Understanding barriers and facilitators to accessing IAPT for people on low incomes.

Zaneta-Eleni Melissourgaki

A thesis submitted in partial fulfilment of the requirements
of the University of East London
for the degree of Professional Doctorate in Clinical Psychology

May 2023

ACKNOWLEDGEMENTS

I would firstly like to thank participants in this study, for sharing their experiences with me. Thank you also goes to those who offered their thoughts and suggestions as part of shaping this project.

I would like to express my gratitude to my supervisor, Dr. Lorna Farquharson, for her steady guidance and her support throughout the process. The careful balancing act between structure and flexibility was just what I needed to navigate this project. I am also grateful to Dr. Zoe McAndrews, my last supervisor as an Assistant Psychologist, for insisting that I apply for the DClinPsy, when I thought I did not stand a chance.

I would also like to thank some very important people in my life for their continuous support. My parents, who instilled in me the values of learning and perseverance – this work is also yours. My sister, for her smile and unwavering encouragement when sticking to these values feels hard. My friends, for their patience over the past few months (or years). And finally, my partner. Thank you for moving to London with me and for always being by my side. I cannot wait for where the journey takes us next.

ABSTRACT

Low-income communities have a poorer experience of care in Improving Access to Psychological Therapies (IAPT) services. This study explored: a) how IAPT referral and treatment rates have changed for people on low incomes after Covid-19 (Study 1); b) barriers people on low incomes face in accessing IAPT and what could facilitate access (Study 2). The study thus comprised two parts. Study 1 used national data on IAPT referrals received during 2018-2022 (*N* = 6,544,536). The treatment access rate, access gap and completion rate were calculated for each socio-economic group, separately for each year. Outcomes between those most and least deprived were compared using chi-square tests. Associations between time of measurement (pre/post-pandemic), level of deprivation and treatment access or completion were explored using log-linear analyses. Study 2 involved semi-structured interviews with people on low incomes who had not accessed IAPT (*N* = 5). Data were analysed using Thematic Analysis. Study 1 suggested that IAPT referrals decreased during Covid-19, but more so for the most deprived group; referrals exceeded pre-pandemic levels in 2021-2022. Treatment access and completion improved during Covid-19, however the most deprived group benefited less. The gap between those most and least deprived has widened after Covid-19 regarding treatment access and completion. Study 2 identified three themes: 1) Navigating the system; 2) Us and Them; 3) Perceived mismatch between needs and available support. The findings of the two studies are discussed separately and in conjunction, with reference to the literature on IAPT and the experiences of people on low incomes in psychological services. It is argued that IAPT services need to attend to the socio-economic context within which mental health difficulties occur and consider their relevance for low-income communities, given the number of low-income individuals who do not access the service and widening inequalities in treatment access and completion following Covid-19.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

A&E	Accident and Emergency
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CP	Clinical Psychology
DOH	Department of Health
DWP	Department for Work and Pensions
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
ICL	Inverse Care Law
IMD	Index of Multiple Deprivation
JRF	Joseph Rowntree Foundation
MH	Mental Health
NCCMH	National Collaborating Centre for Mental Health
NHS	National Health Service
NHSE	NHS England
SU	Service User
SUGAR	Service User and Carer Group Advising on Research
TA	Thematic Analysis
UEL	University of East London
UK	United Kingdom
UN	United Nations
WHO	World Health Organisation

LIST OF TABLES

LIST OF FIGURES

1. INTRODUCTION

The chapter begins by discussing inequalities in access to health care in the context of the values and obligations derived from a human rights-based framework and the National Health Service (NHS). Poverty is examined, as a major factor driving health inequalities. Different definitions are explored, alongside societal discourses and the current situation in the United Kingdom (UK). The chapter focuses on the link between poverty and mental health (MH) and its implications for service use. Inequalities in access to psychological services for low-income communities are highlighted. A review of the literature is summarised to describe the experiences of people on low incomes in Improving Access to Psychological Therapies (IAPT) services. The chapter ends with the study's rationale and research questions.

1.1. Health And Access To Care

1.1.1. The Right To Health And Health Care

The concept of the right to health originated in the Universal Declaration of Human Rights (1948), a set of standards developed after World War II, accorded to all human beings by virtue of being human. Article 25 specifically addressed health in relation to the right to adequate life standards. Building on this, the United Nations International Covenant on Economic, Social and Cultural Rights (1966) recognised the right to health as "the enjoyment of the highest attainable standard of physical and mental health". It thus articulated the right to health as an independent yet inclusive right, which extends to life conditions and affords entitlements, including an equal opportunity to access good quality care (Sen, 2008).

Despite limitations in the enforceability of health as a human right (Wiles, 2006) and its omission in key legal instruments, including the Human Rights Act (1998), the human rights paradigm has been invaluable in discussions around health and access to care. First, it adopts a broad definition for the right to health, bringing attention to social determinants (e.g., income) and places health in a complex constellation of rights and needs (Sen, 2008). Moreover, the state is held responsible for addressing inequalities and systematic disparities in health outcomes and access to care (World Health Organisation [WHO], 2018). Lastly, and importantly for this research, a human rights framework links health to access to care, with equity of access emerging as a core principle (San Giorgi, 2012).

In the UK, the conceptualisation of the right to health care was advanced by the establishment of the NHS, the largest publicly funded health system worldwide (Rosso et al., 2021). By creating the NHS, the National Health Service Act (1946) promoted health care from a social aid to a state obligation (Saleh, 2013) and from a privilege to a right for citizens (Redhead et al., 2022). Since its inception, the NHS has aspired to provide comprehensive care, free at the point of access, based on need and independently of ability to pay. Providing a service “available to all” is a key principle in the NHS constitution, guiding the service and all its work (Department of Health and Social Care, 2012). Commitment to this idea has oscillated over the years. However, despite multiple NHS reforms and restructures, providing free care for all survives as a basic tenet.

Discussions around health care in the UK have thus been informed first by the human rights paradigm, as established in United Nations (UN) conventions ratified by the UK and codified in regional and local law. Next, the creation of the NHS as a universal health service has reinforced the link between health and access to care and public expectations that the state delivers adequate health services. Lastly, beyond statutory obligations, the values of interdependence and solidarity and the notion of a shared social obligation have made access to care a matter of public concern in the UK (Redhead et al., 2022). The vision of health care “for all” is the common thread through these three layers of protection, a vision revitalised as evidence on health inequalities has entered public discourse.

1.1.2. Not For All, After All: Health Inequalities

Despite the vision for universal health care, state bodies, independent organisations and cross-disciplinary research have exposed pervasive health inequalities. These are systematic disparities between groups of people, in terms of health status and the distribution of health resources, based on social determinants including one's socioeconomic position, education, employment and income, as well as characteristics like gender, sexuality and ethnicity (WHO, 2018).

Despite some conflicting findings, there is little doubt that such factors powerfully shape people’s health, their chances of becoming ill and their life expectancy (Braveman & Gottlieb, 2014; Elwell-Sutton et al., 2019). Years after the landmark Black report (1980) and the Acheson inquiry (1998), the work of Marmot et al. (2010; 2020) has unveiled social patterns in the distribution of health in the UK. The researchers demonstrate that the lower one’s social position, the worse their health outcomes, with inequalities evident in mortality, morbidity, self-reported health, MH and life expectancy.

Differences in health outcomes in turn determine the level of healthcare need. This is reflected in healthcare delivery, including both the distribution and use of health resources. Examining healthcare delivery, Tudor-Hart (1971) observed that health resources were less available and of lower quality in areas of greater need, with those most likely to need care less likely to receive it. Tudor-Hart’s Inverse Care Law (ICL) has since gained further support and significant nuance. Cookson et al. (2021) suggested that in countries like the UK, the distribution of health resources remains inversely correlated to social disadvantage not in absolute but in relative terms, when disparities in healthcare need and illness prevalence are considered. Healthcare use also increases among disadvantaged groups, in line with prevalence rates but not proportionately to need (Ford et al., 2022).

