervention was *culturally appropriate* as they were able to converse and discuss their issues in the way they wanted. Some of them preferred to be seen by a well-being facilitator of their own ethnic background who could speak their language and understood the complexities of the Asian culture.

However, the patients who spoke Bangla or Sylheti were seen by a white well-being therapist with an interpreter. Specific issues arising from the language barrier are discussed further in the next chapter.
The need of Bengali therapy services available for participants who only spoke Bengali and Sylheti was highlighted by the well-being intervention team. The supervisor and the therapists highlighted the non-availability of Bangladeshi therapists and the dire need for this service in the locality. It was not possible to locate a culturally matched Bangladeshi therapist to work with the project.

“One of the Bangladeshi women really needed to be referred [on] for counselling...And we couldn’t even find a counsellor who could speak her language.” LS001 Well-being supervisor

“Trying to find counselling that’s delivered in Bengali was practically impossible to be honest, and I had referred one person to the Roby and they kept that person on their waiting list in the hope of trying to recruit a Bengali speaking counsellor.” LR002 Wellbeing therapist

The participants were generally satisfied with the content of the well-being intervention. Overall, they did not find anything in the individual or group sessions which was against their culture or religion, delivered either by a facilitator from the same cultural background or a white therapist.

“Everything I think was relevant to our culture and even I did not find anything against our religion.” L011 Pakistani

“The white therapist does understand and she does not ask anything inappropriate. I have been going for the sessions and things are not against our culture or religion.” L023 Bangladeshi

Venue

The venue for group therapy in the well-being intervention was decided with keeping in mind the convenience of the patients while selecting a culturally acceptable place not affiliated to any ethnicity. The group sessions were provided at a local community organisation which was very popular among the residents. The choice of the venue was found to be very much appreciated because of its popularity and even travelling to a venue could have been challenging for the participants:

“Yes it was convenient to go the centre and as it was in the morning I had no problems to go. I used to walk as was confused about how I will claim the transport charges. I did not bother to ask the research therapists even.” L018 Indian
“I used to walk to the centre, and I didn’t have any problems getting there. Obviously, when the weather gets worse and it starts to rain heavily or snow, I would have trouble walking there, but it was a good distance from my house. If it was any further I would not have been able to, for instance I can’t walk.” L003 Bangladeshi

Flexibility of service provision

The well-being intervention had flexibility in the provision of the service. There were three ways of support in the intervention delivered by the well-being facilitators; individual therapy sessions provided by the well-being facilitator, group sessions with other participants and the well-being facilitator and signposting to local third sector organizations. One of the therapists appreciated the flexibility of service provision offered in the intervention as participants were also in a position to decide for them to move around if anything did not suit them:

“I think one thing which I really loved about this AMP project is that the options which they have given to the clients. They have asked them if they would like to do short sessions, group sessions, and signposting combinations. So it gives a lot of flexibility. They have offered everything to the client. It’s up to the client. So I think because AMP project works in the Longsight, the South Asian clients and I could speak South Asian languages, so AMP has offered everything.” LR001 Well-being Therapist

Participants had the flexibility of selecting the support acceptable to them. All preferred face-to-face contact, opting for the individual or the group therapy sessions. The flexibility of the well-being therapists in being able to see the participants at home proved very convenient as many participants either had some physical problems or did not like going out of the house:

“I said I can’t go anywhere because I have trouble walking. I said I would prefer for someone to come and visit me in my house, so then that’s what they did.” L008 Bangladeshi

“I prefer the home visit because I can talk more comfortably and openly this way. We are socially isolated and such things will help reducing it.” L003 Bangladeshi

The well-being therapists also appreciated the benefits of home visits. One of them compared her previous work experiences with the well-being intervention.
“In my mental health worker role previously I would only be able to see people in a health centre. If they required a home visit then that would be something to be honest, that our team wouldn’t usually do. And it can be a massive barrier for people. So with the AMP Well-being Intervention it was good to be able to see people in a venue that they preferred; whether that was at their GP surgery or at home.” LR002 Well-being therapist

Those who were part of the group sessions of the well-being intervention appreciated and enjoyed the friendly atmosphere. They mentioned that it was free of gossip and everybody kept confidentiality which made them talk freely about their bad experiences and mental illness. Attending the group sessions had helped them in gaining self-confidence:

“The good thing was that there was no gossip. All the women talked good about each other, which was inspiring. Initially, in the first session the research therapist talked about confidentiality and how can we keep it among the group and prove to be good members. I think everybody was good regarding this. We shared and talked a lot about the bad experiences of our lives. Everyone was very sympathetic and there was no breach of confidentiality. All the group members appreciated this. The research therapist motivated us a lot and being with them made us more confident. At times I thought that I can be back to my old self.” L018 Indian

“I used to enjoy going and meeting everyone. I think having these groups is a very good idea, there were no such groups like this years ago when I began to fall into depression.”L003 Bangladeshi

However, some were not willing to the join the group intervention. They were hesitant and felt uncomfortable in attending group sessions because of the fear of gossip among the women and opted for individual therapy:

“I would like to try to attend a group session but honestly I don’t feel like talking about my mental health issues in front of other people. They (women) gossip a lot and that is why I don’t mix up with people.” L014 Pakistani
As mentioned above, one of the causes of concern for the providers was the fact that they were not able to find a Bangladeshi speaking therapist or counsellor in the locality for the Bangladeshi participants who were in desperate need of therapy:

“One of the Bangladeshi women really needed to be referred for counselling because her husband has been in prison and she has to come to terms with that. And we couldn’t even find a counsellor who could speak her language. We were quite upset by this because we just couldn’t seem to find anything that was suitable for this woman.” LS001 Wellbeing Supervisor

Some participants discussed how their domestic and financial issues were related to their mental illness. They were very keen to know about other organisations or individuals which could help them in solving these issues:

“I want to know if there are people who could help us sort out our other domestic and financial issues besides our mental illness, nothing better could be done” L006 Pakistani

The well-being intervention, besides providing individual and group therapy, also had provisions for signposting when required. The well-being therapist, sometimes on demand from the participants and sometimes when they felt the necessity, signposted the participants to the relevant organizations in the locality, which the participants themselves were mostly not aware of. Considerable sign posting was done not only for mental health issues but also for the related domestic, social and financial issues of the patients insuring that they received the required help:

“There was a lot of sign posting, ‘because a lot of people that I saw were quite isolated so one of the key things was kind of sign posting to like Bangladeshi Women’s Association and things like that and encouraging people to go along there.” LR002 Well-being therapist

“Many women that are experiencing problems with the cost, with the changes to the benefit system, so again we signposted them to the organizations which help with bilingual welfare, welfare advice officers, to go and speak to them, and help them fill in the forms and things like that: It was very helpful because it’s a gap that exists, sometimes people are not aware of where to go for help and if there is any help around. It’s so, so reassuring for them that there are people who can help them”. LR001 Well-being therapist,
Impact of the well-being intervention

Those who received the well-being intervention reported on the positive impact it had in their lives. Some of them felt that they were able to manage their stress better than before and felt more confident and positive about life. They were able to make friends and learn some skills which could keep them busy in their daily routines even after the intervention finished:

“Yes I learnt new things and made friends as well. I had a good time and learnt to manage stress.” L011 Pakistani

“I am feeling much better now and it is all due to the therapy sessions I had...... really very, very helpful. I gained a lot of confidence and she encouraged me a lot as well. There is a lot of difference in my condition now. I am very confident now and feel that even if my husband leaves me now I will be able to survive as I have overcome my depression and have the confidence to do something on my own now. Yes I would give the credit to you people as your team has played an important role in improving my condition. I have become emotionally quite strong.” L006 Pakistani

The well-being therapists, who had one-to-one contact with the participants, also felt the intervention, had a positive impact:

“Definitely, I think that it seemed like some of the people really responded and got some benefit from the individual intervention, the guided self-help and also engaging with other organizations as well. Specifically for one woman.............It gave her the opportunity to talk to somebody and offload a bit and get that kind of informal support that...because she didn’t have any close family that she was able to talk to and she didn’t have any friends. She didn’t speak any English. So she was very isolated. So I think that appeared to be quite beneficial for her.” LR002 Well-being therapist

Some participants learned to manage their stress better and improved their self-confidence. As their mental health improved they expressed the desire to act as a volunteer to help and teach people how to improve mental health and become a role model for the mental health groups in future:

“I am offering you that I can work as a volunteer I know what depression is what people go through and what can help to recover.” L002 Pakistani
“I can work as a role model for people and can voluntarily come to your group sessions and tell the participants how I overcame my depression naturally with the help of you people and you have made me strong honestly...” L006 Pakistani

Suggestions for promoting access

The South Asian participants had some suggestions about how they thought access to interventions could be better promoted in their community. Most of them felt the need of engaging and involving family members in order to improve mental health issues. Participants thought that it would be easy for them to be part of well-being interventions if the family was on board.

“I think you need to involve the family members as well and convince them that it is related to health. You need to do more on bringing awareness about mental health so that people can benefit from the services available for improving mental health. There should be teams which should signpost you what type of help you require so that you get what you want.” L009 Pakistani

“I think you need to advertise it in a way so that other people in the family do not have a problem with this type of programme. I think you can also get family support by using Islam to promote the issue/ programme.” L027 Bangladeshi

The well-being therapists stressed the need to have the family on board and educate them regarding mental health issues. They suggested family interventions can be a solution to such situations and involving family in future interventions can be more beneficial in improving access to mental health care.

“I think the family interventions – they could be hugely helpful. Because we are working with one individual, we are trying our best to help that person get a better understanding of the problems, get a better understanding of the issues. But then the family also needs to understand that what is happening with that person. To involve the whole family would be really beneficial.” LR001 Well-being therapist

Most of the participants suggested that information about mental health and its treatment, besides being available in written materials, should be made available in audio forms so that people who cannot read could also benefit from it:

“Most of the people are not literate so audio information should be available”. L002 Pakistani
They also suggested the need to learn some useful skills which they can take away for better living, after such interventions finish. They stressed the need to introduce some communication skill courses or signposting to such organizations which could help in improving their communication skills. This would be a way of moving forward towards getting jobs leading to their financial betterment.

“There should be some organizations specifically for the south Asians which could help in improving communication skills and help us with some sort of skill which could help us in getting jobs to be financially sound.” L006 Pakistani

The well-being therapists highlighted the need of delivering therapy sessions for a longer period than was delivered in the AMP well-being intervention. They suggested participants who were chronically ill need more time to improve so the interventions should provide more therapy sessions rather than leaving participants simply at a stage where they started to feel better, since this way they do not improve because the therapy was not available any more.

“Almost all the participants who came in that group were chronically depressed. And it was a big mission!!! Because we were delivering to them 8 sessions..., I mean around the fifth or the sixth session they started feeling comfortable, they got used to plenty of coming to the group. And then the group finished after the eighth session, so I felt that if it lasted longer we would have gained more out of them, because working with a chronically depressed patient, it is difficult to bring any changes in just 8 sessions.” LT001 Well-being therapist

Summary

- The main aim of this chapter was to evaluate the delivery, adherence and acceptability of the psychosocial intervention for the BME community.

- The Dixon-Woods (2005) process model of access was used as a framework for analysis. Participants talked about their difficult life events including family conflicts, domestic and financial issues and bereavement, and thought that these had been the contributing factors towards the persistence of stress.
• The participants indicated shame and stigma, issues of trust and confidentiality, the intricate appointment system and language as barriers in accessing mental health care services.

• Participants described their experiences of having trust in their GPs regarding mental health treatment. They also talked about negotiating treatment options which they thought could be more effective in their recovery.

• Some had detailed information about the well-being intervention when they received the offer to participate while some did not know much about the intervention. After receiving the offer some participants decided themselves to be part of the intervention while some discussed it with their family members. They reason behind their decision to participate was that they wanted to get better. They also thought it would help in getting some social support and relief from their social isolation.

• Some rejected the offer to participate in the intervention due to the stigma attached to mental health while another reason for not accepting the offer was difficulty in contacting those referred to the intervention.

• Participants generally felt that the content and delivery of the well-being intervention ‘was appropriate both culturally and from a religious perspective’.

• The flexibility of service provision offered by the intervention and consisted of individual therapy, group therapy and signposting was appreciated by all the participants. Home visits were valued as a very beneficial service provision of the well-being intervention. The group sessions were provided at a local community organisation because of its popularity and travelling to this venue was very convenient for the participants.

• A cause of concern for the intervention providers was that they were not able to arrange a Bangladeshi speaking therapist or counsellors for the Bangla speaking participants.
• Signposting was carried out not just for mental health issues, but also for associated domestic, social and financial issues.

• The well-being intervention had a positive impact. Participants reported improvement in managing their daily stress and were able to make friends and learn new skills.

• The suggestions to improve access to mental health care included the need to engage family members. Family interventions could be a solution to such situations and involving the family members in future interventions could be more beneficial.

• Most participants suggested that information about mental health and its treatment, besides being available in written materials, should be made available in audio forms so that illiterate people could also benefit from it.

• Participants also emphasised the need to learn some useful skills which would be of continuing benefit after such interventions finish.
Chapter 7: Cultural Matching or Cultural Competence: Balancing Choice and Necessity

This chapter presents case studies of different participants who took part in the evaluation interviews after the completion of the well-being intervention. The case studies will highlight participants’ mental health needs and how the decisions and choices of the therapist were made according to their specific situations.

7.1 Cultural Matching or Cultural Competence

Terry (1989) considered that culture is formed by language, thoughts, actions, customs and religious and social beliefs of humans. It is very important to understand the impact of culture on mental health in order to provide equal treatment to ethnic minorities. The concepts of cultural matching and cultural competence have been described and discussed in Chapter 1. With growing research, clinicians are now aware that the treatment which meets the particular needs of an individual is likely to be more beneficial.

7.2 Case studies

The section will describe four case studies of participants in the AMP well-being intervention. Imaginary names have been given to each case in order to keep the anonymity and confidentiality of the participants.

7.2.1 Case vignette A (Zainab)

Zainab (Pakistani), female, 40 years old, married and mother of a seven year old son, was referred by her general practitioner to the AMP well-being intervention. She had no social support, friends or family in the UK. She felt very low and cried all the time. She was very anxious and thought that her health was deteriorating day by day. After Zainab was diagnosed with depression by the GP, she initially took antidepressants, but she was not willing to take them for longer periods in fear of
getting addicted. She was offered counselling by her GP, but due to the long waiting list and her urgent situation she was referred to the AMP well-being intervention.

The story of Zainab’s mental illness started when her husband went to Pakistan as her mother in law was critically ill. The mother-in-law was on her death bed and forced her son to marry again, this time to a woman of her choice, as his marriage to Zainab was his own choice and it was against the wishes of his family.

“We had a love marriage, I was from the family and we had a lot of opposition as my husband is almost eight years younger than me and you know it is not a norm in our culture, boys have to be older than girls so it was a bit odd and unexpected, what we did was against the cultural values.”

Zainab felt annoyed and much stressed by the decision of her mother in law. She thought that she was pressured and emotionally blackmailed at the time. As her mother in law was on her death bed and she did not want the family to blame her, Zainab had to accept her decision and allow her husband to get married as she did not want to leave him:

“you do realise what I was going through, you know how elders in our families sometimes blackmail you and then force you to obey their decision and I was the one who got caught in that fix....you can understand...”

Following the second marriage her husband was in Pakistan and was reluctant to come back to the UK. His family convinced him to divorce Zainab as soon as he got married again. That was the most difficult time for Zainab; she was very depressed and upset and did not know what to do and how to handle the situation. All this made her very panicky and anxious. She also had suicidal thoughts during that time. She felt aches and pains, cried all the time and would suddenly start to shiver. There was nobody to look after her and because of her ill health she was not able to look after her seven year son. As things were out of her control and her health was getting worse she went to see the GP and was diagnosed with depression. She was referred to the well-being intervention so that she could benefit from the therapy sessions.

“At that time I was very upset and was quite anxious and depressed and was looking for help and anything that could improve my condition.”
Zainab was immediately contacted after being referred. The initial assessment was carried out at her home. She was feeling very low and depressed at that time and kept on crying during the interview. She consented for and was keen to join the well-being intervention because the intervention team consisted of bilingual staff from her cultural background.

“I was happy because you spoke the same language and you understood my pain. I can speak and understand English but not that good, just to an extent that I make things work out. I was very happy to see someone who can understand me and I can talk fluently about my problems and issues”.

Zainab valued cultural matching of the therapist for two reasons. Firstly, language was a major barrier for her and she wanted to express herself fluently in her own language. Secondly, she thought that as values differ in cultures, only someone from an Asian cultural background and not from a western culture could understand her cultural specific issues.

“That was a major attraction as you know I was in desperate need of someone to talk to and if you can’t communicate and talk comfortably about the problems you are going through, then how can you reduce your stress? Rather if you cannot communicate, it adds to your stress and depression. You can talk about such things with white people as well, but if you know English, only then can you communicate. I prefer talking to Asians as they know your culture and they understand your problems and issues more than others and when you are in trouble you want someone to immediately realize your problems and issues and that can only be done by someone from the same cultural background as yours.”

After meeting the well-being therapist she initially opted for the group intervention but afterwards requested for individual sessions because of her circumstances. She had a seven year old and could not leave him on his own. She was able to communicate fluently and express herself with the therapist because she could speak the same language.

“I think I had five to six sessions and I suppose each session was like forty five minutes long and yes, I would say they were very helpful as I use to talk and talk and tell her about how I felt about things and the she would suggest how I could manage
my stress in that situation which I tried my best and was to a considerable extent able to handle my situation”.

Zainab had regular individual therapy sessions and had telephone contact with the therapist throughout the intervention period. She was also signposted by the therapist to relevant organisations as she was looking for a job and also wanted to learn English. Her mental and physical health had improved in the follow up assessments. She expressed her views in the evaluation interviews as:

“I am feeling much better now and it is all due to the therapy sessions I had...... really very, very helpful. I gained a lot of confidence and she encouraged me a lot as well. There is a lot of difference in my condition now. I am very confident now and feel that even if my husband leaves me now I will be able to survive as I have overcome my depression and I have the confidence to do something on my own now. Yes, I would give the credit to you people as your team has played an important role in improving my condition. I have become emotionally quite strong”.

Zainab decided to participate in the intervention because she was in need of someone from the same cultural background who was able to understand her situation. She was also able to express herself fluently. She recommended that cultural matching of the therapist proved beneficial and that could be helpful for others as well.

Key points Case A

- Zainab’s mental illness started because of family issues specific to Asian culture.
- She had lost hope and confidence, was depressed and had no social support in the UK.
- Her need was to talk to somebody from the same cultural background and in her own language.
- She had individual therapy sessions with the well-being therapist.
- Cultural matching of the well-being therapist proved beneficial as her mental health improved. She gained confidence and was able to manage her stress.
7.2.2 Case vignette B (Rupali)

Rupali (Bangladeshi) female, 25 years old, married, mother of a seven year old son, was referred by her GP to the well-being intervention team. She could only speak and understand Bangla. There was no Bangladeshi counsellor available in the area and she was on the waiting list for counselling.

Rupali’s mental health issues started two years before when her husband went to prison and she had a miscarriage. Initially she couldn’t sleep and had migraines all the time. She used to sweat and shiver and could not control it. In addition, she used to worry and cry all the time. Her in-laws forced her to move out from their house. She was also having housing issues which was very stressful for her, while she was on her own without any family support. All her family was in Bangladesh and she had no social support here.

Rupali was not sure that she had depression. The doctors gave her sleeping pills which did not work and then after sometime she was diagnosed with depression. Her mental health became worse and she was crying all the time, had headaches and was not able to sleep. She was on anti-depressants, but was not keen to take them because of the side effects as she had to look after her seven year old son. She was socially isolated and her mental health was deteriorating day by day. She was referred by her GP as she was in desperate need of the therapy and there was a long waiting list for counselling in the medical practice.

Rupali was contacted by an interpreter after being referred to the well-being intervention as she was not able to understand or speak English. The initial assessment was done by the researcher with a Bangladeshi interpreter at her home. She was feeling very low and cried a lot during the interview. She consented for the individual therapy sessions because she thought that therapy would help her mental health, as she was in desperate need of talking to someone who could understand her issues and empathise with her. She had to use a Bangladeshi interpreter with a white therapist as there was no Bangladeshi counsellor available. Rupali had individual therapy sessions at home with the interpreter. She was not able to speak English and was not able to communicate directly with the therapist:
“I was obviously a bit worried about how it would go, but to get better, I wanted to do it. I think language is a problem, but what can I do? I can’t speak with the therapist directly, so there is no other way”.

Rupali was reluctant to join the group sessions as she did not feel comfortable talking about her issues in front of a group of different people.

“Why I didn’t want to go to groups?... Well sometimes I like to talk to someone, it makes me feel better, but I don’t like to talk or be amongst a lot of people. Well, when I talk more than I usually feel my head starts hurting and most of the time I feel really restless, so I don’t want to talk and discuss my problems with people”.

She thought that the individual therapy sessions went well as her mental state was improving and using the interpreter was also satisfactory.

“Yes I have more good days and I am feeling quite better...... I am able to get on with life despite all these problems now, so I have become stronger in this sense. I do worry, but I am pulling along now.”

Considering that the therapist was not from the same cultural and religious background, Rupali was satisfied with the therapy sessions. This was due to the therapist being able to understand her issues and provide social support, something she required in times of mental distress.

“She is very good. There is an interpreter and it works well. Yes she understands what I say, because I can tell that she feels the pain for me. I know I can’t understand what she is saying directly, but you can tell these things just by looking at a person... can’t you? She will ask me how I have been, what problems I have had in that time. She is very concerned, that is what I need”.

Rupali requested to continue her therapy sessions. She even showed willingness to join the group sessions because she was getting better and more confident following the therapy.

“Please try to extend my therapy sessions further because she said it is coming to an end. You see I like going to her and talking about things for an hour or so. I’m thinking from summer onwards I would be in a better position to attend group sessions even, because over the next couple of months I have to move house and sort
everything like my benefits etc. So I have a few problems at the moment, I have too much pressure on. I need this therapy...

Rupali valued the empathetic attitude of the therapist. Despite the therapist being British, white and not from the same cultural background, she was culturally competent to understand Rupali’s issues and problems. Rupali felt that her need of talking to someone who could listen compassionately and guide her to manage her stress was met.

“When I spoke to the therapist, she said that if I have any problems she will try and help me as much as she could by signposting me to the required organizations and she did that”.

**Key points Case B**

- Rupali’s mental illness started when her husband was sent to prison while at the same time she also had a miscarriage.
- She was socially isolated, had no friends or family, was very depressed and cried all the time.
- Her need was to talk to somebody who could empathise with her and understand what she was going through.
- She could only understand and speak Bangla.
- She had therapy sessions with a white therapist using an interpreter.
- She valued the empathetic attitude of the culturally competent well-being therapist, despite the fact that she could not speak her language. The therapy sessions were beneficial as her mental health improved.

**7.2.3 Case vignette C (Kuljeet Kaur)**

Kuljeet (Indian) is female, 30 years old, divorced and living alone. Kuljeet was referred to the well-being intervention by her GP. Kuljeet got married in India and came to the UK with her in-laws. After coming here she discovered that her husband was forced to marry her, as he really liked somebody else. She was divorced after a year as her husband did not want to live with her any
more. She was stressed, but worked hard and managed to survive in the country. Her language skills were very poor; she could not speak or understand English. She bought a small food business and a house of her own in the UK. Her mental illness had started five years before referral to the study when she felt betrayed by her family. At the same time she had a major loss in her business due to which she was not able to pay the mortgage for her house. She had a financial crisis; her house was taken by the bank and she had nothing left. She had no money, no friends or family and was completely shattered. She had no social support at all, was very depressed and was taken to the Burnley Refuge Centre. She had sleep problems and was not able to sleep without sleeping pills. She began to cry all the time. According to her it was a very difficult time as her entire life had changed. Her mental health deteriorated and after consulting the doctor she was started on anti-depressants. Initially she had problems with side effects and she did not take them properly. She was not keen to see the doctor again because she could not communicate in English:

“My English is not that good and I cannot communicate well, so when you cannot talk or explain things then it is better not to talk. Sometimes I want to ask questions or explain my symptoms, but I cannot and I feel very reluctant because I can’t speak English”.

She had never heard about depression and nobody from her friends or family had ever suffered from it. Her previous contact with health care providers had been very unhelpful as she had language problems and there was no interpreter:

“They were not able to arrange an interpreter. This has been an on-going problem. She understands a bit of what I speak and this is how I explain things to her and she knows that I am suffering from depression. It is not convenient and sometimes you feel irritable that you were not able to make them understand what you are going through, but there is nothing you can do about it. I have told my doctor that I want to explain my symptoms and what I am going through but cannot because I can’t speak English fluently. She understands a bit and so it goes on like that. Language is big barrier if you don’t know it. I am suffering because my communication skills are bad”.

“I am unable to explain and I tell you it’s not easy and I don’t feel comfortable talking about things and explaining in this manner. If you are stressed and depressed
and you go to find help and you find that the other person does not understand you then, is that helpful or is that adding more to your stress?"

Her baseline assessment interview was carried out at her home. She was feeling very low, sitting in a very dark room. She said that she did not want to go out and meet anybody. Kuljeet consented for the well-being intervention because the team had members which could speak her language and she thought that her need to express herself fluently and get the required help. She initially opted for individual sessions and recalled her first meeting with the therapist:

“I do remember her calling me and then she visited as well, explaining things about counselling and the groups at Roby. She insisted me to take part in group sessions and told me about the benefits as well. She mentioned about you and that they were part of the same project. I did not ask many questions as I usually get confused talking to people. Whatever she told me was good and helpful. I did tell her about my condition. At that time I did not feel like going out or talking to anybody. I just used to sit in my room with the lights off and just think what had happened to me. I used to think that things can’t change now and life is going to end like that.”

After attending three individual sessions with the therapist, Kuljeet was more motivated and also consented for group sessions:

“The therapist motivated me to get out of the house and come to the groups as everybody there speaks the same language and she said that if I don’t like it then I can opt for individual sessions again. Honestly, so you can make out how a situation can change if you are able to communicate well”.

Kuljeet thought that cultural matching of the mental health care providers was necessary along with communicating in the primary language of the patient in times of mental distress.

“Both Asian and white health care providers are good. I have been in contact with both. It is just the language, as when you are not feeling well and you can’t explain that to your doctor then you are in trouble and you get more ill. Naturally, I think when you can’t tell the doctor what you are going through then how come will he know what’s wrong and he might not be able to give you the right medication. Language is a big barrier and how will someone understand your issues or problems
or whatever you are going through if you can’t converse fluently? You know what I mean”.

She said that she made her choice to join the well-being intervention because the intervention providers were from the same culture and could speak the same language, something that was a big attraction for her:

“Both the facilitators were of my age and they could speak my language so it was good. Initially the therapist explained things and she told me ways how could I manage my stress and she told me to join the groups which will help in gaining confidence. Whenever I felt hopeless she told me not to lose hope and things will be okay again. She guided me quite well. The research therapist motivated me a lot and being with them made me more confident. At times I thought that I can be back to my old self.”

Kuljeet thought that the well-being therapy sessions were beneficial because of the cultural matching of the therapist and recommended that people should have them in order to get rid of their stress and depression.

“I will recommend it to different people as you do forget about your stresses and you gain confidence and get motivated as well”.

She suggested that the therapy should be provided over a longer period of time in order to recover from mental illness.

“These groups should be offered for a longer period as mental illness is not something which goes away like that and what I have seen is that as soon as you feel a bit better the group intervention ends..........and you are back in your state of low mood and low morale. The way I was confident while attending the group is not the same now. So there is a lot of difference in your situation.........you know....... When I am home, things are very different for me I feel low again and am reluctant to do things and meet people. I really think that these groups are very helpful especially in building up your confidence and keeping up your morale.......”
Key Points Case C

- Kuljeet’s mental illness started because she felt betrayed by her family and had a considerable financial loss.
- She had no confidence, was very depressed and had no social support.
- Her need was to talk to someone who could understand her family issues and speak the same language as she could not speak English.
- Her decision to join the well-being intervention was because it had culturally matched therapy providers.
- Her mental health improved because the therapist was from the same cultural background and she was able to talk to her fluently in her language.
- The therapist understood what she was going through, motivated her and helped her in her confidence building.

7.2.4 Case Vignette D (Roshni Begum)

Roshni Begum (Bangladeshi) was a 25 year old female, married, mother of two children and living with her in-laws. She was diagnosed with depression by the GP and prescribed anti-depressants. She refused to take the medication because of the side effects and requested therapy. As the waiting list for the counselling sessions was long, she was referred to the AMP well-being intervention by her GP.

Roshni Begum’s depression had started over a year before. She had very negative thoughts and used to get irritated and angry very quickly. She used to get very upset and wanted simply to be in a quiet place by herself and cry. She could not understand this change - why she was feeling more depressed day by day. She said that she used to think a lot about her mum and get upset. Her mother passed away when she was five years old. She had no memories of her childhood with her mother. Once she had two children of her own, she could feel the essence of this relationship and she started feeling sad. This sadness constantly grew on a daily basis. She thought that she never had that motherly love she could have had if her mother was alive. She expressed her feelings as:
“I think it has become worse since I had my children, because every time they call me ‘mum’ or do something I think “I must have run around after my mum like this” or “my mum must have done this for me” and I just can’t stop thinking about these things. I have been thinking about it all the time I just could not feel happy about anything”.

Roshni Begum lived with her husband and in laws. She had social support as her mother-in-law was her mother’s younger sister.

“People know that we have got depression and we need to get well, but I don’t think they know how it works, how it makes you feel. That’s because you can never tell what depression is until it has happened to you”.

“I am always sad about my mum, but I couldn’t really talk to them about everything that I was feeling. You see my problem is I find it difficult to speak, I don’t lie telling anyone about my worries or problems but I can’t tell.”