It is noted that determining healthcare need is methodologically challenging (Pulok et al., 2020) and that data on healthcare use largely assume that one can access the care they need, which is contestable (McKee et al., 2012). It is also acknowledged that the language of social determinants is conceptually ambiguous (Regidor, 2006), potentially implying that such factors are linearly related to health; an intersectional lens (Crenshaw, 1989) is instead crucial. Characteristics like race and gender combine to create interactive and multiplicative disadvantages, in the context of patriarchy, heteronormativity, racism and ageism (Brown et al., 2016). The language of social determinants may also obscure the role of power in shaping health outcomes (Braveman & Gottlieb, 2014) or understate how the actions or omissions of those in power perpetuate inequality (Sharma et al., 2018).

1.1.3. The Policy Context

Health inequalities reflect shortcomings of the NHS as a universal healthcare system (Redhead et al., 2022). Equality nevertheless remains a key policy goal, with the NHS seen as pivotal in reducing health inequalities in the UK (Watt, 2018). For example, the Department of Health (DoH) published a Programme for Action on Tackling Health Inequalities in 2003, a commitment renewed with the Health Inequalities: Progress and Next Steps report (2008) and the Health and Social Care Act 2012. Public Health England was established with the mandate to reduce health inequalities and was later replaced by the Office for Health Improvement and Disparities, to continue that mission. The NHS Long Term Plan (2019) embeds equality in service planning and delivery, by tying funding with a requirement for local areas to address health inequalities.

Despite a “disconnect between the rhetoric of addressing health inequalities and the reality of health care where it is needed most” (Watt, 2018, p. 563), the pandemic has brought new visibility to the impact of health inequalities (Buzelli et al., 2022). Covid-19 has been exacerbated by the synergistic forces of structural and social inequalities, has disproportionately affected marginalised groups, and has thus been named a syndemic (Bambra et al., 2020). The Health and Care Act 2022 echoes the experiences and lessons learnt from Covid-19, by prioritising action to reduce health inequalities, with disparities in access to care as a target area.

1.2. On Poverty

The literature on health inequalities exposes poverty as significantly impacting people’s health outcomes and access to care. This section focuses on poverty as a construct. Poverty is understood as a “wicked problem” (Rittel & Webber, 1973): multidimensional, convoluted and elusive. It encompasses different factors, processes and experiences and remains difficult to formulate and comprehend. This section does not aim to provide a conclusive definition or claim to diagnose the problem’s root causes. Instead, the complexity is acknowledged and embraced.

1.2.1. Definition And Terminology

Defining poverty has been a contested issue, challenging researchers, policy makers and interest groups. Various ways of defining and measuring poverty have been introduced, reflecting occasionally conflicting attempts to balance specificity and reductionism; one may be deemed poor under one definition but not poor under another, although their conditions or experiences remain identical. An intersectional lens (Crenshaw, 1989) is essential, as factors like gender, race or disability interact, producing cumulative disadvantage and financial insecurity (Maroto et al., 2019).

A basic definition is that of absolute poverty, representing a form of minimum subsistence (Bellù & Liberati, 2005). This refers to lacking the means to meet basic needs, like food and shelter, based on Rowntree's (1902) observation that survival requires a minimum income. Relative poverty, on the other hand, considers one's standard of living in relation to others (Decerf, 2021), building on Townsend's (1979) definition of poverty as the inability to meet the life conditions deemed ordinary in each society. Relative poverty is context-specific and varies between different societies and over time, such that relative poverty in one society constitutes relative affluence in another society or at a different time (Bellù & Liberati, 2005).

Other poverty measures attempt to capture its multidimensionality, beyond income. For example, the Index of Multiple Deprivation (IMD) combines income indicators with measures of education, employment, health and disability, neighbourhood crime, access to housing or services and quality of one's living environment (McLennan et al., 2019). These dimensions are combined into an area-level indicator, which produces a ranking and allows between-area comparisons. Official publications often use IMD deciles, representing 10 equal groups of varying deprivation. IMD thus builds on income-based measures of relative poverty, by articulating deprivation as an accumulation of disadvantage. The human-rights framework also espouses a multidimensional approach to poverty (Sengupta, 2010) and has contributed to a broader understanding of the experiences it encompasses.

Finally, income inequality has taken centre stage in debates around poverty, (Wilkinson & Pickett, 2010). Relative poverty is inherently related to income inequality: when income inequality increases, relative poverty follows (Bellù & Liberati, 2005). Inequality, however, is also a social experience (Prowse, 2007).

Social class is relevant here and remains influential in British society (Rickett et al., 2022). Social class refers to one's socio-economic status including occupation, family education, neighbourhood background, but also the interplay between one's economic, social and cultural capital. Hagan and Smail (1997) argue that class colours everything one does, from how they speak to who they know. Importantly, class operates symbolically, assigning individual value and reinforcing comparisons between different groups (Savage et al., 2013). Although many subcategories have been suggested, a common distinction is made between upper, middle and working classes, with poverty associated with the latter.

1.2.2. Societal Discourses

How poverty is defined shapes its understanding and guides remedial action, as the "what points to the why, which informs the how" (Nyasulu, 2010, p.147). Alongside divergent definitions, societal discourses have informed relevant policy as well as public attitudes towards those in poverty (Chung et al., 2018), and have impeded consensus on how poverty can be tackled (Shildrick & Rucell, 2015).

A major point of division relates to balancing individual agency and the impact of social structures. Low-income individuals are often castigated for personal choices seen to perpetuate their life circumstances, as poverty is reduced to moral failings, a rejection of available support or "fecklessness" (Shildrick & Rucell, 2015). These assumptions construct an artificial "culture of poverty" (Lewis, 1961) seen as leading to disengagement and hostility towards the state and its institutions. In a framework that individualises culpability, people are held responsible for bringing poverty on themselves, shamed for personal failures and deemed undeserving of support.

Individualised accounts of poverty undermine efforts to tackle it. For instance, the idea of "intergenerational cultures of worklessness", an assumed rejection of employment opportunities bestowed across generations, has been used to justify welfare reforms (MacDonald et al., 2014). The discourse of worklessness and welfare dependency and the emphasis on promoting work re-emerged in the UK after the 2008 financial crisis (Pantazis, 2016), are reignited during recessions (McArthur & Reeves, 2019) and remain influential, as evidenced by the 2022 Growth Plan (HM Treasury, 2022). This is despite the lack of evidence that there are families or communities fostering idleness (MacDonald et al., 2014). In fact, in-work poverty is at an all-time high (Joseph Rowntree Foundation [JRF], 2022) and the UN has reprimanded the UK for its in-work poverty rates (Alston, 2018).

When low-income communities are discussed sympathetically, poverty is not contextualised and power structures not interrogated (Bullock et al., 2001). Structural factors determining the distribution of wealth are omitted and accounts about poverty remain superficial and uncritical (McKendrick et al., 2008). The focus is often on prevalence, with little consideration of policies and political choices that create or aggravate the situation (Barr et al., 2015). Factors which correlate with poverty, like family breakdown and poor education, are artificially attributed a causal role, with other factors, like low pay, omitted (Pantazis, 2016). The myth of meritocracy persists (Shildrick & Rucell, 2015), with limited acknowledgement of the intergenerational cycles of disadvantage (Lillywhite, 2022). Accounts disrupting such suppositions are marginalised (Tranchese, 2019).

It is the non-poor, Lister (2004) argues, that shape societal discourses around poverty, constructing “the poor” as “other”. This process of othering operates through extensive classification of population groups, by stereotypically presenting groups of people as homogenous, and through stigmatisation, such that poverty becomes associated with shame; poverty as a term is often unwelcome by those experiencing it (Thomas et al., 2021). This “us and them” approach, Bacchi (2009) added, undermines social relations and the effectiveness of relevant governmental policy.

1.2.3. Poverty In The UK: The Current Situation

Official poverty rates in the UK employ measures of disposable household income, differentiating between households in relative low income (below 60% of the median) and those in absolute low income, adjusting the median for inflation (Francis-Devine, 2023). In April 2023, one in six people in the UK were in relative low income, a number rising to one in five when housing costs are considered. This represents approximately 14.4 million people, with families from racialised communities, single-parent families, families with a person with disability and families with three or more children more likely to be affected (JRF, 2021). This is despite the UK being one of the most prosperous countries in the world (International Monetary Fund, 2023) and reflects high levels of income inequality (Gornick, 2022).

Multiple factors contribute to bleak forecasts for the future: Brexit and its effect on low-income households through changes in tax revenues, product prices and real wages (Cambridge Econometrics, 2018); a global pandemic disproportionately affecting marginalised groups (McGowan & Bambra, 2022); high energy and food prices following the war in Ukraine, particularly affecting low-income families, who spend a larger proportion of their budget on energy and food (Francis-Devine, 2023); soaring inflation devaluing real-term income, savings and benefits (Corlett & Try, 2022); years of welfare reforms intensifying food insecurity (Sosenko et al., 2022). The number of people in poverty is therefore forecasted to rise, with 800,000 more people expected to be in absolute low income in 2023-2024 (Brewer et al., 2023).

Socio-economic disadvantage has recently regained political interest in the UK. Already present during the Brexit referendum (Tomaney & Pike, 2020), the language of “levelling up” dominated the 2019 election. It featured in the programme of the Conservative party, which promised support for communities left behind. Covid-19 further accentuated social inequalities (McCay, 2022). The government responded with the Level Up Unit and a Levelling Up White Paper (2022) and by directing further funding to the cause. The Build Back Better policy paper (2022) followed, professing the government’s determination that recovery from Covid-19 be felt equally by all. Whether propelled by electoral gains or a sincere commitment to remedying inequality, “levelling up” remains socio-politically prominent, as evidenced by the Conservative party’s 2022 leadership contest. Health, including MH, is central in the “levelling up” agenda (Davey et al., 2022); deprivation was named one of “the most pervasive and apparent MH inequalities” in the Advancing Mental Health Equalities Strategy (NHSE, 2020, p.20). This connection is further explored below.

1.3. Poverty And Mental Health

1.3.1. A Well-Established Link

Decades of research have exposed a socio-economic gradient in MH, with MH problems unequally distributed across the population. Poverty has been linked to higher prevalence rates for MH difficulties across the spectrum of severity. People living in poverty are more likely to report lower subjective wellbeing, stress and low mood (Friedli, 2009) or be diagnosed with an anxiety disorder or depression (Meltzer et al., 2013); 25% of people receiving these diagnoses are estimated to struggle financially (Acton, 2016). Diagnoses of psychosis or bipolar affective disorder are also more prevalent among those who have experienced greater neighbourhood disadvantage in childhood (Hastings et al., 2020), with increased rates of psychotic symptoms in low-income populations (Pomerantz, 2003). Furthermore, rates of post-traumatic stress disorder (Meneses et al., 2021), substance misuse (UK Drug Policy Commission, 2012) and suicide (Kerr et al., 2017) are higher in low-income groups.

Although often studied independently, these presentations may be experienced simultaneously, particularly among people in poverty (Reisinger-Walker & Druss, 2017) and there is evidence to suggest that MH problems are more severe for those on low incomes in cohorts of people with the same diagnosis. Low socio-economic status has been associated with more severe depressive symptoms (Iob et al., 2020) and self-reported anxiety (Generaal et al. 2019), poorer functioning in people with a schizophrenia diagnosis (Amoretti et al., 2021) and more recurrent depressive episodes in people diagnosed with bipolar disorder (Schoeyen et al., 2011).

Relevant to severity is duration, with some evidence that MH problems persist more for those socio-economically disadvantaged. For example, people with lower socio-economic status experience depression earlier in life (Agerbo et al., 2021) and have more depressive episodes in their lifetime (Joinson et al., 2017), with each episode lasting longer (Gilmer et al., 2005). Poverty and unemployment have also been reported to increase the duration of episodes of anxiety (McManus et al., 2016) and evidence suggests that people spend more time off work for MH concerns in more deprived areas (Gabbay et al., 2015).

The association between poverty and MH difficulties, Belle (1990) argued, is “one of the most well established in all of psychiatric epidemiology” (p. 385), emerging in longitudinal (Kim et al., 2015) and cross-sectional studies (Smith et al., 2020); national (Mangalore et al., 2007) and cross-national comparisons (Lund et al., 2010); countries as diverse as the UK, China, South Africa, India and Ecuador (WHO, 2014); using measures of income rank (Collishaw et al., 2019), income inequality (Pickett & Wilkinson, 2015), relative deprivation (Smith et al., 2020) or composite indices (Skapinakis et al., 2005). It is noted, however, that there are some mixed findings regarding specific poverty indicators, like income or class (Lund et al., 2010); different indices are discussed above, in line with a multidimensional understanding of poverty. While the terminology in this section matches that of the studies cited, it is acknowledged that summarising relevant findings along the lines of prevalence and severity potentially reifies psychiatric diagnoses and mislocates problems within individuals; retaining a contextual framework is crucial.

1.3.2. Disentangling The Nexus

Despite the strong link between poverty and MH problems, the nature and direction of the relationship remains undetermined. Important factors involved are considered.

1.3.2.1. *Which comes first? Two hypotheses*: A central debate is that between the social causation and the social selection hypothesis (Mills, 2015), both seeking to answer a fundamental question about the relationship between poverty and mental ill health: which comes first? The social causation hypothesis attributes a causal role to poverty, suggesting that the associated socio-economic conditions lead to MH difficulties. Joffe (1988) named poverty “the cause of the causes” of distress (p. 57); many have agreed on this direction of influence (Hudson, 2005; Lee et al., 2020; Wadsworth & Achenbach, 2005). In contrast, the social selection hypothesis posits that people with MH problems drift into poverty because of limitations in functioning associated with their MH problems; a genetic predisposition is often assumed (Gupta & Huston, 2009). The social selection hypothesis has received support (Dembling et al., 2002; Saraceno et al., 2005), but also significant criticism (Mills, 2015).

WHO (2001) has recognised both approaches as relevant; others, too, have attempted their integration. Some, like Lund et al. (2010), have argued that social causation applies to conditions like depression and the social drift hypothesis to diagnoses like schizophrenia. This position evidently assumes diagnoses represent distinct illnesses, as per the bio-medical model. Others, like Read (2010), formulate a more refined analysis, arguing that there is sufficient evidence that poverty both causes distress, as social causation implies, and maintains it, in line with the social selection hypothesis. A two-way relationship emerges, whereby MH difficulties aggravate material problems and vice versa (Clark & Wenham, 2022).

1.3.2.2. *Mediating factors:* Financial and MH difficulties therefore often co-occur. The stress related to financial challenges and poor material conditions has been suggested as an explanatory mechanism, with particular emphasis placed on food insecurity (Bramley et al., 2021), unemployment (Brown et al., 2003), unstable housing (Evans et al., 2003) and debt (Fitch et al., 2011). Such findings support evidence that MH problems rise after economic crises (Barr et al., 2015) and general worry in the population eases when unemployment drops (Clark & Wenham, 2022).

Moreover, traumatic events associated with the emergence of MH difficulties (e.g., neglect) are more prevalent in low-income communities (Walsh et al., 2019). Adults reporting multiple adverse childhood experiences are more likely to live in areas of socio-economic disadvantage (Bellis et al., 2014). Poverty has been linked to both individual traumas and clusters of them (Lacey et al., 2022). Alongside increased exposure to such experiences, the support of one's family and community, otherwise serving as buffers, may be compromised, as poverty often affects both individuals and their networks (Lewer et al., 2020). It is noted that poverty remains associated to distress even after accounting for childhood adversity (Crouch et al., 2020).

Hagan and Smail (1997) introduced power as a mediator, linking distress to powerlessness. Other researchers confirm the detrimental effect of one's awareness of their low societal rank (Kraus et al., 2013) and the role of inequality in fuelling insecurity around status (Friedli, 2009). Such findings support evidence that, across countries with comparable income, more people have a diagnosable MH condition in more unequal societies (Wilkinson & Pickett, 2010). Discussing discrimination and powerlessness, the intersectionality between factors like race or gender and economic adversity is acknowledged (Seng et al., 2012).