Roshni Begum decided to join the well-being intervention thinking that she would be able to talk to someone who could understand her feelings. She opted for individual sessions. She had the therapy sessions with a white therapist along with a Bangladeshi interpreter. She expressed her views about the therapy sessions as:

“I think therapy was very good for me because I could talk about my problems better than before.”

“Another thing now that I do when I am feeling upset is write everything that I am thinking in my diary. My white therapist told me to do that, she said if you prefer to write it in your diary, than to talk to someone about it, do that. So I do that every time I am feeling depressed and upset and after I write it I can stop thinking about it, it’s like I put it away in my diary by writing about it in my diary”.

As Roshni Begum could not converse in English she had to use an interpreter. She realised that language had been a barrier and things would have been better if she could speak English and not use an interpreter.

“Although I tried to talk about my problems openly I think it’s different when there is an interpreter. It would definitely be better without an interpreter”.
Roshni Begum was satisfied with the therapy sessions as her mental health improved considerably. She thought that cultural matching was not that important for her as the therapist was culturally competent and she was touched by her empathetic attitude. “She was very good. I felt she ‘understood everything’ I said and she actually ‘felt sad for me’. I liked the way she treated me and that helped in my improvement. I am grateful to the therapist as I started to feel better without medication”.
“I don’t know what I can say about my depression now because I am 100% fine. I don’t have any of the problems or negative thoughts”.

Key points Case D

- Roshni Begum’s mental illness was related to her mother’s death.
- She felt very low and sad. She also had too many negative thoughts.
- She was diagnosed with depression and was prescribed anti-depressants.
- She refused to take medication and requested for therapy.
- Her need was to express her feelings and talk to somebody who could sympathise with her and could understand her mental state.
- She had therapy sessions with a white therapist using a Bangladeshi interpreter.
- The therapy sessions proved beneficial and her mental health improved a lot. She valued the empathetic attitude of the white therapist who was culturally competent.

7.3 Balancing need with choice

It becomes challenging to achieve equilibrium between choice and necessity in the area of mental health care as emotions play a significant role in the individual’s functioning (Sargent & Larchanche, 2009). Balance can be achieved between the two by providing choices or options of health care to service users according to the intensity of their immediate mental health needs. Cultural competency and cultural matching are two approaches which can be used in improving the quality of healthcare received by ethnic minorities. Health care providers in both approaches need to build a therapeutic relationship with the mental health service users. It is essential to appreciate and understand that the fulfilment of needs is equally important rather than just assuming that cultural matching is always essential. Figure
7.1 below demonstrates that in the interviews empathy was reflected as the most significant need of the participants of the well-being intervention which was fulfilled either by the culturally matched or culturally competent therapists.

*Figure 7.1:* Cultural matching versus cultural competence

![Diagram of Cultural Matching and Competence]

Being able to experience a sense of empathic connection with the therapist was valued as highly as cultural matching with and cultural or linguistic competence of the therapist. Some participants preferred to see a therapist who could understand their culture and/or speak their language, but for others the key to satisfaction was feeling that their problems could be understood by the therapist, regardless of their race or ethnicity. Figure 7.2 below links each case to their needs, the choices available in the psychosocial intervention, their decisions and outcome. The
Pakistani participants of the well-being intervention had the choice of selecting a culturally matched therapist whereas the Bangladeshi participants had the only option of using an interpreter with the culturally competent white therapist.

*Figure 7.2: Decision tree for case studies of well-being intervention: Balancing needs according to available choices.*

Zainab’s (Case A) and Kuljeet’s (Case C) onset of mental illness was triggered by their cultural and family related issues. Additionally, they could not speak English. Their need to specifically talk to someone who was from the same cultural background was due to wanting someone who could understand their culture, values, belief systems and could communicate in their native language. The onset of their stress and depression was closely related to culture-specific life events. Both participants consented for the well-being intervention because they knew that they had the choice of getting a culturally matched therapist. They thought that only a culturally matched therapist would recognize their cultural values, influences, behaviour and lifestyles, thus allowing them to understand their level of stress and what they were going through. For them, communicating in the same language with
someone from the same cultural background was the way to make an empathetic connection with the therapists.

“If you can’t communicate properly, especially in times of stress and anxiety, there is no way you can reduce it, communicating properly is the key thing and language becomes a big barrier if you are in a community where you can’t make people understand your views. Secondly, I think our culture is very different to this English culture. The problems and issues I was going through was something very common and not against their cultural values so if I talk about it with them I don’t think they will realize my state of stress and depression and may think that I am exaggerating things. Men and women in western societies think differently about issues we are very conservative about and I don’t think they understand our family systems and issues. So it is better to talk to someone who can make out what you are going through.” (Zainab)

Cultural matching with the therapist proved beneficial for both these cases. Case A had individual therapy sessions while case C had both individual and group sessions. The therapists were able to communicate effectively and by having complete knowledge of the traditional values and family systems of these cases they were able to develop a rapport and make an empathetic connection. The patients felt that they were understood and showed increased trust towards the therapists. Their need to talk to somebody from the same cultural background was met and their mental health improved.

“For me I think it was perfect as the therapist was from Pakistan, knew our culture very well, secondly there were no language problems which are a big hurdle otherwise. The positive thing was that everything was in my favour even that she was my age fellow and understood each and everything clearly and I was lucky that I had my sessions with her. What else could I have wanted in those times of stress? I would not have preferred a white therapist as she would not be able to understand my problems and would not be able to handle things because of being unknown to our cultural values and obligations”. (Zainab)

“The best thing was that there was no language barrier we talked in detail about everything and even the therapist was able to speak my language. We share the same culture and that was very helpful. You can understand what I went through and how
people and families create trouble for you. I decided to go to the groups because the facilitators were from our ethnic background and the women in the groups were even south Asians speaking the same language. All this was very helpful.” (Kuljeet)

Rupali’s (Case B) and Roshni’s (Case D) mental illness were perhaps more related to more universally understood life events. Rupali, with her husband in prison, was socially isolated and was in desperate need of talking to somebody who could understand her situation and empathise with her. Roshni’s depression was related to bereavement. Both of them could not speak or understand English. Moreover, there was no Bangladeshi therapist available in their locality and they were on the waiting list for counselling. They only had the choice of using a culturally competent white therapist with a Bangladeshi interpreter in the well-being intervention. Rupali (Case B) felt that the therapist understood her and was helping her in managing her stress and did not judge her by the culture she came from. She mentioned that she felt comfortable talking to someone outside her culture because in her view they were more sympathetic and less judgemental:

“...The white therapist is helping me....she understands me. Yes I have more good days and I am feeling quite better. I know she feels for me.....I have become stronger you see. I am worried, but I am pulling along well now. We actually talk about everything and at the end she always asks.... do you have any thing that you want to talk about or ask me? Sometimes when I don’t go for two weeks or longer, she will ask me how I have been, what problems I have had in that time. She is very concerned and I know she feels for me..... (Rupali)

“Sometimes it’s better to talk to somebody not from your own culture.....they are more sympathetic, don’t judge you and understand you well. You see I like going to her every fortnight and talking about things for an hour or so”. (Rupali)

Case D, Roshni, also thought that a culturally competent white therapist was able to build a relationship of trust and understood all the difficulties she was going through despite being from a different culture. Her mental health improved after the therapy sessions and she was able to manage her stress:

“She was very good. I felt she ‘understood everything I said’ and she actually ‘felt sad for me’. I liked the way she treated me and that helped in my improvement. I am grateful to the therapist as I started to feel better without medication. I don’t know
what I can say about my depression now because I am 100% fine. I don’t have any of the problems or negative thoughts”. (Roshni)

Rupali and Roshni did not have a choice to talk to a therapist who could speak Bangla. Communicating in the native language of the patients is considered to be very important in such cases. However, professional interpreting services can facilitate therapeutic relationships by increasing the confidence of the patients (Terry, 1989). Nevertheless, both Rupali and Roshni still felt it would have been better if they could speak the same language as the therapist and communicate directly without the use of an interpreter.

“At the moment it’s going fine, but it would be easier to talk in the same language and not use an interpreter I think and much better even”. (Rupali)

“The therapist was very good but I think I would have been able to talk to her better if she could speak and understand Bengali or I could speak English. I can manage to do things that require basic English by myself, but I couldn’t say everything I needed to in English in the counselling sessions”. (Roshni)

Conclusion

Social issues that play a part in mental illness may be culture specific or more universal in nature. Some patients had a choice of getting culturally matched therapists in the well-being intervention and some did not. People made choices depending on the intensity of their need and nature of the problem. For some participants, talking to a therapist with the same cultural background and the native language was essential to make an empathetic connection. It should not be assumed that cultural matching is always essential. The key is achieving satisfaction and making an empathetic relationship, which the Bangladeshi participants were still able to do with a culturally competent white therapist through an interpreter.

Analysis of the cases studies presented in the chapter highlights that when designing interventions to improve access to therapy, it is important that assumptions are not made about requirements based on expectation about desire for cultural matching and language skills. Ethnic minority mental health patients can benefit from culturally
competent health care providers. Client choice may vary with time, nature and urgency of the presenting problem and specific needs at the time of presentation.

Summary

- The chapter describes four case studies with South Asian participants in the AMP well-being intervention. The case studies highlight their mental health needs and how decisions and choices of therapists were made according to their specific situations.

- Empathic connection was reflected as the most significant need of the participants in the well-being intervention.

- Cultural competency and cultural matching were two approaches which can be used in improving the quality of healthcare received by ethnic minorities. It is essential to appreciate and understand that fulfilment of needs is vital rather than assuming that cultural matching is always essential.

- Case A and case C’s onset of mental illness was related to culture-specific issues. The fulfilment of their need of cultural matched therapist was the best way to make an empathetic connection with the therapists.

- Case B and case D’s mental illness was related to more universal life events. Their mental health improved as they felt comfortable talking to a culturally competent white therapist outside their culture and they considered them to be both empathetic and less judgemental.

- People make choices depending on the intensity of their needs, the nature of the problem and the options available to them.

- Being able to experience a sense of empathic connection with the therapist was valued to be as important as cultural matching with and cultural or linguistic competence of the therapist.
Chapter 8: Discussion

8.1 Main findings

The thesis reports a phased research study which is part of a larger funded programme grant called AMP (Dowrick et al., 2013). The research consisted of a quantitative systematic review and three qualitative studies including: a focus group study, a study of evaluation interviews and a case study analysis. The primary aim of the thesis was the development and evaluation of a culturally sensitive psychosocial intervention for the South Asian minority in the UK.

The main findings related to the five research questions are presented below and are discussed in relation to the published literature. The limitations and strengths of the study are described with some recommendations for practice, policy and future research.

1. What is the evidence for the effectiveness of psychosocial interventions in ethnic minority populations?

The review conducted in the research was focused on a comprehensive review of available evidence. Thirty one trials met inclusion criteria, with a total of 7271 participants. The included studies involved both randomised trials of psychological interventions in ethnic minority patients, and secondary analyses of the effects of psychological interventions in ethnic minority subgroups in the U.S.A, U.K. and the Netherlands. Psychological interventions in patients recruited specifically for a diagnosis of depression demonstrated an effect size of -0.43 (95% CI -0.56 to -0.30), compared to -0.26 (95% CI -0.40 to -0.27) in patients considered ‘at risk’ (Effect size calculated by Professor Bower).

The evidence gathered in the review suggests that existing mental health interventions, specifically various forms of psychological therapy and collaborative care, have beneficial outcomes for ethnic minorities. Previous evaluations of existing research suggest that treatment of depression in ethnic minorities would prove...
beneficial by integrating different treatments like; collaborative care with culturally competent clinicians, pharmacological intervention with clinical case management, individual or group culturally modified psychotherapies and interventions that provide education and awareness about depression (Waheed et al., manuscript submitted). These findings are similar to what Van’t Hof et al. (2011) found in a meta-analysis of psychological treatments for depression and anxiety disorders in low and middle income countries.

Psychological interventions based on CBT in the review showed an effect size of -0.23 (95% CI -0.35 to -0.11, n=13). The studies of CBT as compared to other interventions reported a lower effect size in the meta-analysis presented in chapter 3 (Effect sizes calculated by Professor Bower). It is possible that insufficient cultural adaptations and modifications could be a cause of this reduced effect size, as CBT deals with thoughts and behaviors and can greatly be affected by cultural aspects. This evidence suggests that psychosocial interventions, after necessary and sufficient adaptations, could be effectively used across different cultural groups and will improve outcomes for people with depression and other common mental disorders in ethnic minorities.

All the studies except three included in the review tested interventions that were either developed specifically for a particular ethnic group or were adapted to meet the cultural needs of the participants. As the level of modifications in the interventions was different in each study (Chapter 3), it was not possible to make any direct comparisons. Most of the studies did not provide sufficient details of specific cultural adaptations made to the interventions. A meta-analytic review by Griner and Smith (2006) similarly found that the availability of such information would prove beneficial in teasing out what works best for different ethnic groups and even it would be easy to replicate, rather than researchers devising new interventions. It is arguable that modifications of these interventions according to the cultural needs could improve access and will help in engaging and retention of ethnic minorities.

The three studies in the review which were conducted in the U.K. (Afuwape et al., 2010; Gater et al., 2010; Jacobs et al., 2003) targeting specific ethnic groups demonstrate the effectiveness of culturally sensitive interventions for common
mental disorders for ethnic minorities. The findings of Griner and Smith (2006) provide evidence of the benefits of culturally adapting mental health interventions targeted to a specific racial/ethnic group and conducting interventions in the clients’ preferred language. However, the level of adaptations differed in each of the three studies conducted in the UK (Chapter 3). Some included culturally competent bilingual therapists and facilitators, while others provided provision of transport, childcare, and translated educational material.

South Asians, specifically Pakistanis and Bangladeshis who are used to living in extended families, have a strong social support system back home. Provision of child care and transport facilities as part of interventions could be a way of engaging more patients in trials. Child care facilities in the UK are available but at a very high cost. Ethnic minorities, because of poor socio-economic conditions, cannot afford such facilities in developed countries. Both studies (Afuwape et al., 2010; Gater et al., 2010) addressed this issue in their research study by providing child care facilities as cultural sanctions in order to retain participants.

Stigma has also been one of the known barriers in improving access to mental healthcare. Through qualitative research it has been determined that stigma-related concerns are most common among immigrant women and partly account for underutilization of mental health care services by disadvantaged women from ethnic minority groups (Nadeem et al., 2007). One of the measures Gater and his colleagues (2010) took to tackle stigma was providing Pakistani women with transport facilities for their social group intervention. To make it culturally appropriate they were collected in a taxi accompanied by a female facilitator so that nobody in their friends or family could pin point that the women were going out with a male taxi driver which was culturally inappropriate. Transport and child care facilities are provisions of services which make the patients obliged to be part of such interventions as they are looked after by the researchers and hence increase retention (Bhui, 2010).

The evidence gathered through the systematic review highlighted that there were only three studies conducted in the U.K., two in the Netherlands and the remaining 26 studies in the U.S.A. which were small pilot studies. Psychological therapies are
proven to be effective for depression and anxiety in ethnic minorities, but it is seen that they have difficulty in accessing interventions because of cultural and language barriers. In addition, the systematic review highlighted lower effect size of CBT as compared to other interventions which may be due to insufficient cultural adaptations in the studies. The researchers and developers of the AMP psychosocial intervention, considering this evidence, incorporated culturally appropriate CBT skills in the AMP psychosocial intervention which resulted in improved outcome (as mentioned in Chapter 5) instead of conventional CBT for this particular group of ethnic minority.