While it is useful to consider how poverty is psychologically distressing, poverty should not be misconstrued as a psychological rather than a social issue (Mills, 2015). Individual outcomes are determined by collective factors, including neighbourhood deprivation and welfare reforms (Curtis et al., 2021). Thomas et al. (2019) warned about the medicalisation of poverty and argued that conceiving distress as mental illness (e.g., depression) rather than a natural response to poverty and inequality, locates the problem within individuals, obscuring the socio-political context. This invites individualised interventions (e.g., antidepressants) which, Mills (2015) cautions, preserve the conditions that create or maintain distress.

1.3.2.3. *Multiple pressures:* Those experiencing both financial and MH difficulties may not share researchers' preoccupation with the time-order relationship between the two or "complex arrays of interrelated variables" (Hagan & Smail, 1997, p. 259). The JRF Grassroots Poverty Action Group (2022) instead emphasised the impact of multiple pressures: the exhaustion of trying to make ends meet; constantly worrying about the future; struggling to clear debt when it might be the only way to support one's family; the confusion of navigating complex and inaccessible systems of support; the resulting isolation. The psychobiological mark of chronic stress on one's physiological responses to life events, capacity for recovery, self-regulation and, ultimately, MH (Friedli, 2009) is also worth considering, as is the impact on areas like relationships and employment (Elliott, 2016).

Covid-19 powerfully illustrates the nexus of forces at play. The pandemic disproportionately affected low-income individuals, who were more exposed to the virus (e.g., due to living in over-crowded accommodation), but also more likely to experience financial uncertainty resulting from unstable working conditions and incomes (Patel et al., 2020). Covid-19 has additionally created anxiety about infection; loss and bereavement; reduced access to support and resources; difficult family dynamics, including domestic violence. These conditions have disproportionately affected low-income communities (Pieh et al., 2021), although clinically significant levels of distress rose across the population (Pierce et al., 2020). It is this compound effect of multiple stressors that this section emphasises. The impact of Covid-19 on people on low incomes and their mental health outcomes is further explored in section 1.3.4.

1.3.3. Patterns Of Service Use

The increased prevalence and severity of MH difficulties in low-income communities amplifies the need for MH care. Indeed, General Practitioner (GP) consultations for MH difficulties are more common in low-income communities (Woodhead et al., 2017). Prescription rates and use of psychoactive drugs are also inflated in disadvantaged areas (Taylor et al., 2019). Furthermore, people experiencing economic adversity are more likely to attend Accident and Emergency (A&E) departments for MH concerns (Baracaia et al., 2020) or be admitted to psychiatric hospitals (Curtis et al., 2006); a 1% increase in area income deprivation has been associated with a 1.5% increase in psychiatric admissions (White et al., 2014), which are more likely to be compulsory in poorer areas (Weich et al., 2017).

On the other hand, people facing financial hardship and anxiety or depression are almost twice as likely to have requested but not received MH support and to have an unmet MH need (McManus et al., 2016). This potentially supports the ICL as documented by Tudor-Hart (1971) and refined by Cookson et al. (2021). Low-income individuals are less likely to start psychological therapy following referral (Grant et al., 2012) or be assessed for it (Saxon et al., 2007). Instead, they are more likely to receive medication for their MH difficulties (Giebel et al, 2020), despite evidence that therapy is preferred over medication in low-income communities (Nadeem et al., 2008) and that psychological distress and life satisfaction can improve during therapy, for people of any income (Behn et al., 2018).

When people on low incomes access therapy, outcomes tend to be worse, regardless of the modality used (Falconnier, 2009). Berzins et al. (2018) documented that post-treatment distress levels remained higher for low-income individuals than their wealthier counterparts. Moreover, those on low incomes discontinue therapy more often, perhaps due to poor expectations of therapy (Finazzi & MacBeth, 2021) or negative experiences in therapy or interactions with services (Abrams et al., 2009). Other explanations include slower improvements in MH and life satisfaction (Behn et al., 2018) or perceived social class disparities, which therapists may not acknowledge (Trott & Reeves, 2018). When they complete therapy, low-income individuals are more likely to re-experience distress later (Lorimer et al., 2021).

Overall, current patterns of service use indicate that, accounting for MH need, low-income communities are less likely to access and benefit from psychological services. Gulliford et al.’s (2002) definition is considered here, with access to care encompassing the adequacy of service provision; acceptability, reflected in service use and uptake; efficacy, demonstrated by service outcomes; and fairness of access. Inequalities in access to care directly contradict the NHS’s commitment and obligation to provide health care for all and reflect systematic failures to respond to distress appropriately and prevent avoidable suffering (Reilly et al., 2012). Inequalities in primary MH care are further examined, focusing on IAPT.

1.3.4. The Impact of Covid-19

Covid-19 created a global health crisis that had a wide-ranging impact, the full extent of which remains to be determined. A decline in population mental health was observed across the UK at the onset of the pandemic (Pierce et al., 2021), associated with increased concerns around infection and health, but also the financial aftermath of Covid-19, the changes brought on by public health mitigation policies and disruptions in the delivery of mental health services (Byrne et al., 2021). This section focuses on the mental health trajectory of low-income communities during the pandemic.

Inequalities in the mental health impact of Covid-19 became apparent early in the pandemic. Data from March 2020 indicated that lower annual income was associated with higher levels of poor mental health, including more severe anxiety and depressive symptoms as well as poorer overall mental wellbeing (Smith et al., 2020). In the months that followed and leading up to October 2020, data from the UK Household Longitudinal Study support that, despite a deterioration in the average population mental health at the start of the pandemic, most people started to recover following the first national lockdown (Pierce et al., 2020). However, within deprived neighbourhoods distress levels remained elevated compared to the general population, with some people also exhibiting a further decline in their mental health over time (Pierce et al., 2021). Fancourt et al. (2022) identified those of lower socioeconomic status as one population group experiencing higher levels of distress during Covid-19 and continuing to report increased symptoms much later in the pandemic. Financial difficulties in fact emerged as a predictor of mental health deterioration, such that having a lower income was associated with increased mental health problems, that were also more severe (Stroud & Gutman, 2021).

Alongside general wellbeing, studies on the pandemic’s impact have also focused on specific mental health presentations. For example, Chandola et al. (2020) documented a higher prevalence of anxiety and depression for people affected by unemployment and financial problems. Their findings are corroborated by Pieh et al. (2020). More severe presentations, like suicidal ideation, were also more widespread in socially disadvantaged groups (O’Connor et al., 2020), as were behaviours like alcohol consumption (Russell Jonsson et al., 2023). The importance of an intersectional analysis is again highlighted. For example, young adults have been reported to have been more heavily impacted by restrictions related to Covid-19, however, within this specific age group, low income once again emerges as related to poorer mental health, highlighting an intersection between age and socioeconomic background (Thorpe & Gutman, 2022).

Such was the differential impact of Covid-19 on low-income communities, that Patel et al. (2020) described them as “the forgotten vulnerable” (p. 110). It is noteworthy that evidence on the mental health impact of the pandemic on those on low incomes comes from cross-sectional (Smith et al., 2020) as well as longitudinal studies (Thorpe & Gutman, 2022); studies using different measures of poverty, such as household income (Waite et a., 2020) or area-level deprivation (Pierce et al., 2021); studies that employed measures of general mental health (Stroud & Gutman, 2021) and studies using disorder-specific questionnaires (Smith et al., 2020); independently of whether or not one controls for pre-pandemic trends for different populations groups (Banks & Xu, 2020). The longer-term mental health implications of the pandemic remain an area of scientific interest.

1.4. Improving Access to Psychological Therapies (IAPT)

1.4.1. Service Description

The IAPT programme was introduced in 2008 to improve the availability and accessibility of psychological therapies for anxiety and depression. The name of the model reflects its ambition (Clark & Whittington, 2023). Anxiety and depression affect approximately one in six adults (McManus et al., 2016), and have been associated with long-term physical, social and occupational limitations (Zivin et al., 2015). Their high prevalence therefore represents a major challenge for public health, seen as having a significant cumulative cost to society (Knapp & Iemmi, 2014).

The development of IAPT followed a set of guidelines published by the National Institute for Health and Care Excellence for the treatment of anxiety (2004a) and depression (2004b), recommending Cognitive Behavioural Therapy (CBT) as an evidence-based treatment. The London School of Economics later issued a report (2006) suggesting that if more people with depression or anxiety accessed therapy, the cost of this service would be covered by reductions in public costs, including medical expenses and welfare benefits, and revenue increases from people staying in or returning to work. A large-scale heath initiative followed, as funds transferred from the Department of Work and Pensions (DWP) allowed the DoH to pilot a stepped-care system of CBT-based interventions for anxiety and depression.

After a pilot deemed successful, IAPT expanded nationally; all commissioning regions now have an IAPT service. Available modalities include counselling, couple therapy and interpersonal psychotherapy, although CBT remains the main option. Quality of care and service users' (SU) progress are monitored with outcome measures. Treatment is matched to level of need, ranging from guided self-help (low-intensity) to weekly individual sessions (high-intensity). This stepped-care model reflects a wider hierarchical MH provision, spanning from primary to inpatient care; IAPT is the main NHS provider at the primary level of MH care. In 2023, while this research was ongoing, IAPT services were renamed NHS Talking Therapies, following a public consultation (Clark & Whittington, 2023).

1.4.2. The IAPT Revolution

IAPT services have attracted both reverence and scepticism. Major arguments on both sides are outlined below.

1.4.2.1. *Accomplishments:* The IAPT three-year report on its first million SUs (DoH, 2012) presented recovery rates over 45% and a total of 45,000 people leaving the welfare system. A review marking IAPT's decade milestone also reported large therapeutic gains for anxiety and depression symptom severity and a moderate effect on functional impairment (Wakefield et al., 2021). Proponents of IAPT further hail its contribution to increased public awareness of psychological therapies; its transparency in making data publicly available; its cost-effectiveness, reducing welfare costs and increasing productivity; its contribution to remedying inequalities in access to care; its conceptualisation as a large-scale public healthcare initiative based on scientific evidence (Clark et al., 2018). IAPT has made therapy available, to thousands of people who would have not otherwise received support (Maconick et al., 2021) and attest to the NHS embracing therapy as an adequate alternative to medication, "a door which will not be easily closed again" (Taylor, 2015, p. 262).

Celebrated as revolutionary (Clark, 2019), the IAPT model has been replicated in other countries, like Norway (Knapstad et al., 2018). In the UK, investment in the service has been rising since 2008. IAPT was afforded a key role in the “No health without mental health” strategy (DoH, 2011), which aimed at improved MH outcomes across the population and parity of esteem between physical and MH. The service has expanded to new patient groups, such as people with long-term physical health conditions. In 2020/2021, 1.81 million people were referred to IAPT (NHS Digital, 2022), a number expected to increase, as the NHS Long Term Plan (NHSE, 2019) aims to further expand access to the service to 380,000 more people annually.

1.4.2.2. *Challenges:* On the other hand, IAPT has attracted severe criticism. Its effectiveness has been questioned, due to high non-attendance and non-completion rates (Martin et al., 2022; Roscoe, 2019). The lack of long-term data has caused concern, as have the lack of active control conditions and the use of as-treated rather than intent-to-treat analyses to assess effectiveness (Scott, 2021). Such methodological errors jeopardise IAPT’s socio-economic case, particularly in the absence of independent reviews (Marks, 2018). IAPT does not seem to have reduced rates of anti-depressant prescription (Sreeharan et al., 2013), which have been steadily rising (Clark & Wenham, 2022). Moreover, it does not appear to have halted rises in the use of secondary MH services (Maconick et al., 2021). Coupled with the finding that only 25% of adults with depression and anxiety receive treatment (Mental Health Policy Group, 2015), some have questioned whether IAPT meets the needs of those it purportedly serves (Martin et al., 2022) and its added valued compared to services it replaced (Timimi, 2018).

IAPT’s ethos and values have received further scrutiny. The language of productivity, costs and savings, present since the service’s inception, persists in its operation (Cotton, 2018). High SU drop-out rates are complemented by reports of compassion fatigue and burnout in the workforce (Roscoe, 2019). The emphasis on data collection has been criticised as creating a regulated and bureaucratic environment that neglects individual needs (Rizq, 2012). Moreover, the careful match between diagnosis and treatment, manualised protocols, the rigidity of the stepped-care model and the limited number of sessions offered, are viewed as upholding medicalised accounts of distress (Timini, 2018).

Finally, despite IAPT's vision, access and treatment inequalities persist. The latest IAPT manual (National Collaborating Centre for Mental Health [NCCMH], 2021) urges for equality-focused services to address the needs of under-represented groups. These include LGBTQ+ people (Rimes et al., 2019), people with a learning disability (Dagnan et al., 2022), older adults (Laake et al., 2021b) and racialised communities (Faheem, 2023). Improving access initiatives have targeted these groups, often deemed "hard to reach" (Skilbeck et al., 2020), with positive practice guides published to support clinicians (e.g., Beck et al., 2019). Low-income communities are explicitly mentioned in the IAPT manual (NCCMH, 2021) as under-represented in the service, but fewer improving access efforts have addressed their needs. This is the group the current study focused on.

1.5. Literature Review

Given documented inequalities in IAPT, a literature review was conducted to explore existing evidence on the provision of care for low-income communities in IAPT.

1.5.1. Literature Review Strategy

A narrative review (Ferrari, 2015) was deemed most appropriate for this literature review, since the aim was to broadly summarise the literature on the topic, including main findings, key issues and existing gaps in knowledge, and contextualise the current study. The search was conducted on CINAHL complete, APA PsycInfo and Academic Search Complete, as the databases most relevant to the topic. Search terms centred on two areas: IAPT and poverty, with careful consideration of relevant terms. The reference lists of articles identified through the review were further explored for relevant studies, alongside a citation search using Google Scholar. Details of the search strategy and a flow-diagram (Moher et al., 2009) summarising the process of study selection are available in Appendix A and B respectively. The review synthesises evidence published before May 2023.

1.5.2. IAPT And Low-Income Communities

1.5.2.1. *Accessibility and acceptability:* In line with general mental ill health prevalence rates, anxiety and depression, the main difficulties IAPT targets, are more prevalent in socio-economically disadvantaged areas (Delgadillo et al., 2016a). This is reflected in higher numbers of IAPT referrals (Moller et al., 2019); referral rates were 76% higher in the most deprived compared to the least deprived areas of England in 2020/21 (Baker, 2021). Exploring local patterns is important. Green et al. (2012) mapped incoming referrals at one IAPT service against local deprivation levels. Referral rates were increased in some highly deprived parts of the borough, however the authors identified areas of high deprivation and low referral rates, reflecting disparities between estimates of need and service uptake for the service.

Higher demand for psychological therapy does not increase access to it, Delgadillo et al. (2016a) warned. Alongside referral rates, the researchers explored data on the number of people receiving therapy, after being referred to IAPT. They identified a treatment access gap, whereby those on low incomes are more likely to need psychological support but not equally likely to access it. Covid-19 may have exacerbated this gap, as early explorations suggest that referrals for people living in areas of socio-economic adversity have increased (Bauer-Staeb et al., 2021) but this again has not translated in higher access rates. The full impact of Covid-19 remains to be established; no further studies were identified, exploring differential outcomes in IAPT based on socio-economic group during this period.

Low-income individuals are under-represented in case-load sizes (Delgadillo et al., 2016a) and they are less likely to enter treatment (Baker, 2021). This could be related to non-attendance at assessment and/or therapy. Sweetman et al. (2022) reported that those on low incomes are more likely to miss their assessment appointment with IAPT, as well as their first treatment session once assessed. This finding was replicated by Saxon et al. (2023). Jonker et al. (2020) analysed medical records from seven GPs to explore rates of attendance following referral to IAPT. While almost half of those deemed suitable for IAPT by the GP did not subsequently attend the service, no socio-economic differences were observed between those who attended and non-attenders. This contrasts other studies and may be related to Jonker et al. (2020) collecting data from GPs, rather than IAPT services like Sweetman et al. (2022) and Saxon et al. (2023). GP records may not record outcomes for those who self-referred to IAPT, therefore the IAPT dataset presumably reflects attendance rates more accurately.