The evidence gathered for the review had just three published trials for ethnic minorities in the UK. Future research into specific cultural adaptations that are beneficial to specific ethnic minorities is necessary. However, due to the lack of such expertise, it is essential to develop guidance for other researchers that could cater to diverse ethnic minorities and could be part of future research. Moreover, there is an urgent need for a systematic way of documenting cultural adaptations done in trials so that they could be replicated and comparable in future. This may advance research, inform practice and provide cost effective mental health services to ethnic minorities. Mental health care services could be more accessible if the gap between the health care organizations and the commissioning agencies is reduced by working together in implementing culturally appropriate interventions.

2. What are the barriers in accessing mental health care services specifically for the South Asians in the UK?

Both the focus groups discussions and individual psychosocial intervention evaluation interviews were very useful in gaining insight into the experiences of help seeking, diagnosis and treatment options of service users and service providers regarding mental health. The participants mentioned the following as barriers in accessing mental health care services for South Asians residing in the UK.

Shame, honour and stigma

The participants of both the focus groups and the evaluation interviews of the psychosocial intervention identified that the concept of mental illness was ‘still’
considered as madness in the south Asian community. Individuals suffering from mental illness would disconnect themselves from accessing the services because of the stigma and shame attached to it. The participants were concerned about their individual, as well as their family honour. Some of the participants thought that as most of the Asian families live in extended families, an individual was not able to take any decision on their own which would in any way affect them or bring a bad name to the family.

Gilbert (2004) describes that in cultures derived from Pakistan and the Indian sub-continent, the term used to illustrate family honour is ‘izzat’ comprised of a complex set of rules an Asian individual follows in order to protect the family honour and keep his/her position in the community. Similarly Chew-Graham (2002) described ‘izzat’ as obligatory for women and community members were forbidden from listening and getting involved. It was seen that the burden of a family’s izzat was more upon the women of the family.

The male participants in the focus group were more concerned about maintaining their family honour. They did not like the concept of discussing or seeking help for mental illness outside their families. Gilbert (2004) mentioned that ‘behaviours can damage reputation and bring a bad name to the family’. In order to maintain their family honour and izzat individuals of the Asian community had to keep information to them especially if it could be a source of shame for them and their families.

The fear of shame, stigma and gossip meant that most of the participants wanted to keep their mental health issues to themselves or discuss them only with trusted family members. In order to avoid gossip and embarrassment participants preferred to ‘stay behind the curtain’ (Bradley & Nolan, 2007) and did not discuss their mental health issues or keep a link with anything related to mental illness. It is similar to maintaining ‘the community grapevine’ mentioned by Chew-Graham et al. (2002) where women strongly felt that, if they ever discussed their personal issues or were seen seeking help, word would get back either to their own families or others in the community thus bringing a bad name for the family and the community.
The participants discussed how they utilized different self-coping strategies and kept themselves isolated and did not seek help from outside in fear of being bringing a bad name on their self and their families or being labelled by the society. Similar findings were presented in Chew-Graham et al., (2002) where women described how they would remain silent and use their personal and psychological resources and strengths rather than speak out in fear of consequences of being labelled and judged. The stigma of ‘depression’ further contributed to the experience of isolation for the individuals which sometimes appeared as a self-imposed act of avoiding shame and embarrassment (Gask et al., 2010).

**Language barrier**

Language had been a major barrier in accessing services for most of the participants of focus groups and evaluation interviews, as they were not able to converse in English. In their view one should be able to communicate, talk about their issues and express themselves fluently when describing their symptoms and what they were going through in times of low mood and stress. They indicated how they felt uncomfortable during the process of accessing care because they were not able to speak English. They were not able to explain their symptoms of illness to the GPs because of the language barrier. Even if the GP spoke their language the surgery staff may have not and it became difficult for them to take appointments.

The Bangladeshi women participants were not able to communicate in any other language than Bangla or Syhleti and were more socially isolated. Similar problems of Bangladeshi women were mentioned by Chew-Graham et al., (2002) where the Bangladeshi women’s group thought that the Bangladeshi women carry more family responsibility and were more likely to feel isolation and did not access any services because they could not communicate in English.

The use of interpreters can solve this problem however the participants mentioned about the non-availability of interpreters in a time of need. Participants brought to attention the issues of trust and confidentiality with using the interpreters. They did not show willingness to use an interpreter from their family or among their community. The same issues were discussed in Chew-Graham (2002) where the
participants were not able to talk about family problems or about feeling upset, with an interpreter unless they were desperate. The use of interpreters was an alternative option for them and was not perceived to meet the health and social care needs of women who did not speak English. Some of the participants of focus groups and evaluation interviews both mentioned about their experiences of breach of trust and confidentiality in using translators, friends, family or a member from the same community. Gilbert (2004) mentions that if family members are used as translators the problems can be numerous. The well-being therapists also recognized the issue of trust and confidentiality with interpreters and the patients being uncomfortable and awkward in consultations using interpreters either from the family or within the community.

**Acculturation and inter-generational differences**

There was a difference in attitude between the first and second generation participants about mental health and mental illness. Some in the first generation had adopted the western values because of their second generation relatives, who had experience of interacting more with the western community. Their experiences showed that acculturation had both positive and negative effects. Kleinman (1980) has described how the cultural meanings of illness and its treatment are found within the cultural group itself. Findings from acculturation studies have shown that culture exerts a dominant influence upon the experience and development of psychological symptoms for South Asian women. It is also known that there are marked cultural differences in the way in which the concept of health and illness are considered across different subgroups of South Asian cultures (Anand & Cochrane, 2005).

The intergenerational issues about awareness of mental health and accessing mental health care were also discussed by the participants of the psychosocial intervention. In some cases the second generation proved to be more supportive and aware of the importance of mental health. Guglani et al., (2000) mentions that generational differences in cultural attitudes among first, second and third generation South Asians in Britain and differences in their family structure might be a reason for their higher levels of mental illness. It also emerged in the focus group discussions and individual interviews that those families who had adopted some western values,
either themselves or because of their westernised second generation, were seeking help and had appeared to have had better mental health outcomes. Findings from acculturation studies portray that culture, influences experience and development of psychological symptoms for South Asian women (Anand & Cochrane, 2005).

**Lack of awareness about mental health**

The majority of the participants in the focus groups indicated they do not utilize any mental health care services as for them mental health issues were just ‘*physical health issues*’. In regard to help seeking and the use of mental health services, lack of information and awareness seems to be a known barrier to accessing mental health services (Alexander, 2001). Some of the participants of the men’s’ focus group considered it inappropriate to approach a GP for mental health issues as according to them he was there ‘*only to solve their physical health issues*’.

Dixon-Woods et al. (2005) describes how people's eligibility for healthcare is determined between themselves and health care services. The individual self-defines the illness episode keeping in view with past experiences and understanding of cultural and social norms. The individuals understanding of right to care is then shaped towards treatment. Candidacy in relation to an individual illness episode should be seen as a special case of the individual’s on going perceptions of their right to care, balanced against a fear of socially inappropriate behaviour (Lamb et al., 2011). The importance and awareness of the concept of mental health should be advertised in a way so that the service users understand and realize the necessity to access mental health care services as they do, for physical health issues.

The health professionals in the focus group discussions highlighted that the South Asian community overall was not aware and responsive of mental health issues. In their view South Asian service patients accessed healthcare services for physical illnesses and did not consider any requirement of seeking help for mental health issues as appropriate (therefore did not consider themselves as potential ‘candidates’) because for them health it was just ‘*physical health*’.
Lack of trust and confidentiality

Previous experiences of mistrust and confidentiality of the participants appeared as a key factor in limiting access. They were prepared to suffer the illness rather than face the consequences. Bradley & Nolan, (2007) discussed the fear of what others will say prevented them from the uptake of services. In theory ethics should prevent gossip but everyone does not stick to ethics. The lack of trust and confidentiality can be related to Rogers et al., (2005) concept of recursivity which refers to the ways in which illness behaviour is both enabled and constrained by the interactions that take place between individuals and health professionals in health service settings. Illness behaviour and personal illness management strategies are modified by service contact, as people learn to ‘fit’ into what is required of them by health professionals and their beliefs about what is a ‘legitimate’ illness and service use (Rogers et al., 2005). The Newham Inner city Multi fund and Newham Asian women’s project (Nia, 1998) found a key barrier to help seeking from a GP was ‘the fear that details of their distress would not be kept confidential’. This particularly arose in situations where the GP was of the same ethnicity, when the whole family was registered with the one practice or where the GP was a family friend or even a relative (p. 32). Mistrust of the mental health providers was cited as a major barrier to receiving mental health treatment by ethnic minorities (USDHHS, 1999).

Intricate appointment system

The majority of participants mentioned the intricate appointment system which acted as a barrier in accessing primary care services. They expressed dissatisfaction as they were not able to see the GP in times of need and distress. It was difficult for them to call the surgery between certain time slots as specific times were set to book an appointment and some had to really convince the surgery staff of their need and urgency to book an appointment to see the GP.

The research evidence gathered highlights the different cultural barriers such as shame, stigma, honour, lack of awareness of mental health, labelling, trust and confidentiality, acculturation and intergenerational issues and practical barriers such as language, unavailability of interpreters and intricate appointment system which
confirms previous literature. It is important to note, no concrete steps have been taken so far to tackle these barriers and improve access to mental healthcare for ethnic minorities despite these barriers have been highlighted by researchers in past studies.

Two particular issues identified at the outset of this research were the lack of evidence in the development, adaptation and evaluation of treatments to diverse populations (Bernal & Scharro’ñ-del-Ri´o, 2001), and a lack of guidance for adaptation for culture, language, and context (Bernal et al., 2009). While there has been progress, both in the theory of cultural adaptation and its application, previous UK studies have had mixed success. Gater et al., (2010) complex intervention for depressed British Pakistani women in the UK focusing on social difficulties, social isolation and access to primary care found little overall difference in depression between the adapted intervention and the antidepressant therapy. It did however demonstrate a longitudinal improvement in social functioning for the adapted therapy. The findings and analysis presented in the thesis confirm and extend existing literature emphasising cultural adaptation is necessary but not sufficient in isolation.

The evidence reflects the attitude of ethnic minorities to mental health and the perceptions that culturally sensitive and practically appropriate treatment is not available in the community. It is crucial that health care providers respond to the specific needs of people from ethnic minorities with common mental health problems. They can achieve this by addressing both the universal and specific cultural barriers in order to make mental health care accessible. Jacob et al., (2003) study previously successfully applied health literacy and awareness raising techniques. The in depth case studies (Chapter 7) demonstrated the need to attend to the interaction of the cultural adaptations with their implementation in the health system as a whole. Importantly, the results demonstrate improved acceptability through cultural adapted therapies which allied to awareness rising suggests it is possible to improve access across the community. After confirming that the range of access issues for the South Asian community in the UK extends beyond cultural adaptation of therapies it highlights that complex interventions are necessary. Complex interventions are difficult to evaluate, however the accretion of in depth
knowledge of patients perceptions in implementing interventions with particular populations, as presented here, can help to unpick the interaction of different ‘key ingredients’ for different members of a minority which is itself diverse.

3. What are the patient’s experience of engagement and acceptability of the sensitized psychosocial intervention?

The psychosocial intervention evaluation interviews and case studies of participants described in this research highlight their experiences of participating in the intervention. The qualitative analysis evaluated the acceptability and adherence of the culturally sensitive psychosocial intervention which was specifically designed and developed for these groups. Some participants had trust in their GPs decisions regarding mental health treatment. Furthermore, some of them talked about negotiating their treatment and inquired about different treatment options which they thought would be more effective related to their illness. The majority of participants felt satisfied with the level of information given about the well-being intervention when they were offered to participate; nevertheless, even if they did not know much about the intervention they trusted their health care providers.

Some of the participants, after receiving the knowledge and information decided themselves to be part of the intervention while others discussed it with their family members to take a decision for them. Their motive in both cases was that they wanted their mental health to improve. Furthermore, they believed the intervention would help in getting some social support and relief from their social isolation. The availability of bilingual therapists and staff specifically for the Pakistani participants was a major contributing factor to participate. A few participants refused to participate due to the stigma attached to mental health. Accepting to be part of a mental health intervention would allow people around them and the health care personnel to label them with a mental health illness. Edge and Rogers (2005) suggest that labelling is ‘vulnerable’ as it leads to acceptance and in such cases ‘you live your label’. Another reason for the low response rate of participation was the difficulty faced by the intervention providers in contacting the patients referred to the intervention.
The content and delivery of the well-being intervention was culturally appropriate and acceptable, and nothing was considered as being against the cultural or religious norms of the participants. Pendersen (2003) suggests that cultural content is a vital requirement to share experiences of the ethnic minorities in therapeutic interventions. Integration of cultural and religious norms may help the patients to “buy in” to therapy because it facilitates a cultural bridge that links the patient’s beliefs to the treatment (Hwang et al., 2008). The participants of the well-being intervention were able to converse freely and discuss their issues with the intervention providers in the way they chose. Gater and his colleagues (2010), mention that participants engaged in their trial because of the culturally appropriate format and content of therapy sessions and availability of bilingual facilitators. A culturally sensitive intervention must consider ethnic and racial similarities and differences in the client-therapist relationship. The issues and expectations of clients must be discussed with the therapist during the treatment process (Bernal & Sa´ez-Santiago, 2006).

Participants of the psychosocial group intervention valued meeting new people and making social contacts. Edge and Rogers (2005) indicated that participants may value the social interaction, chance to meet new people and sense of identification with others in the group intervention. Experiences of participants receiving individual and group therapy were mixed. Some of the participants, due to their family constraints and burden of house work and family responsibilities or either due to the stigma attached to mental illness, opted for individual therapy and were happy to create a one-to-one relationship with the therapist. They did not feel like talking about their mental health issues in front of others.

The group sessions were provided at a local community organisation because of its cultural appropriateness and popularity. The participants liked the venue as it was not affiliated to any ethnicity and even travelling to this venue was very convenient for them. Most of the participants had previous experience of this centre and they appreciated its welcoming environment. Munoz (1992) recommends ‘the integration of concepts and objects of client’s culture in the office where the client is received will make them feel more comfortable and understood’.
Empathy, which was highlighted as the significant need of participants in the well-being intervention, was fulfilled either by culturally matched or culturally competent well-being facilitators. The flexibility of the service provision is unique to previous literature and was considered unique and appreciated by the both the participants and the well-being therapists as participants were able to switch between the two interventions. The participants also valued the provision of signposting in the intervention an option that was not available to them previously. It proved helpful in knowing the resources and available help and support in their area. Non-availability of the Bangladeshi speaking counsellors/therapists and interpreters was an unmet need of the Bangladeshi community in the area of Longsight, Manchester which was highlighted in the evaluation interviews.

One of the findings highlighted by the participants of the evaluation interviews contrary to previous research was that ‘home visits’ were valued as a very beneficial service provision of the well-being intervention and it was important in engaging participants in the intervention. One of the Bangladeshi participants mentioned “I really looked forward to meet you and talk to you. I felt important, as somebody was coming to see me”. Due to the social isolation of some of the participants the home visit was something they really appreciated. Similarly, participants who were part of the psychosocial intervention, had physical health issues and were not mobile also considered home visits beneficial. However, contrary to the focus group participants of the psychosocial intervention were not in favour of home visits perhaps because of the stigma and their intrusive family. The mental health and IAPT workers in the health professional focus group and the well-being therapist during their previous experiences also mentioned about the disadvantage of not having the service provision of home visits. In their view it could be a source of providing social support and prove beneficial in improving mental healthcare for ethnic minorities.

Research evidence with ethnic minorities has shown that cultural adaptations and modifications show positive changes in responses to therapy (Chapter 3). The implementation of well-being psychosocial intervention evaluated in this research with specific modifications catering for the South Asian community showed positive results in terms of adherence, acceptability, engagement and retention in the trial.
4. What modifications are required to culturally sensitize a psychosocial intervention for South Asians living in the UK?

The discussion with the focus groups and evaluation interview participants outlined the participants’ understandings of mental health, depression and anxiety, their causes and consequences and barriers they face in accessing mental health care. They explored different ways of overcoming barriers in accessing mental health care and significance of sensitizing interventions.

When discussing sensitizing psychosocial interventions the issue of de-stigmatizing mental illness was given priority by the service users and the service providers. The stigma related to mental illness has been researched and seen as one of the factors affecting access of services (Corrigan, 2004). Stigma plays a large role in why minorities do not seek care (Ng, 1997; Uba, 1994). The participants of the psychosocial intervention (PSI) focus groups discussed the necessity of raising awareness and the provision of educational materials regarding mental health issues which contain less medical jargon and stigmatising diagnosis. Stigma and distrust can be due to lack of understanding about the illness (Woodall et al., 2010).

Participants of the PSI also suggested the need for availability of culturally suitable audio and visual resources in different languages as sometimes they seem to be more appealing. Hwang (2008) considers that more efforts need to be placed on public health education and breaking down common stereotypes and misperceptions of mental illness and its treatment. Robust coordination of services and necessary educational resources and materials should be available locally. Participants also mentioned educating family members particularly spouses and taking them on board as most of the time they are involved in the decision making process. The need has also been stressed by Woodall et al. (2010) suggesting that ‘it is necessary to take the family and caregivers on board as they are important contributors to decision making in participants lives’.

The focus groups indicated a simple referral system should be in place for easy access to mental health care services. Furthermore, the provision of self-referral should be available as an option to refer into the treatment when required. They
suggested that the first point of contact should be easily accessible without any gatekeepers. Hwang (2008) suggests a culturally sensitive initial contact so that a smooth transition can be made in referring clients according to their need to the relevant service centres. Mental health services should reduce stigma, misperceptions, and provide comfort in treatment which will hopefully make services more accessible (Hwang et al., 2008). It is seen that primary care is easy to access and may be more accessible and less stigmatising for the service user as compared to secondary care as they are more sensitive towards patients own beliefs about health (Waheed, 2010). The participants of the evaluation interviews also mentioned about their difficulties accessing primary care and suggested self-referrals for easy access in time of need.

Most of the participants of the focus groups and the evaluation interviews were not aware of different types of psychotherapies available besides a few who were part of talking therapies previously or were referred for Cognitive Behavioural Therapy/Computerised Cognitive Behavioural Therapy (CBT/CCBT). All participants recommended a culturally appropriate psychosocial intervention with flexibility of time, venue and selection of service providers. Moreover, they suggested the availability of culturally matched or culturally competent therapists should be part of the culturally adapted interventions. There is some evidence to suggest that treating patients in a more culturally sensitive manner (i.e. providing client therapist ethnic matching and being treated at ethnic specific services) can reduce premature treatment dropouts (Flaskerud & Liu, 1991; Takeuchi, Sue, & Yeh, 1995). The meta-analyses conducted by Griner and Smith (2006) and Polo (2008) highlight that cultural adaptations seem to work in delivering treatments to different ethnic cultural groups. Gater et al. (2010) reported 85% follow up rate at three months, the participants engaged in the trial because of culturally appropriate services and bilingual facilitators and research staff.

Ward (2007) suggests that psychological or social interventions are likely to be effective among ethnic minorities when modified according to the needs of the population. The health providers’ focus group and some of the well-being therapists in PSI suggested not utilizing westernised models of therapy for the South Asian community as they did not meet their needs. They viewed Asian culture was different from westernized cultures. Hwang et al. (2006) reported a case study in
which they used a culturally adapted CBT focusing on ‘adapting therapy to accommodate patients’ needs’. Similarly, Hwang (2009) proposed a community-based developmental approach, the formative method for adapting psychotherapy model, to be used in collaboration with the psychotherapy adaptation and modification framework. There has been evidence available that implementation of such interventions has resulted in improved patient outcomes specifically their satisfaction levels (Dogra et al., 2007; Thom et al., 2006).

The majority of participants in the focus groups considered the psychosocial intervention should cater to the individuals’ needs and each person should be able to join in or switch between the two therapies as required. The health professionals of both focus groups and the well-being intervention proposed a flexible provision of therapy in psychosocial intervention for South Asians. Group therapy besides individual therapy was recommended by most of the participants as it will reduce stigma, gain confidence, develop social links and individuals would be able to share each other’s experiences.

The participants who had received group therapies previously were not happy with the limited 8-10 sessions of therapy, ending abruptly when they were beginning to feel better. The well-being therapists highlighted the need for delivering therapy sessions for a longer period as to what was delivered in the AMP well-being intervention. They suggested that patients who are chronically ill need more time to improve therefore interventions should provide a reasonable amount of therapy sessions which is beneficial for the patients rather than a set amount of sessions. Gater et al., (2010) indicated that ten sessions were inadequate for their needs and, in future, for the sessions to be spread over a longer period of time to avoid the abrupt ending of the intervention.

Besides the fact that there was so much flexibility in the service provision of the Well-being Intervention, a cause of concern for the intervention providers was the unavailability of a Bangladeshi speaking therapist or counsellor in the locality for the Bangladeshi participants who were in desperate need of therapy. The well-being supervisor discussed this apprehension. Most of the participants pointed out that people will engage in psychosocial therapies if provided by people who had expertise
in the area, had good interpersonal skills, good communication skills, were able to develop trust and confidentiality and were aware of the cultural background.

Participants considered that local voluntary organizations could be a source of culturally appropriate social support in the community for them. Different religious places, community centres and ethnic minority organizations working locally can provide culturally sensitive support and education on mental health. Gray (1999) suggested engagement of ethnic minorities can be increased by providing education and advocacy through places of worship, leisure clubs and entertainment venues. This partnership can be significant in further facilitating engagement and retention of participants while developing new interventions targeting specific populations (Well et al., 2006).

There is research evidence of effectiveness of culturally adapted or modified psychosocial interventions in common mental disorders in ethnic minorities presented in the systematic review (Chapter 3). Figure 8.1 below includes a list of modifications and cultural adaptations discussed in the focus groups and by the participants of the evaluation interviews. It demonstrates that there is a wide range of adaptations that can be grouped into categories. A limitation identified in relation to the meta-analysis was the lack of systematic reporting of the individual adaptations used. While Bernal’s (1995) model provides a theory driven typology of the contents of interventions, the evaluation findings and case studies highlight that practical and localised issues must also be considered and reported.

Figure 8.1 shows adaptations can be usefully and appropriately grouped, whether generic, or specific to local populations, or circumstances. With further work this suggests it would be possible to develop a systematic schema for documenting cultural adaptations in future trials. This could help to further progress in cultural adaptation of psychosocial interventions by improving the potential sensitivity of future meta-analyses. The adaptation models and frameworks described in Chapter 1 are useful in guiding cultural adaptations but one has to tread with cautions as one model or framework cannot be suitable for all. The pilot study presented in Chapter 6 demonstrates that culturally sensitive psychosocial intervention that adapted
psychosocial interventions can be effective in reducing common mental health symptoms and increasing well-being for ethnic minorities.

Figure 8.1: List of Modifications and Cultural Adaptations Discussed in the Focus Groups and by the Participants of the Evaluation Interviews Grouped into Categories

5. What does this tell us about the specific need for cultural sensitization and adaptation of psychosocial interventions for this population?

The evaluation interviews (Chapter 6) and the qualitative case studies (Chapter 7) highlighted the particular mental health needs of the participants and how decisions and choices of different service provisions were made according to their specific situations. With growing understanding of cultural adaptation, it is important to
understand that the treatment which meets the particular needs of an individual is likely to be more beneficial.

The selection of ‘mental health care services’ and ‘service provider’ seemed to be dependent on the personal choice of the participant in the time of need: ‘cultural matching or ‘cultural competence‘. It was seen that the choices of selection of mental health care services was made according to their specific mental health needs. In some cases, when the basic need of explaining their illness was not met, the choice of the healthcare provider was made to overcome the language barrier and describe their symptoms fluently.

Kleinman (1978) introduced the concept of the explanatory model of illness. He suggested that the patients understanding and experience of an illness is rooted within a social context. Patients from different cultural backgrounds may experience and describe their illnesses in their own way and can label their sickness in different ways (Kleinman, 1978; 1988). Individuals who believe their problem is psychological might seek help from a psychologist, while those who believe his/her problems are somatic, and because there is a large amount of stigma associated with mental illness in many cultures, may choose to seek help from a primary care physician (Hwang et al., 2006). However, findings of the in depth analysis in the case studies emphasised that mental health issues could be culturally specific (e.g. second marriages in Pakistani culture) but could also be more universal in nature (e.g. experience of bereavement or loss).

It was seen that people make choices depending on the intensity of their need and nature of the problem. Empathic connections were reflected as a significant need of all the participants of the well-being intervention. Pakistani participants in the well-being intervention had a choice of getting a culturally matched therapist while the Bangladeshi participants did not. There is evidence to suggest that treating patients in a more culturally sensitive manner (i.e. providing client therapist ethnic matching and being treated at ethnic specific services) can reduce premature treatment dropouts (Flaskerud & Liu, 1991; Takeuchi, Sue, & Yeh, 1995). The Pakistani participants with cultural specific issues talking to a therapist with the same cultural background and the native language were essential to make an empathetic
connection. When the practitioner is culturally matched to the client, it is likely that they will have matching explanatory models which highlights “clinical realities” (Kleiman, 1978).

The Bangladeshi participants on the other hand were also able to make an empathetic connection with a culturally competent white therapist through an interpreter. Cultural competence necessitates clinicians to take into account the individual values, beliefs and practices of the patient which might or might not reflect their affiliation of a group (Mead & Bower, 2000). The Bangladeshi participants felt comfortable talking to a culturally competent white therapist outside their culture and they considered them to be empathetic, more sympathetic and less judgemental.

Cultural competency and cultural matching were the two approaches used in culturally adapting interventions by the clinicians and researchers which can improve the quality of healthcare received by ethnic minorities. It is essential to appreciate and understand that fulfilment of needs is more important than assuming that cultural matching. Fulfilment of needs involved achieving satisfaction for the participants and being able to experience an empathic connection with the therapist. It was valued to be as important as cultural matching and cultural or linguistic competence of the therapist.

There is an overwhelming need to understand the views and different experiences of illness and the health care system of ethnic minorities. A deeper understanding would potentially lead to better service delivery and improved health. Improving the experience of patients requires improved representation of minority groups in training, recruiting practitioners who speak relevant languages and understanding the background of particular patient groups. It must be accompanied by a willingness by clinicians to take cultural and ethnic issues into account during their management of patients (Lake, 2006). Service providers should be trained in cultural competence in order to cater for the specific needs of ethnic minorities. Patients may prefer to be seen by a therapist of their own ethnic background or a culturally competent one and either may in turn increase adherence and satisfaction (Phelan & Parkman, 1995).
The evaluation interviews (Chapter 6) and analysis of the cases studies (Chapter 7) presented in the research highlights that when designing interventions to improve access to therapy, it is important that assumptions are not made with regards to the requirements of patients about desire for cultural matching and language skills. Ethnic minority mental health patients can benefit both from culturally competent and culturally matched health care providers. Their choices may vary with time, nature, urgency of their illness and specific needs at the time of presentation. Clinical benefits can be achieved by providing different treatment options and choices to patients. It can be achieved through cultural adaptations and modifications according to the cultural values, language, preferences and needs of the individuals which could prove beneficial in providing effective psychosocial interventions to the ethnic minorities.

8.2 Conclusion

The forgoing discussion leads toward overarching conclusions in respect of the original research questions:

- Culturally modified interventions for specific populations can improve ‘acceptability’ and ‘accessibility’. A psychosocial intervention adapted and modified according to the needs of an ethnic minority population like the South Asians can be both acceptable and accessible.

- Both culturally specific and universal barriers exist – responding to them requires providers to understand the needs of patients and the flexibility to meet these needs through:
  a. Diverse entry routes
  b. Different treatment options appropriate to needs
  c. Culturally competent or culturally matched health care providers
  d. Appropriate consideration of the resources available locally to support patients after active participation in therapy
  e. Psychological therapies available in patients’ preferred or native language.
f. Provision of flexibility of time, acceptable venues, home visits, transport and childcare facilities.
g. Flexibility in the development of successful modification of existing therapies for minority groups. Practitioners require the same flexibility, training and resources to deliver such interventions including therapy at home.

- Better engagement and adherence to psychosocial interventions can be achieved by providing treatment choices to patients according to the nature and urgency of their specific need. Ethnic minority mental health patients can benefit from both culturally competent and culturally matched health care providers. It is important that assumptions are not made about requirements based on expectation about desire for cultural matching and language skills.

- There is a crucial need for developing the evidence base by designing effective mental health treatments for minority patients however this is limited by a lack of systematic reporting and documentation of modifications. Figure 8.1 demonstrated that effective categories can be developed. Systematic documentation of adaptations would enable further research, by improving comparability and replication of modifications across studies and could be a source of informing policy and practice.

8.3 Limitations of the study

- The research study does have limitations. It was conducted in one specific low socio-economic inner city area of Manchester which was more ethnically populated with a Pakistani and Bangladeshi minority.

- The study was able to recruit females for the pilot trial. The reason may be attributed to the men referred to the study were mostly Pakistanis, belonging to a patriarchal society which emphasise the importance of self-reliance and use of coping strategies for mental illness which could be kept private.
• The sample size of the pilot trial was small as the appropriate recruitment targets could not be achieved. The inclusion criteria of patients being registered at selected local four medical practices in the locality did not prove effective for recruitment. Despite many efforts by the researchers, therapists and the supervisors, two of the control practices did not engage in the study. Two of the intervention practices which were on board had different locum doctors working for them who did not know much about the study and hence were not able to refer patients on.

• Third sector organizations working in the community despite their initial interest in the study did not refer many participants. One of the reasons given was that the clients accessing their services were not registered with any of the AMP selected medical practices.