People access IAPT after a GP referral or by referring themselves. Brown et al. (2014) suggested that the self-referral pathway contributes to equity of access to the service, after observing that socio-economic differences were more pronounced in comparisons between a community cohort and people referred to the local IAPT service by their GP, rather than IAPT self-referrals. Individual preference may be significant here. Participants in Jonker et al.'s (2020) survey seemed to favour a GP referral, particularly those who were invited to self-refer but did not. Thomas et al. (2020) warned that people on low incomes may be deterred from accessing IAPT when invited to self-refer, perceiving this as invalidating. The researchers reported that as many as 40% of those who were encouraged to self-refer to IAPT subsequently did not. Alongside practical difficulties, like lacking access to a phone, participants described the experience of being asked to refer themselves as "being fobbed off", a significant discord with the experience of GPs, who supported self-referral, as a way of assessing motivation to engage in therapy.

1.5.2.2. *Treatment outcomes:* Treatment outcomes in IAPT are typically defined based on reliable improvement and recovery on the Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001), used to measure depression symptoms, and the Generalised Anxiety Disorder Assessment (GAD-7) (Spitzer et al., 2006) for anxiety symptoms. One is deemed to have reliably improved if their post-treatment score represents a change of six or more on PHQ-9, or four on GAD-7. The two questionnaires also provide cut-offs for "caseness", for difficulties deemed within the clinical range. If, following treatment, one moves below the "caseness" cut-off (nine on PHQ-9; seven on GAD-7) and thus in the non-clinical range, they are deemed to have reliably recovered. Changes in the opposite direction represent reliable deterioration. Engagement, defined as the number of sessions attended, and attrition rates also fall under treatment outcomes.

While Poots et al. (2014) did not observe socio-economic differences in treatment outcomes for depression at their local IAPT, the literature overall suggests that low-income communities have worse treatment outcomes. Acton (2016) reported significantly lower recovery rates for people struggling with debt, alongside low mood and anxiety, compared to those without financial concerns. This is in line with studies demonstrating that people in deprived neighbourhoods achieve reliable recovery on measures of depression and anxiety less often following therapy (Delgadillo et al., 2016a; Finegan et al., 2019; Moller et al., 2019). A 17% difference in recovery rates has been reported in comparisons between the most and least deprived areas of England (Moller et al., 2019) and recovery rates were below the national target of 50% in the three most deprived deciles in 2020/2021 (Baker, 2021). Researchers have explained differences between socio-economic groups by referring to factors including social comparisons to those better off; access to enjoyable things or activities; social connectedness; and expectations about the benefits of therapy.

Baseline symptom severity is also relevant. Those living in areas of higher deprivation experience more severe difficulties when entering IAPT, reflected in higher scores on baseline measures (Green et al., 2015). This finding seems to persist in comparisons between areas of medium and high deprivation, reflecting a wider socio-economic gradient in therapy outcomes (Poots et al., 2014). Symptom severity remains higher post-treatment in more deprived neighbourhoods (Finegan et al., 2019). Stochl et al. (2021) reported that socio-economic status was not itself statistically related to recovery rates, however it was associated with baseline severity, in turn significantly affecting recovery. This could suggest that symptom severity is an important mediator. However, Finegan et al. (2019) reported that the association between deprivation and treatment outcomes persists, even after controlling for patient-level symptom severity and employment status.

In fact, IMD emerges as a significant predictor of treatment outcomes. In a study by Green et al. (2015), IMD was the second most significant predictor, after symptom severity. Clark et al. (2018) reached a similar conclusion using a national dataset and suggested organisational factors as mediators, including waiting times and number of sessions offered. Finegan et al. (2019) focused on neighbourhood income and crime and reported that these explained 4-5% of the variability in treatment outcomes, after controlling for individual factors, including unemployment. Firth et al. (2023) also used area-level indicators and reported that socio-economic factors (e.g., area income or employment) explained most of the neighbourhood variance in treatment outcomes. It has been further suggested that socio-economic deprivation mediates the relationship between ethnicity and treatment outcomes, with the differences between White British and other ethnic groups decreasing when socio-demographic variables including IMD are considered (Amati et al. 2023).

The association between socio-economic background and treatment effectiveness has implications for service delivery. Delgadillo et al. (2016b) assessed the outcomes of a group intervention across five IAPT services and observed higher levels of distress and socio-economic disadvantage for SUs in the service which reported worse outcomes post-treatment. They suggested that implementation of the intervention should be adjusted to match the needs of the local community. Flexibility may also be required regarding treatment duration. While Stochl et al. (2021) reported that people in more deprived areas improve more rapidly on measures of depression (but not anxiety), Finegan et al. (2019) proposed that those unemployed or living in socio-economically disadvantaged neighbourhoods require lengthier and more intensive interventions to benefit from IAPT. The authors suggested that neighbourhood poverty influences one's self-perception, hope for change or sense of control over their life; while therapy may help achieve rapid symptomatic change, as suggested by Stochl et al. (2021), such experiences may be harder to shift.

Attendance is another area attracting attention. Poots et al. (2014) compared areas of high, medium and low deprivation and reported higher rates of treatment disengagement as deprivation levels increased. Smyth et al. (2022) support this finding, while unemployment has also been found to predict treatment completion (Firth et al., 2020). To explain the inflated attrition rates, Binnie & Boden (2016) proposed that low-income individuals may face additional social, financial, practical or health difficulties inhibiting attendance; have competing priorities, such as work; may feel less confident about the rationale of sessions, because of negative experiences in education and health services; or may rely more on avoidance as a coping strategy. IAPT clinicians have also highlighted practical problems as causing treatment disruptions (Fairak, 2018). Interestingly, Firth et al. (2020) reported that socio-economic similarity to others in a group intervention predicted treatment engagement, such that participants were more likely to complete the intervention when surrounded by people of a similar socio-economic background.

SU accounts on care provision for low-income communities in IAPT are limited. Participants in a study by Weir et al. (2022), which included IAPT clinicians and people receiving therapy in the service, agreed that recovery is influenced by one's socio-economic context, financial difficulties and unemployment; therapy cannot undo years of deprivation and disadvantage, one participant argued. Omylinska-

Thurston et al. (2019) interviewed people who had disengaged from CBT, some of whom expressed that financial instability hindered their ability to use therapy. It is important to consider whether more sessions, as Finegan et al. (2019) suggested, would sufficiently address such sentiments. Some have urged for support for financial (Acton, 2016) and practical problems (Fairak, 2018) to be integrated within IAPT. Such interventions may have SUs' approval; participants in a study by Belcher et al. (2022) supported an intervention combining money advice and therapy.

1.5.3. Critical Reflection

Some reflections are offered to inform interpretation of the findings summarised for the literature review. First, it is noted that no data on socio-economic status were reported in initial evaluations of demonstration sites, when IAPT was first rolled out (Clark et al., 2009; Parry et al., 2011). IAPT services now use the IMD measure (see section 1.2.1.) as a socio-economic indicator, classifying SUs in IMD groups based on home postcodes. NHS Digital first added analyses against the IMD in the 2015/2016 IAPT report. Employment status is also recorded.

The studies included in this review used multiple socio-economic indicators (e.g., unemployment, IMD, income), measured at the level of the individual or local area. Some studies collected data from a single IAPT service, others used the national IAPT dataset, and some drew their sample from GPs. This heterogeneity adds to the complexity of defining poverty or socio-economic disadvantage and introduces challenges to the process of interpreting the findings, understanding contrasting outcomes, attempting comparisons, and drawing conclusions about affected groups.