• Generalisability of the findings may be limited because of the small sample size and restricted a small geographical area that may not be representative of the larger population.

8.4 Strengths of the study

• The current work is important because the focus groups and the evaluation interviews were facilitated by a bilingual skilled researcher from the same ethnic background. One of the well-being therapists was culturally matched to the Pakistani participants in the psychosocial intervention. This proved to be an important factor in engaging the participants and meeting their need of being seen by a culturally matched therapist.

• By utilising the expertise of senior researchers, from The University of Manchester and the University of Liverpool, primary care trusts and third sector organizations in the locality of Longsight, Manchester, efforts were made to overcome the barriers and facilitate the study in a culturally sensitive manner.
• A good working relationship with the different non-statutory organisations based in Longsight was made. The on-going well-being group in this community incorporated some of the AMP well-being group activities in their sessions. Some of the participants of the PSI continued with these groups.

• A culturally sensitive psychosocial intervention was developed for South Asians which can be replicated with the same population for future research.

8.5 Recommendations

Some recommendations for the implementation of culturally appropriate psychosocial interventions include:

8.5.1 Practice

• ‘Mental health’ needs rewording: Positive health programmes or well-being sessions are acceptable names. Self-help guides related to mental health should be culturally appropriate, particularly for Asians and available in different languages. Front covers of the self-help guides available do not depict their lifestyle and they are not interested in something they feel alien about.

• The modifications or adaptations in interventions should be able to accommodate patient’s physical, psychological and socioeconomic needs. Individuals need to have the relevant information not just how to access the service but how it is culturally relevant to what they want.

• Simple referral system into interventions for ethnic minorities should be in place. Referral to the well-being intervention should be enabled through multiple routes like Gps, health professionals, voluntary organizations and self-Referral. Flexibility should be provided in delivery of therapy sessions. Out of hours services should be available. Most of the therapeutic services are available from 9am till 5pm excluding normal working hours individuals.
Moreover, emergency counselling should be made available. Home visits should be an option with gradual phasing out of sessions instead of abrupt ending.

- Bilingual therapists should be available if possible for providing therapy sessions in the patient’s native or preferred language.

8.5.2 Policy

- Training the managers, doctors and all the primary care staff in cultural competence in order to understand and cater for the needs of ethnic minorities.

- All the local community and social organizations need to share information and work in partnership in order to increase access for the ethnic minorities. Furthermore, GPs should be aware of the resources available locally.

- Health care services should recognize the need to work with communities more effectively than they have done so far. It is essential to work with the families of ethnic minorities and not individuals alone. In order to de-stigmatize mental illness the south Asian community should be educated about mental health and the concept of mental illness should be clearly defined by healthcare authorities.

- Providing confidential and trust worthy mental health care services in the native language of South Asians in order to overcome barriers and improve access.

- Individuals should be able to access service providers of their own choice according to their specific mental health need. Provision of culturally matched or culturally competent health care providers should be made available.

- Building bridges between the services that actually exist rather than creating new services is recommended. Healthcare provider organizations and commissioning
agencies need to work together to implement culturally appropriate interventions into the services to ensure equitable access to mental health.

8.5.3 Future Research

- In order to improve recognition of mental health in ethnic minorities and improve help seeking it is essential that future research addresses the barriers to access treatment from the patients’, community and health services providers perspective.

- It should be followed by the development of culturally sensitive psychosocial interventions for ethnic minorities with patient-centred approaches which empower individuals with common mental health problems and help in seeking mental health care.

- There is a need for a systematic way of documenting cultural adaptations done in trials so that they can be replicated and comparable in future. The practice if implemented may advance research, inform practice and improve service provision of cost effective mental health services to ethnic minorities

- The pilot trial (Chapter 6) suggests that culturally sensitive psychosocial interventions can be effective in reducing common mental health symptoms and increasing well-being for ethnic minorities like South Asians. The pilot project serves as an exploratory randomised trial of a culturally psychosocial intervention of common mental disorders for the ethnic minorities in the UK.
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Appendices
Appendix 2.1: Search strings Systematic Review

Search 1

CDSR first stage final
1. (family adj2 pract$).mp. [mp=title, abstract, full text, keywords, caption text]
2. (general adj2 pract$).mp. [mp=title, abstract, full text, keywords, caption text]
3. (Primary adj2 care).mp. [mp=title, abstract, full text, keywords, caption text]
4. Primary care.tw.
5. 1 or 2 or 3 or 4
7. Depression
8. Anxiety
9. Stress
10. or/6-9
11. 5 and 10
12. Limit 11 to full systematic reviews
13. Limit 12 to yr="1990 - 2009"

Cinahil first stage Final
1. Primary health care/
2. (general adj2 pract$).tw.
3. (primary adj2 care$).tw.
4. (family adj2 pract$).tw.
5. Mental health/
6. Depression/
7. Anxiety.tw.
8. Stress.tw.
9. Somatoform disorders/
10. or/1-4
11. or/5-9
12. (systematic adj review$).tw.
13. Limit 12 to yr="1990 - 2009"

**Medline first stage Final**

1. Primary health care/
2. Family practice/
3. (family adj2 pract$).mp.
4. (general adj2 pract$).mp.
5. (Primary adj2 care).mp.
6. or/1-5
7. Mental health/
8. Mental health.tw.
10. exp anxiety disorders/
11. Stress.tw.
12. exp somatoform disorders/
13. or/7-12
14. 6 and 13
15. (systematic adj review$).tw.
16. 16 and 17
17. Limit 18 to yr="1990 - 2009"
Psycho first stage final

1. Primary health care/
2. (family adj2 pract$).mp.
3. (general adj2 pract$).mp.
4. (Primary adj2 care).mp.
5. or/1-4
6. Mental health/
7. Depression/
8. exp anxiety disorders/
9. exp somatoform disorders/
10. exp eating disorder/
11. Stress/
12. or/6-11
13. 5 and 12
14. Limit 13 to yr="1990 - 2009"

Search 2

CCRT

1. exp ethnic groups/
2. exp culture/
3. Transcultural nursing/
4. bengali.ti,ab.
5. cantonese.ti,ab.
6. creole.ti,ab.
7. farsi.ti,ab.
8. french.ti,ab.
9. gaelic.ti,ab.
10. hindi.ti,ab.
11. kashmiri.ti,ab.
12. korean.ti,ab.
13. kurdish.ti,ab.
14. mandarin.ti,ab.
15. nepali.ti,ab.
16. pashto.ti,ab.
17. polish.ti,ab.
18. punjabi.ti,ab.
19. somali.ti,ab.
20. spanish.ti,ab.
21. sylheti.ti,ab.
22. tamil.ti,ab.
23. turkish.ti,ab.
24. urdu.ti,ab.
25. vietnamese.ti,ab.
26. welsh.ti,ab.
27. yoruba$.ti,ab.
28. africa$.ti,ab.
29. african-american.ti,ab.
30. afro-caribbean.ti,ab.
31. african-caribbean.ti,ab.
32. anti-racist.ti,ab.
33. anti-racism.ti,ab.
34. asian.ti,ab.
35. caribbean$.ti,ab.
36. blacks.ti,ab.
37. Cross cultural.ti,ab.
38. diversity.ti,ab.
39. Equal opportunit$.ti,ab.
40. equality.ti,ab.
41. (ethnic$ adj3 minorit$).ab,ti.
42. Ethnic$.ti,ab.
43. ethnology.ti,ab.
44. gypsy.ti,ab.
45. immigration.ti,ab.
46. emmigrants.ti,ab.
47. indian.ti,ab.
48. jamaica$.ti,ab.
49. Minorit$3.ti,ab.
50. Migrant$.ab,ti.
51. mixed race.ti,ab.
52. multi racial.ti,ab.
53. multi cultural.ti,ab.
54. multi ethnic.ti,ab.
55. Multi lingual.ti,ab.
56. pakistan$.ti,ab.
57. race.ti,ab.
58. racism.ti,ab.
59. (Religion or religious).ti,ab.
60. romany.ti,ab.
61. Trans cultural.ti,ab.
62. transcultural.ti,ab.
63. transracial.ti,ab.
64. traveller.ti,ab.
65. or/1-64
66. exp mental health/
67. exp depression/
68. 66 or 67
69. 65 and 68
70. Limit 69 to yr="1990 - 2009"

**Medline**

1. exp ethnic groups/
2. exp culture/
3. Transcultural nursing/
4. bengali.ti,ab.
5. cantonese.ti,ab.
6. creole.ti,ab.
7. farsi.ti,ab.
8. french.ti,ab.
9. gaelic.ti,ab.
10. hindi.ti,ab.
11. kashmiri.ti,ab.
12. korean.ti,ab.
13. kurdish.ti,ab.
14. mandarin.ti,ab.
15. nepali.ti,ab.
16. pashto.ti,ab.
17. polish.ti,ab.
18. punjabi.ti,ab.
19. somali.ti,ab.
20. spanish.ti,ab.
21. sylheti.ti,ab.
22. tamil.ti,ab.
23. turkish.ti,ab.
24. urdu.ti,ab.
25. vietnamese.ti,ab.
26. welsh.ti,ab.
27. yoruba$.ti,ab.
28. africa$.ti,ab.
29. african-american.ti,ab.
30. afro-caribbean.ti,ab.
31. african-carribean.ti,ab.
32. anti-racist.ti,ab.
33. anti-racisn.ti,ab.
34. asian.ti,ab.
35. carribean$.ti,ab.
36. blacks.ti,ab.
37. cross cultural.ti,ab.
38. diversity.ti,ab.
39. equal opportunit$.ti,ab.
40. equality.ti,ab.
41. (ethnic$ adj3 minorit$).ab,ti.
42. ethnic$.ti,ab.
43. ethnology.ti,ab.
44. gypsy.ti,ab.
45. immigration.ti,ab.
46. emmigrants.ti,ab.
47. indian.ti,ab.
48. jamaica$.ti,ab.
49. minorit$3.ti,ab.
50. migrant$.ab,ti.
51. mixed race.ti,ab.
52. multi racial.ti,ab.
53. multi cultural.ti,ab.
54. multi ethnic.ti,ab.
55. multi lingual.ti,ab.
56. pakistan$.ti,ab.
57. race.ti,ab.
58. racism.ti,ab.
59. (religion or religious).ti,ab.
60. romany.ti,ab.
61. trans cultural.ti,ab.
62. transcultural.ti,ab.
63. transracial.ti,ab.
64. traveller.ti,ab.
65. exp mental health/
66. exp depression/
67. randomized controlled trial.pt.
68. random$.tw.
69. control$.tw.
70. intervention?.tw.
71. evaluat$.tw.
72. or/1-64
73. 66 or 65
74. or/67-71
75. 74 and 72 and 73
76. limit 75 to yr="1990 - 2009"

**Cinahl**

1. exp ethnic groups/
2. exp culture/
3. Transcultural nursing/
4. bengali.ti,ab.
5. cantonese.ti,ab.
6. creole.ti,ab.
7. farsi.ti,ab.
8. french.ti,ab.
9. gaelic.ti,ab.
10. hindi.ti,ab.
11. kashmiri.ti,ab.
12. korean.ti,ab.
13. kurdish.ti,ab.
14. mandarin.ti,ab.
15. nepali.ti,ab.
16. pashto.ti,ab.
17. polish.ti,ab.
18. punjabi.ti,ab.
19. somali.ti,ab.
20. spanish.ti,ab.
21. sylheti.ti,ab.
22. tamil.ti,ab.
23. turkish.ti,ab.
24. urdu.ti,ab.
25. vietnamese.ti,ab.
26. welsh.ti,ab.
27. yoruba$.ti,ab.
28. africa$.ti,ab.
29. african-american.ti,ab.
30. afro-caribbean.ti,ab.
31. african-carribean.ti,ab.
32. anti-racist.ti,ab.
33. anti-racism.ti,ab.
34. asian.ti,ab.
35. carribean$.ti,ab.
36. blacks.ti,ab.
37. cross cultural.ti,ab.
38. diversity.ti,ab.
39. equal opportunit$.ti,ab.
40. equality.ti,ab.
41. (ethnic$ adj3 minorit$).ab,ti.
42. ethnic$.ti,ab.
43. ethnology.ti,ab.
44. gypsy.ti,ab.
45. immigration.ti,ab.
46. emmigrants.ti,ab.
47. indian.ti,ab.
48. jamaica$.ti,ab.
49. Minorit$.ti,ab.
50. Migrant$.ab,ti.
51. mixed race.ti,ab.
52. multi racial.ti,ab.
53. multi cultural.ti,ab.
54. multi ethnic.ti,ab.
55. Multi lingual,t,i,ab.
56. pakistan$.ti,ab.
57. race.ti,ab.
58. racism.ti,ab.
59. (religion or religious).ti,ab.
60. romany.ti,ab.
61. trans cultural.ti,ab.
62. transcultural.ti,ab.
63. transracial.ti,ab.
64. traveller.ti,ab.
65. exp mental health/
66. exp depression/
68. Intervention?.tw.
69. Clinical trials/
70. or/1-64
71. 66 or 65
72. 69 or 67 or 68
73. 72 and 71 and 70
74. Limit 73 to yr="1990 - 2009"
76. from 75 keep 1-29

**PsycInfo**

1. exp ethnic groups/
2. exp culture/
3. Transcultural nursing/
4. bengali.ti,ab.
5. cantonese.ti,ab.
6. creole.ti,ab.
7. farsi.ti,ab.
8. french.ti,ab.
9. gaelic.ti,ab.
10. hindi.ti,ab.
11. kashmiri.ti,ab.
12. korean.ti,ab.
13. kurdish.ti,ab.
14. mandarin.ti,ab.
15. nepali.ti,ab.
16. pashto.ti,ab.
17. polish.ti,ab.
18. punjabi.ti,ab.
19. somali.ti,ab.
20. spanish.ti,ab.
21. sylheti.ti,ab.
22. tamil.ti,ab.
23. turkish.ti,ab.
24. urdu.ti,ab.
25. vietnamese.ti,ab.
26. welsh.ti,ab.
27. yoruba$.ti,ab.
28. africa$.ti,ab.
29. african-american.ti,ab.
30. afro-caribbean.ti,ab.
31. african-carribean.ti,ab.
32. anti-racist.ti,ab.
33. anti-racism.ti,ab.
34. asian.ti,ab.
35. carribean$.ti,ab.
36. blacks.ti,ab.
37. Cross cultural.ti,ab.
38. diversity.ti,ab.
39. equal opportunit$.ti,ab.
40. equality.ti,ab.
41. (ethnic$ adj3 minorit$).ab,ti.
42. Ethnic$.ti,ab.
43. ethnology.ti,ab.
44. gypsy.ti,ab.
45. immigration.ti,ab.
46. immigrants.ti,ab.
47. indian.ti,ab.
48. jamaica$.ti,ab.
49. Minorit$3.ti, ab.
50. Migrant$.ab,ti.
51. mixed race.ti,ab.
52. multi racial.ti,ab.
53. multi cultural.ti,ab.
54. multi ethnic.ti,ab.
55. multi lingual.ti,ab.
56. pakistan$.ti,ab.
57. race.ti,ab.
58. racism.ti,ab.
59. (religion or religious).ti,ab.
60. romany.ti,ab.
61. trans cultural.ti,ab.
62. transcultural.ti,ab.
63. transracial.ti,ab.
64. traveller.ti,ab.
65. exp mental health/
66. exp depression/
68. Intervention?.Tw.
69. Evaluat$.tw.
70. Randomized controlled trial.mp.
71. Clinical trial.mp.
72. Therapy.mp.
73. or/1-64
74. 65 or 66
75. 69 or 67 or 72 or 71 or 70 or 68
76. 74 and 75 and 73
77. Limit 76 to yr="1990 - 2009"
Appendix 2.2: Topic Guide Focus group (Service Users)

Focus Group Topic Guide for Patients

Preamble

Thank for agreeing to take part in this focus group.
Introduce the study and aims of the focus group.

1. If you felt that you needed help with low mood, stress or anxiety, what would be the best way that you could be helped? For example:

Who would you want to help you?

Would you prefer to be helped on a one-to-one basis or in a group?
   Why?
If you have received help in the past, could you tell us about your experiences?
Explore good and poor experiences.

How long do you think sessions should last and how often should they be?

What – if anything – is important to you about the therapist / service
provider (e.g. their age, sex, ethnic background)?

Where do you think the help should be provided? Would you prefer a therapist / professional to visit you in your home or would you prefer to go to the doctor’s surgery? Or would you prefer to go to somewhere else in the community, like a community centre? What are the reasons for your preferences?

Could you tell us what the problems are that need to be overcome for you to attend the sessions?

Would transport be an issue for you?

Would it be helpful to have crèche facilities?

2. Have you had any experience of using ‘talking therapies’ in the past? What has been your experience?

Did you find the talking therapies helpful? What was helpful and what was not? How could they have been improved?

Did you find the talking therapies easy to access? If not, why not? How could they have been easier to access?

3. What would you think of a therapist helping you by regularly telephoning you (at set times) or by sending you emails?

Have you heard of computerised cognitive behavioural therapy (CCBT)? Are you interested in / comfortable using CCBT?
4. How would you feel about sessions teaching you how to manage stress, manage low mood or solve problems? Would you be interested in attending a group for these? Would you prefer to be involved on an individual basis?

5. If you were feeling low or stressed would you like to be prescribed some kind of exercise by your doctor / therapist? What would you think about walking or yoga? Would you prefer to exercise as a group or on your own?

6. Is there anything that would encourage you to attend group sessions for support? Would you prefer the participants to be of a similar background / age and have similar problems to yourself?

7. If you were feeling low do you think it would be useful to meet people in a similar situation for social activities or events? What sort of activities would appeal to you? What would specifically attract you and encourage you to attend these sessions?

8. Do you think there would be a stigma attached to participating in any of the sessions or activities we have discussed, and if so how do you think it could be overcome?

Conclusion

Thank for taking part in the focus group.

Leave contact details.
Appendix 2.2: Topic Guide Focus group (Service providers)

Focus Group Topic Guide for Health Professionals

Working with BME Patients

Preamble

Thank for agreeing to take part in this focus group.

Introduce the study and aims of the focus group.

List some of the terms used to describe psychosocial ‘therapies’ / ‘treatments’ / ‘interventions’, and ask participants which they prefer.

Ask them to reflect on their day-to-day contact with BME patients who may be experiencing common mental health conditions…

1. Could you tell us the sorts of problems and challenges you and your colleagues face in responding to the needs of BME patients?

2. In an ideal world, what types of psychotherapeutic / psychosocial interventions would you like to have been able to provide / referred them to?

   Why that treatment in particular? Why do you think it might help?

3. As we said, we are particularly interested in the needs of BME patients who may have common mental health conditions.

   What sorts of difficulties do you think BME patients have in accessing appropriate treatment? How might we overcome this? Prompts - stigmatisation.
4. What sorts of psychotherapeutic / psychosocial interventions do you think might be useful for BME patients with common mental health conditions?

To what extent do you think the following interventions might be useful for BME patients with common mental health conditions?

CBT
Mental health education
Stress management
Problem solving
Why?
Are they available?
Do BME patients seem to find them helpful?
Can you think of anything else?

5. What has been your experience of advising / prescribing exercise? How have BME patients responded? What do you think of the idea of advising / prescribing exercise? Do you think BME patients might be interested in individual or group exercise? Can you think of any specific barriers for BME patients?

6. Thinking about BME patients with common mental health conditions, do you think that group therapies or individual therapies would be most acceptable? Why do you say that?

7. Thinking again about BME patients, do you think that they would prefer to be seen in a medical setting, at home, or in some other community setting? Why do you say that? What do you think might prevent BME patients from accessing services through primary care? What can be done to overcome these obstacles?

8. How do you feel about BME patients receiving support and services by telephone and computer (email)? What do you think about the use of computerized CBT?
(CCBT)? Can you think of other ways in which services could be delivered to BME patients?

Do you think that BME patients would be receptive to treatments delivered in these ways? Why do you say that?

9. The research we have conducted has indicated that social interventions may be useful for BME patients. We are hoping to encourage BME patients to attend group sessions in order to help them overcome the problem of social isolation and to help improve their social networks. What kind of group activities do you think might appeal to BME patients? How can we make the groups as accessible and acceptable as possible?

10. What could we do to encourage BME patients to attend group sessions for therapeutic input and support? Can you think of any specific barriers? How might we overcome them?

11. If we did run group sessions, do you have any suggestions about how they could be evaluated?

For example, do you think it would be useful to record and compare pre- and post-treatment anxiety and depression scores in order to determine whether the intervention has been effective?

12. Would you like to say anything else?

13. Do you have any questions?

Conclusion

Thank for taking part in the focus group.

Leave contact details.
Appendix 2.3: Topic Guides Evaluation Interviews for the Service user

PSI Evaluation (Process): Acceptability; (Access): Care Pathways; Cultural appropriateness.

Interview Schedule

1. Opening

Clarify ethical implications, confidentiality, and consent

Ensure that participants have read and signed the consent form. Emphasise that the data from the interview will be treated in a confidential manner, that they can stop at any point without negative consequence, and ask them if they have any questions.

Explain the AMP programme and the aims of the research

The aim of the AMP programme is to find ways which will make it easier for people to get help for common mental health problems. We want to understand what problems people face in accessing mental health care when they need it. We also want to find the ways to solve and prevent these problems. In other words, we are looking at how to make available the right type of help in the right way, right time and right place. The wellbeing programme, which you (or someone you know) have completed, has been part of our attempt to do this.

Explain the purpose of the interview

We are interested in getting some feedback about people’s experiences of the wellbeing programme that they have either completed personally, or experienced indirectly through a friend, family member or someone they care for. We want to know about what has and what hasn’t worked for people, and try and understand the reasons for this.

Highlight the areas to be covered

I’d like to find out your views on how you found out about the wellbeing programme, why you decided to take part in it, what it was like, and what effects (if any) it has had on you. I’d also like to find out how you have been since you saw [insert name of person who did baseline assessment]. I’d like to know what’s happened since, whether you’ve received any help, if things have improved and whether you’re satisfied with what’s happened.
Invite and answer any questions

I. Discovery
How did you first find out about the programme? Who told you about it?
Were you given a choice about the content of your wellbeing programme?
If so, were given enough information to help you make your choice?
What did you think about how the information was provided? (Probe for suggestions)

II. Engagement
What was it that made you decide to try the programme? (Probe to find about their decision making)
(Try and find out about background/personal circumstances of participant)
Did you have any reservations about taking part? (And how were these overcome?)
What did your friends/family think about it?
Was there anything in particular that made it easier to take part? Did anyone help you?
(Probe about barriers or facilitators towards their decision making. What motivated them?)

2. Views on reasons for accessing the intervention

Examine case notes in advance to establish what particular intervention the participant was offered, and whether they accepted it.

Aim: Participants will have been randomised to either the control or intervention arms. The latter involves a variety of possible options, such as group, individual, or signposting. Explore their opinions about what they were offered.

Those randomised to the intervention arm:

I think you went to see [insert name of Wellbeing facilitator] who did an assessment. How did you find that assessment? Was it easy or difficult to talk about your problem(s)? Did you feel that [insert name of Wellbeing facilitator] was interested in you and understood your problem?
After your assessment/after you saw [insert name of person who did the baseline interview]

Did he/she give you any ideas about help that might be available? What kind of things were you offered?

Did any of them put you off straight away? Why? Did you find anything particularly appealing? Why?

What was it that influenced your decision to choose what you did? Did the facilitator persuade you to try something that you might not have thought of?

Can you talk a bit about [insert name of wellbeing facilitator] the wellbeing facilitator? (How much contact did you have with them? What did you think about their approach? Did you get on with them? Were they friendly? Did you feel that they listened to you properly? And understood what you needed? Did you look forward to seeing them? Do you think seeing the facilitator made you feel better?)

3. Experiences of receiving the intervention

Aim: Encourage the participant to provide a descriptive overview of the programme that they received. Encourage the participant to explore their opinions about the strengths and weaknesses of the programme. Primary areas of questioning: format, delivery, time, and location.

I. Format

How many people were there?

What did you think about the age and the ethnic background of the participants in the group)

What did you do?

Did the sessions change over time or was each one much the same as the rest?

II. Delivery

Who led the sessions?

What did you think of their approach? (Probe about the language, age and ethnic background of the therapist/facilitator?)

III. Time

How did you find the length of each session?
How often were they? (Was that frequent enough/not frequent enough?)

Were you happy with the number of sessions overall?

**IV. Location**

Where did the sessions take place?

Was it easy to get to?

Did you require any special travel arrangements?

**V. Cultural Aspects**

Was there anything in the programme that clashed with your religious views? (Probe about any, and what did they do?)

How is participating in such groups culturally accepted by other members of your society? (Probe about any cultural issues experienced during participation in the programme)

How much do you think that there is stigma attached to mental health?

(Probe about suggestions for changing this: improving on the format, delivery and location of the intervention and cultural appropriateness).

(Probe about the religious and cultural aspects which will *facilitate* participation in such interventions)

**4. Views on outcomes**

**Aim:** Investigate the perceived impacts the intervention has had on those that have taken part.

How do you think that taking part in the wellbeing programme has had an effect on you personally (positive/negative)? Has it helped you? In what ways?

Can you give some examples of this? (Try and relate questions on outcomes to the specific circumstances and wellbeing issues of the individual in question)

Did you enjoy the sessions? Did you look forward to them? Were they better than you anticipated?

How much did you get involved in the activities? How did they meet your needs? Fit with your expectations?

Are you satisfied with what you were offered? Would you recommend it to other people?
Was there anything you didn’t like or would change?

What did you think about how we are measuring the effects of the treatment? (Probe any suggestions for improvement).

5. Closing

**Aim:** Summarise some of the participant’s main thoughts for clarity.

Ask if there is anything else that hasn’t been covered; particularly other suggestions for how the programme could be improved.

Explain the next stages of the programme and how the interview data will be used in relation to them.

Is there anything that you’d of liked me to ask about but I didn’t?

Do you have any further suggestions for how the wellbeing programme could be improved in the future?
Appendix 2.4: Topic Guides Evaluation Interviews for the therapists
PSI Evaluation - Therapists

Interview Schedule

1. Opening

Clarify ethical implications, confidentiality, and consent

Ensure that participants have read the information sheet and signed the consent form. Emphasise that the data from the interview will be treated in a confidential manner, that they can stop at any point without negative consequence, and ask them if they have any questions.

Explain the AMP programme and the aims of the research

The aim of the AMP programme is to find ways which will make it easier for people to get help for common mental health problems. We want to understand what problems people face in accessing mental health care when they need it. We also want to find the ways to solve and prevent these problems. In other words, we are looking at how to make available the right type of help in the right way, right time and right place. The wellbeing programme, which you worked on as a research therapist, has been part of our attempt to do this.

Explain the purpose of the interview

We are interested in getting some feedback about your experiences of working as a research therapist for AMP. We want to know what you think has or hasn’t worked for people, and try and understand the reasons for this.

Highlight the areas to be covered

I’d like to find out how you found out about the wellbeing post, why you decided to apply for it, what you expected it to be like, and what it was actually like. I’d like to know whether you thought that the patients you worked with benefitted from it and how the wellbeing programme might be improved. I’m also interested in the training you had for delivering the wellbeing intervention and the supervision you received.

Invite and answer any questions

Are you happy for me to record the interview?
1. Applying for the research therapist post

How did you first find out about the post of research therapist?
What was it that made you apply for the post?
How does it relate to previous experience and work?
Did you have any reservations about the post?
Were you able to find out enough about the post at your interview?

2. Views on the training

What do you remember about the training you were offered?

Who delivered it?
Was there anything that you found particularly useful?
Was there anything that you thought was unnecessary?

At the time, did you think the training prepared you for delivering the wellbeing programme?
In retrospect, do you think the training prepared you for delivering the wellbeing programme?
How might the training have been improved?

In content
In delivery
3. Delivering the wellbeing intervention

What did/does your role as research therapist involve?

Are there any aspects you found/find particularly rewarding?

Are there any aspects you found/find particularly challenging/frustrating?

To what extent do you feel you’ve been able to meet patients’ needs?

Have there been any particularly difficult areas of need (in general not specific terms)?

What are your views on the wellbeing intervention as a whole?

Views on the individual sessions

Views on the group sessions

Views on the signposting

Was it appropriate for the patients you worked with?

How might the intervention be improved?

How much flexibility did you have in delivering the intervention?

Was that enough/too much/too little?

4. Experiences of supervision

What has been your experience of supervision whilst working as a research therapist?

How does the AMP supervision compare with other experiences of supervision?

Have there been any particularly good/helpful aspects of supervision?

Have you any suggestions for improving the supervision?
5. Other areas

Did you feel you had enough knowledge of the AMP research programme as a whole?

Could you see how your specific work fitted in?

Did you have enough knowledge of the wider AMP team?

6. Closing

Do you have any further suggestions for how the wellbeing programme could be improved in the future?

Do you have any further suggestions for how the training for therapists could be improved?

Do you have any further suggestions for how the supervision for therapists could be improved?

Is there anything that you’d like me to have asked about but I didn’t?

Explain the next stages of the programme and how the interview data will be used in relation to them.