Moreover, a cross-sectional analysis is largely lacking, although studies like that by Amati et al. (2023) indicate that this is important. Similarly, few qualitative studies were identified, and these mostly sampled from IAPT services in deprived areas, without assessing individual socio-economic conditions. This is a significant omission, as the individual experience is not captured by aggregated data, especially when using neighbourhood-level indicators. Thomas et al. (2020) was the only exception, as participants were people who self-identified as living in households with poverty-related challenges. This study further incorporated accounts by people who did not access IAPT, therefore providing important reflections on the accessibility and acceptability of the service.

Lastly, socio-economic differences in treatment outcomes (e.g., Delgadillo et al. (2016a) are alarming, however IAPT defines improvement and recovery on absolute terms, based on pre-determined cut-offs. Changes meaningful for SUs may not be captured. The benefit of therapy is then potentially under-estimated, particularly given that low-income individuals have an increased baseline symptom severity and thus a longer distance to travel to move beyond the cut-off used to identify recovery.

1.6. The Current Study

1.6.1. Summary And Rationale

The significance of addressing health inequalities has been highlighted within the human rights framework, the NHS constitution and governmental policy. Yet inequalities persist, affecting different population groups, including people on low incomes, who are more likely to experience MH difficulties, but less likely to receive or benefit from support. IAPT, the main NHS provider of primary MH care, is a service where low-income communities are under-represented. The literature review that was undertaken demonstrated that those socio-economically disadvantaged are less likely to start or complete therapy in IAPT and see their MH improve. Overall, they have a poorer experience of care.

This fundamentally contradicts IAPT’s conceptual ambition to improve access to care, and its role as a primary care service, uniquely positioned to address health inequalities (Lorenc et al., 2012). Covid-19 has impacted people’s financial stability and MH; those already on low incomes have been disproportionately affected on both fronts (Pieh et al., 2021). The current and forecasted economic conditions will intensify financial pressures (Brewer et al., 2023) and could threaten the MH of increasingly more people. Under these circumstances, demand for IAPT may grow, as the service has been expected to absorb much of the rise in the demand for MH support following Covid-19 (O’Shea et al., 2021). In 2021-2022, IAPT received 24.5% more referrals than the previous year (NHS Digital, 2022) and evidence suggests that low-income communities were referred in higher numbers but again under-represented at the point of accessing the service (Bauer-Staeb et al., 2021). However, the literature review did not identify any further studies focusing on treatment outcomes for low-income communities in IAPT services during the pandemic, thus highlighting a significant gap in the literature.

At the same time, the limited number of qualitative studies on the experiences of low-income individuals in IAPT has left researchers drawing on the general literature on barriers to psychological therapy for low-income communities; little published work to date has attempted to hear from low-income individuals directly affected by inequalities in IAPT. Research on the experiences of those who face such significant barriers that do not access the service is even more limited, although many people in fact never reach the service (Jonker et al., 2020; Thomas et al., 2020).

1.6.2. Aims And Research Questions

This study focused on the experiences of low-income communities in IAPT, to address identified gaps in the literature. First, the study contributed to current efforts to assess the impact of Covid-19 on IAPT services, focusing on outcomes for low-income individuals. Furthermore, the study attempted to hear from people directly affected by inequalities in access to IAPT, recognising their under-representation in both services and the literature. The following research questions were explored:

1) How have the referral and treatment rates in IAPT changed for low-income communities since the start of Covid-19, compared to their wealthier counterparts?

Given the differences already documented between those most and least socio-economically disadvantaged with regards to access and treatment outcomes in IAPT services, as well as in light of emerging evidence on the differential impact of Covid-19 on low income communities and their use of IAPT services, it was hypothesised that the gap between those most and least socio-economically disadvantaged would have widened after Covid-19, with regards to both access to treatment and treatment completion. As such, it was hypothesised that the differences between the most and least socio-economically disadvantaged IMD groups would be larger after the pandemic compared to before, for both treatment access and treatment completion.

2) a. What barriers do people on low incomes face in accessing IAPT?

   b. What could facilitate access to the service?

It is noted that the term “low income” was selected over alternatives, given the harmful discourses surrounding poverty earlier described, and following the example set by Thomas et al. (2021), after consultation with community partners.

2. METHOD

The chapter first outlines the rationale for a critical realist position. The research design is then presented, followed by a description of how SU involvement shaped the project. The study is thereafter divided into a quantitative (Study 1) and a qualitative (Study 2) part. The data source, measures and data analysis of Study 1 are presented first. For Study 2, information on participants, measures used, the procedure followed, and the analysis conducted is included. The chapter reviews ethical considerations regarding participant consent and wellbeing, as well as data management. Finally, research quality, including researcher reflexivity, is discussed.

2.1. Ontological and Epistemological Considerations

This study was informed by a critical realist position (Bhaskar, 1978). Situated between realism and relativism, critical realism is ontologically realist and epistemologically relativist (Bergin et al., 2008). To the ontological question “what exists?”, critical realism asserts an objective reality, independent of the researcher. At the same time, reality is seen as stratified, with subjective interpretations inevitably shaping one’s experience of reality (Zachariadis et al., 2013). Regarding epistemology then, critical realism highlights the limitations of science in its pursuit to produce knowledge. Science, our theories of reality and methods of investigating it, are seen as socially and historically context-dependent (Pilgrim & Bentall, 1999) and thus by definition subjective and fallible (Bhaskar, 1978). Researchers are encouraged to reflect and be transparent around their position within the task of knowledge production (Wiltshire & Ronkainen, 2021).

The study's critical realist position recognises the realities of living on a low income and in poor material conditions, poverty's undeniable core (Sen, 1983), existing independently of the researcher. It acknowledges, however, that such experiences occur within and are ultimately defined by a complex network of socially constructed definitions and narratives around poverty, MH and help. This is relevant for both participants and the researcher and inevitably informed every step of this research.

2.2. Design

This study comprised two different parts:

- Study 1 explored referral, access and treatment rates for people on low incomes compared to their wealthier counterparts, and changes after Covid-19. The study used national data on IAPT services.
- Study 2 involved interviews with people on low incomes who had not accessed IAPT. The aim was to explore barriers they faced and what would have facilitated access to the service.

Combining qualitative and quantitative methodologies is compatible with a critical realist position, which values different perspectives in the investigation of reality (Zachariadis et al., 2013).

2.3. Service User Involvement

Involving SUs and the public is increasingly a priority in psychology research (Owen et al., 2022). Alongside important benefits like increased relevance, rigorousness and reflexivity (Veseth et al., 2017), there is an ethical imperative to include people with lived experience of MH difficulties in research that is ultimately about them (Rose, 2014). While being mindful of concerns that have been raised around SU involvement, including tokenistic practices (Owen et al., 2022) and commodification (Carr, 2019), it was felt that it was important to include the voice of lived experience, both as research participants and in developing the project.

2.3.1. People’s Committee

Preparing the research proposal for this study included a brief consultation with the Peoples’ Committee of the University of East London (UEL). This is a group of people who have accessed MH services and carers, who have loved ones with MH difficulties. Members are employed by UEL and involved in teaching, selection and assessment on the Clinical Psychology (CP) course. I met with a representative of the committee in October 2021, to discuss the acceptability of the project, further opportunities for SU involvement and ideas around participant recruitment.

2.3.2. SUGAR

Following the meeting with the People’s Committee, I sought consultation from the Service User and Carer Group Advising on Research (SUGAR). Founded in 2009, the group is organised around the idea “nothing about us, without us” and meets monthly to discuss and consult research projects. I joined a consultation meeting with nine SUGAR members in July 2022. This involved reflecting on terminology used, reviewing study materials and discussing recruitment. Main comments by SUGAR members included:

- There was great interest in the project and an acknowledgement that this is an important research area. The group reflected on personal experiences of both MH and financial difficulties, underscoring the links between the two. Some shared personal difficulties with accessing MH services.
- The group encouraged reflexivity over the discourses surrounding poverty and provided positive feedback for naming these during the presentation.
- Terminology (e.g., low income, poverty, deprivation) and relevant implications were discussed. The group agreed with the term “low income”.
- Several changes for materials developed for Study 2 were suggested:
    - As the group recommended, terms potentially unfamiliar to the public were identified and subsequently removed from the study poster and pictures were added to reflect a more diverse population.