Thank participant for their time and their contribution
Appendix 2.5: Psychosocial Intervention Information sheets
(Bangla)
আমাদের দিন দিনে চাআলের জল্লির অংশীদারিত্ব প্রদর্শন করা নিয়মিত করা হয় তবে আংশিকতার ক্ষেত্রে ঐতিহ্য থেকে তাদের অংশীদারি নির্দেশনায় একটি বিশেষ করণ করা হয়। বিভিন্ন অংশীদারি তাদের অংশগ্রহণ করার জন্য একটি প্রয়োজন হয় না। এর সম্পর্কে আমাদের সকলের জন্য একটি পর্যালোচনা করা হয়।

এই অনুমানের অন্তর্ভুক্ত হলো আ十二五 প্রণয়নের সাক্ষরতা করার জন্য আমাদের সময় সময় প্রতিস্পর্ধায় অংশগ্রহণ করার জন্য। আমরা আমাদের সমস্ত সময় সময় প্রতিস্পর্ধায় অংশগ্রহণ করার জন্য আমরা সময় সময় প্রতিস্পর্ধায় অংশগ্রহণ করার জন্য।

এই অনুমানের অন্তর্ভুক্ত হলো আ十二五 প্রণয়নের সাক্ষরতা করার জন্য আমাদের সময় সময় প্রতিস্পর্ধায় অংশগ্রহণ করার জন্য। আমরা আমাদের সময় সময় প্রতিস্পর্ধায় অংশগ্রহণ করার জন্য।

এই অনুমানের অন্তর্ভুক্ত হলো আ十二五 প্রণয়নের সাক্ষরতা করার জন্য আমাদের সময় সময় প্রতিস্পর্ধায় অংশগ্রহণ করার জন্য। আমরা আমাদের সময় সময় প্রতিস্পর্ধায় অংশগ্রহণ করার জন্য।

এই অনুমানের অন্তর্ভুক্ত হলো আ十二五 প্রণয়নের সাক্ষরতা করার জন্য আমাদের সময় সময় প্রতিস্পর্ধায় অংশগ্রহণ করার জন্য। আমরা আমাদের সময় সময় প্রতিস্পর্ধায় অংশগ্রহণ করার জন্য।
AMP: Improving Access to Mental Health in Primary Care

The AMP initiative is a comprehensive approach to improving access to mental health services in primary care settings. It involves a multi-faceted approach that includes the following key components:

1. **Enhanced Training for Healthcare Providers**: Providing ongoing training and education for healthcare providers to improve their skills in recognizing and managing mental health conditions.
2. **Mental Health Screening Tools**: Developing and implementing screening tools to identify mental health issues early.
3. **Referral Systems**: Establishing robust referral systems to link patients with appropriate mental health services.
4. **Community Engagement**: Involving community members in the design and implementation of mental health programs.
5. **Technology Integration**: Utilizing technology to improve communication and access to mental health services.
6. **Quality Improvement Strategies**: Implementing quality improvement strategies to enhance the effectiveness of mental health services.

The AMP initiative aims to address the current barriers to mental health care, such as stigma, lack of access, and inadequate training, by creating a more integrated and responsive mental health system in primary care settings.

Advancing Mental Health in Primary Care

The AMP initiative is a collaborative effort involving a network of healthcare providers, community leaders, and mental health experts. The initiative is supported by funding from various government bodies and private organizations.

The AMP initiative has shown promising results in improving mental health outcomes for patients. It has been adopted by several primary care networks across the country, leading to increased awareness and better access to mental health services.

Conclusion

The AMP initiative represents a significant step towards improving access to mental health care in primary care settings. With continued support and implementation, it has the potential to transform the way mental health care is delivered, leading to better outcomes for patients and communities alike.
AMP Improving Access to Mental Health in Primary Care

Why are we doing this?

We are doing this because of the increasing demand for mental health care in primary care. The number of patients seeking help for mental health issues is rising, and primary care professionals are recognizing the importance of providing effective and accessible mental health services.

Who is involved?

This project involves a multidisciplinary team, including psychiatrists, psychologists, nurses, and primary care doctors. The project is led by the AMP team at the University of Liverpool, with support from partners in Primary Care Trusts in Manchester and Liverpool.

What will we achieve?

The project aims to improve access to mental health care in primary care by developing and implementing innovative models of care. The long-term goal is to reduce waiting times for mental health services, increase patient satisfaction, and improve mental health outcomes for patients.

How can you help?

If you are a primary care professional and interested in participating in the project, please contact the AMP team at the University of Liverpool.

http://www.liv.ac.uk/amp/project.htm

Contact Information:

The AMP team at the University of Liverpool
0151 208 7726
email: gabrielle.marr@liverpool.ac.uk

Ms Gabrielle Marr, BA Hon, MBA, Research Governance and Development Manager
Tel: 0151 208 7726; email: gabrielle.marr@liverpool.ac.uk

The project is funded by the National Institute for Health Research (NIHR) and the Department of Health.
Appendix 2.5: Psychosocial Intervention Information sheets
(English)

AMP Programme:
Increasing Equity of Access to High-Quality Mental Health Services in Primary Care

Participant Information Sheet for People from Black and Minority Ethnic Groups

Study title: AMP PSI – Wellbeing Programme

Invitation

You are being invited to take part in a research study. Before you make a decision it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

Patients with low mood or stress may benefit from a wellbeing programme designed specifically for people from black and minority ethnic communities. The main aim of the study is to explore the potential benefit of trained advisors offering personalised wellbeing plans. We will also evaluate whether people find these types of services acceptable. Another aim of the study is to enhance patients’ coping skills and self-management strategies by encouraging the development of informal support networks.
Why do you want me to take part?

You have been chosen because you may currently be experiencing low mood or stress, and you are registered with one of the GP practices that are helping us with this research project.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

If you agree to take part in the study, we will ask you some standard questions about symptoms of anxiety and depression. We will also ask you about yourself, including your age, education and personal circumstances (although it is OK for you to choose not to complete these questions). If you have symptoms of anxiety or depression you will be allocated to one of two groups. Sometimes, because we do not know which way of providing care is best, we need to make comparisons. We do this using a randomised controlled trial (RCT) where people are put into groups and then compared. The groups are selected by a computer which has no information about the individual – i.e. by chance. In our case there are two groups, those receiving personalised well-being plans and those receiving usual care.

If you are chosen to be in the usual care group, you will receive everything you would have received if you had not taken part in the study. In addition, we will be monitoring the effects of your care.

If you are selected to be in the group receiving a personalised wellbeing plan you will be allocated a case manager who will offer you a range of interventions. You
will have a choice about whether to take part in individual sessions, group sessions or other types of activities. Separate groups will be held for men and women. You will develop the plan together and you will keep the plan. You will set goals and targets and you will meet with your case manager on at least 3 occasions over a 4 month period so that the case manager can offer help and support if you are having any problems. All interventions provided by the study will be free of charge.

Regardless of which group you are in, we will visit you again around 20 weeks from our initial visit. This is to see how you are by asking further questions about symptoms of anxiety and depression.

If you agree to take part in the study we may also ask you to take part in an interview. About 100 patients are likely to take part in this study; of these we will select 30 patients for interview. The aim of the interview is to discuss your experiences of the wellbeing programme. Interviews will take approximately 60 minutes, and will be held at a time and place convenient for you. If you are invited to take part in an interview the researcher will explain the aim of the interview and give you an opportunity to ask questions. The interviews will be audio-recorded and transcribed. We may wish to use anonymised direct quotations from the interviews in research presentations and publications. You will have time to consider if you wish to take part in one of these interviews. If you agree to take part you will be asked to complete a consent form. You are not obliged to take part in the interview and you will have the opportunity to opt out at any stage. Any expenses incurred in taking part in these interviews will be reimbursed.

**What are the possible benefits of taking part?**

We hope that your mood and sense of wellbeing will improve whichever group you are allocated to. The information will help us to improve healthcare services in the future for people who need help with regards to their mood and wellbeing.

**What are the possible side effects of the wellbeing programme?**

Patients in the wellbeing group may be asked to take part in activities that they do not usually do. However, the case manager will be available to support you. They
will also be able to offer assistance with child care and interpreters. Being part of the usual care group does not have any side effects either.

What if something goes wrong?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone’s negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

Will my taking part in this study be kept confidential?

If you consent to take part in this project, any of your medical records may be inspected by the researchers for purposes of analysing the results. Your name, however, will not be disclosed outside your GP practice. All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves the GP practice will have your name and address removed so that you cannot be recognised from it.

What will happen to the results of the research study?

The results will be summarised and presented both at medical conferences and through scientific publications in medical, nursing and psychology journals, so health professionals can learn more about the results of our study. At the end of the study you will be provided with a copy of the findings, and invited to attend a presentation meeting to discuss the findings in person with us (we will cover your travel expenses for this). You will not be identified in any report or publication.

Who is organising and funding the research?
The study is being supported by the National Institute for Health Research (NIHR). The study is organised by the University of Liverpool, the University of Manchester, Liverpool PCT and Manchester PCT.

**Who has reviewed the study?**

External reviewers in England and the United States have reviewed the research quality of this study. It has also been reviewed by North West 6 Research Ethics Committee – Greater Manchester South, and been given ethical approval.

**Who knows about the research?**

The researchers who conduct the research are not involved in your health care. Your doctor will be informed about your participation in the study. We will only disclose and act on personal information in certain very specific circumstances: where there is sufficient evidence to raise serious concern about your safety or the safety of others.

**You can learn more about this research study, and the people who are conducting it, by contacting us on the numbers listed below, or by visiting our website:**

http://www.liv.ac.uk/amp/project.htm

**AMP contact details**

Maxine Martin, Research Administrator – Liverpool

0151 794 5607 amp@liv.ac.uk

Naomi Wells, Research Administrator – Manchester

0161 275 1870 amp@liv.ac.uk

**IF YOU HAVE ANY COMPLAINTS ABOUT THIS RESEARCH, PLEASE CONTACT:**

Ms Gabrielle Marr, BA Hons MBA, Research Governance and Development Manager

Tel: 0151 296 7726; email gabrielle.marr@liverpoolpct.nhs.uk.
Appendix 2.5: Psychosocial Intervention Information sheets (Urdu)
کچھ لوگ کے مطابق یہ کام غیر معمولی ہے یعنی جو اب کسی کا کوئی مخصوص دریافت نہیں ہے۔ کچھ سنیات کا کام دیکھا جا سکتا ہے کہ یہ کام انہیں کیا ہے، لیکن اس کے ساتھ ایک مخصوص اوریہ کیسے کام کیا جائے۔

ایک روز کی معاشقہ کے ساتھ ایک بات ہے کہ یہاں کیسے کام کیا جائے۔ روز 292 کے ساتھ ایک اور اترتی کیسا ہے۔

ایک روز کے ساتھ ایک ہم کیسے کام کیا جائے۔ روز 292 کے ساتھ ایک اور اترتی کیسا ہے۔
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Ms Gabriele Marr, BA Hon MA, Research
Government and Development Manager
Tel: 0151 296 7726;
Email: gabriele.marr@liverpoolcic.nhs.uk
Appendix 2.5: Psychosocial Intervention Information sheets (Health Professionals)

AMP Programme:
Increasing Equity of Access to High-Quality Mental Health Services in Primary Care

Information Sheet for Health Professionals

We would like to invite you to take part in a consultation meeting to give your opinion on our proposed methods to enable a wider range of patients to access psychosocial interventions, and to help to make these interventions more acceptable. Please let us know if you have any queries about the information provided here.

The research
The AMP programme is a collaborative study, funded by the National Institute for Health Research, which is exploring ways to help a wider range of patients obtain the services they need to improve their mood and wellbeing, such as psychosocial interventions. Following a year-long consultation period with service users and providers, we now wish to seek your views on our proposed intervention to improve access and acceptability.

Participation
If you decide to take part in this consultation meeting you will be asked to sign two copies of a consent form (one of which you can retain).

Procedure
We intend to arrange the consultation meeting at a time and place that suits you. The participants will be health professionals, like you, who work with patients with
common mental health conditions; two or three researchers will also be present to facilitate the meeting and to take recordings. It is anticipated that the meeting will last for up to an hour. We intend to audio-record the event to help with note-taking; this will enable us to attend to what people are saying.

**After the consultation meeting**

The information obtained from the session will be stored in locked cabinets within the university. Only the researchers will have access to this material. We will type up the recordings, and the material will be stored on password-protected computers. We will change your name and any others names you mention to protect your identity. If we use any extracts from the session in any subsequent research reports it will not be possible to identify the source of the quotes. We will erase the audio-recording when the research has been completed, in accordance with NHS best practice guidelines.

**Benefits of participation**

We anticipate that the study will help (health professionals to help) a wider range of patients gain access to high-quality, acceptable psychosocial interventions through primary care.

**Review**

External reviewers appointed by the National Institute for Health Research have reviewed the research quality of this study. It has also been reviewed by Liverpool Research Ethics Committee, and been given ethical approval.

Further details on this research study are available from those listed below, or from our website: [http://www.liv.ac.uk/amp/project.htm](http://www.liv.ac.uk/amp/project.htm).
Researcher contact details:

Dr Carolyn Chew-Graham, Principal Investigator
Tel 0161 275 1868; email amp@liverpool.ac.uk

Dr Suzanne Edwards, Senior Research Fellow
Tel. 0151 794 5066; email amp@liverpool.ac.uk

Dr Heather Burroughs; Research Fellow
Tel. 0161 275 1876; email amp@liverpool.ac.uk

Mrs Saadia Aseem, Research Assistant
Tel. 0161 306 6819; email amp@liverpool.ac.uk

Ms Pam Clarke, Research Assistant
Tel. 0151 794 5611; email amp@liverpool.ac

If you have any concerns or complaints about this research, please contact:

Ms Gabrielle Marr, BA Hons MBA, Research Governance and Development Manager
Tel: 0151 296 7726; email gabrielle.marr@liverpoolpct.nhs.uk.
Appendix 2.6 Evaluation Interviews Consent forms (English)

AMP Programme:
Increasing Equity of Access to High-Quality Mental Health Services in Primary Care

Consent Form
AMP PSI – Wellbeing Programme

Please initial each box

1) I confirm that I have read and understood the Participant Information Sheet - BME Patient v3 dated 20.08.2010 / Participant Information Sheet - Elder Patient V2 dated 03.03.2010 (delete as applicable) and have had the opportunity to ask questions.

2) I understand that my participation is entirely voluntary and that I am free to withdraw at any time without my medical or legal rights being affected.

3) I understand that sections of any of my medical notes may be looked at by responsible individuals from the research team or from regulatory authorities where it is relevant to my taking part in research.

I give permission for these individuals to have access to my records.
4) I understand that if I will withdraw from the study, information collected up to the point of my withdrawal will still be used

5) I agree to take part in the above study.

6) If I am invited to take part in an interview, I am willing for the interview to be recorded and transcribed.

7) If I am invited to take part in an interview, I am willing for anonymised direct quotations to be used in research presentations and publications

_________________    ___________    __________________
Name of Participant      Date            Signature

_________________    ___________    __________________
Name of Researcher       Date            Signature
Appendix 2.6: Evaluation Interviews Consent forms (Therapists)

AMP Programme:
Increasing Equity of Access to High-Quality Mental Health Services in Primary Care

Consent Form
Therapist Interviews

*Please initial each box*

8) I understand that my participation is entirely voluntary and that I am free to withdraw at any time without obligation or any of my rights being affected.

2) I give my permission for the interview to be audio-recorded.

3) I give my permission for the interview to be transcribed.
4) I agree that anonymised quotes from the interview can be used in publications.

5) I agree that the anonymised written record of my contribution may be kept and used in future research projects.

6) I agree to take part in the above study.

_________________  ___________________  ___________________
Name of Participant  Date                  Signature

_________________  ___________________  ___________________
Name of Researcher  Date                  Signature

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AMP Programme:
Increasing Equity of Access to High-Quality
Mental Health Services in Primary Care

Consent Form
AMP PSI - Well-being Programme

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