  - Changes to the interview schedule were suggested, to match different pathways to MH services.
  - The group offered advice on how to streamline recruitment. Unnecessary steps (e.g., reminders) were removed to simplify the process.

2.4. Study 1

2.4.1. Data Source

The study used publicly available data on IAPT services, which were accessible on NHS England (former NHS Digital). IAPT services collect and subsequently publish data on activity, waiting times and outcomes. Monthly and annual reports are produced; annual reports cover the period from 1st April of one year to 31st March of the following year. The data files and analyses tables used for the reports, as well as interactive dashboards and geographic or demographic breakdowns are also available.

Data for this study were derived from the annual IAPT reports for 2018-2022, covering the period between 1st April 2018 and 31st March 2022. As the first national lockdown was imposed on 23rd March 2020, this period roughly covers the two years before and the two years after the first lockdown. This allowed for a baseline to be established, against which changes over time were explored.

2.4.2. Measures

Using the main data sets for 2018-2022, the following information was extracted:

- Number of referrals received.
- Number of cases that started treatment.
- Number of cases that finished treatment.
- Number of referrals ended before treatment.

Data were accessed at a national level, separately for different socio-economic groups. In the IAPT database, socio-economic groups are matched to the IMD decile, with SUs classified in 10 groups (1= least deprived; 10 = most deprived) based on home postcodes. Appendix C provides definitions for all variables, as specified by NHS England.

2.4.3. Analysis

Data on IMD group and the above measures of interest were extracted from the annual reports for 2018-2022, separately for each year. A total of 6,544,536 IAPT referrals were received across England during this time; IMD group was stated for 99.7% of cases. As the amount of missing data for IMD group was negligible (0.3%), a complete case analysis was conducted (Little et al., 2022), excluding cases for which IMD group was unknown.

The number of referrals received, number of cases that started treatment, number of cases that finished treatment and number of referrals ended in each IMD group were aggregated per financial year to allow for comparisons between groups and over time. The following percentages were calculated and presented graphically: the percentage of people starting treatment against the number of referrals received (access rate); the percentage of referrals ended before treatment against the number of referrals received (access gap); the percentage of people finishing treatment against the number of those starting treatment (completion rate).

As the study focused on low-income communities, further analyses explored outcomes for the most deprived IMD group (group 10), using the least deprived group (group 1) as the comparison group. Independent samples chi-square tests were applied for between-group comparisons, using the weighted cases procedure. To explore the impact of Covid-19, data from the years 2018-2019 and 2019-2020 were merged to form the pre-pandemic condition, with years 2020-2021 and 2021-2022 forming the post-pandemic condition. Associations between time of measurement (pre/post-pandemic), IMD (most/least deprived) and treatment access (entered treatment/no treatment) or treatment completion (completed treatment /disengaged) were explored using three-way hierarchical log-linear analyses. Further chi-square tests were performed for 2×2 interactions. For all analyses and in line with significance testing, the null hypothesis stated that there would be no significant differences between the IMD groups compared. Effect sizes were calculated using Cramer's *V* and odds ratios. The formula $[p_1/(1-p_1)]/[p_2/(1-p_2)]$ was used for this, as in

Field (2009), where p represents the possibility of the event occurring. Significance was set at $p < .05$. Data were analysed using Excel and the Statistical Package for Social Sciences v.27.

2.5. Study 2

2.5.1. Participants

2.5.1.1. *Inclusion criteria:* Participants were people on low incomes who had experienced MH difficulties but had not accessed IAPT.

The following inclusion criteria were applied:

- Adults (>18 years old).
- English-speaking.
- Self-identifying as being on a low income, defined as experiencing challenges like low pay, unemployment and poor housing, as in Thomas et al. (2020).
- Had experienced MH difficulties, like anxiety and low mood.
- Had considered self-referral or had been referred to IAPT but had not accessed the service.

For this study, access to IAPT was defined in terms of whether one received psychological therapy. Those who started therapy and subsequently discontinued were excluded, as were people whose needs were met in secondary services and therefore did not meet referral criteria for IAPT.

Non-probability sampling methods were used, resulting in a convenience sample of people who responded to the study advertisement. A sample of six participants was sought, in line with recommendations regarding non-probabilistic sample sizes for interviews offered by Guest et al. (2012). The authors suggested that a sample of this size allows for meaningful themes and interpretations to be developed and may thus be sufficient for data saturation. It is noted that this served as a general guide rather than a precondition, in line with a critical approach to the concept of data saturation (Braun & Clarke, 2021a).

2.5.1.2. *Participant demographics:* Five people participated in the study. Their demographic information is summarised at a group-level, to protect anonymity.

Participants were aged 18-51 (*M* = 30.8, *SD* = 13.27). Two identified as male, and three as female. Moreover, two participants identified as White British and three as Asian British. Regarding their employment status, one participant was a student, two were employed and two were receiving benefit payments. One participant identified their MH difficulties as being anxiety and stress-related, with the remaining endorsing both anxiety and depression/mood-related difficulties. All participants reported experiencing challenges related to living on a low income: financial problems (*N* = 3), job insecurity/unemployment (*N = 2),* poor housing (*N = 2),* limited access to services and resources (*N* = *4),* and social isolation (*N* = 3).

2.5.2. Measures

Data were collected through individual semi-structured interviews. The interview schedule (Appendix D) was developed based on the research questions and following recommendations by Bearman (2019) on writing semi-structured interview schedules. It was then reviewed in thesis supervision and the consultation meeting with SUGAR. Further refinements followed a pilot and role play. The interview schedule broadly explored: participants' history of MH difficulties and help-seeking; their understanding of how MH and financial difficulties are related, if at all; barriers they encountered when accessing services and potential facilitators; participants' suggestions for improved service accessibility for people on low incomes.

A set of demographic questions was included. These were developed to mirror the information collected in IAPT and included age, gender, ethnicity and employment status. Participants were asked whether their MH difficulties were anxiety/stress-related or depression/mood-related, or whether they experienced other difficulties. A question on challenges associated with living on a low income was added.

2.5.3. Procedure

The study poster (Appendix E) was shared on social media, community centres across London, community organisations, SU groups (e.g., National Survivor User Network) and charities (e.g., Anxiety UK). Several organisations supported the project, for example by including the poster on their noticeboard or bulletin. I was also invited to a community event to promote the intervention in person, among the attendees. Recruitment took place from September 2022 to January 2023.

Prospective participants could contact the researcher over e-mail, call or text in response to the study advertisement. Those interested in participating were offered the Participant Information Sheet (PIS, Appendix F). Eligibility screening was completed over e-mail or the phone and again at the start of the interview. Each interview was arranged at a date and time convenient to the participant, once consent for participation was obtained. Participants were given the choice of an interview at a community centre in their local area, at UEL's Stratford campus, over Microsoft Teams or the phone.

Interviews lasted up to an hour and started with a brief discussion about the study and an explanation of the interview process. This provided an opportunity for the researcher to confirm eligibility and consent, and for participants to ask questions. Demographic questions were completed, followed by the main body of the interview. Interviews concluded with time for debrief and reflections. All participants received £10 Amazon vouchers, for their time and expertise. Interviews were recorded using a dictaphone and subsequently transcribed for analysis. Transcription was verbatim and included pauses and speech fillers; transcripts were then "tidied up" (Willig, 2013, p. 114), with repetition of words and non-linguistic elements omitted.

2.5.4. Analysis

Interview data were analysed using Thematic Analysis (TA), a method selected for its accessibility and potential for producing a rich analysis (Clarke & Braun, 2018). The analysis followed the steps delineated by Braun and Clarke (2006, 2021b): moving from familiarisation with the data and generating initial codes, through producing, reviewing and defining themes, to developing a coherent interpretative account. A theme was defined as capturing an important idea, shared across participants or within individual data items, based on meaning rather than topic; researcher subjectivity in defining importance and the impact of interpretative choices in developing themes are acknowledged (Braun & Clarke, 2019). Given the research question, the analysis focused on themes related to barriers and facilitators to accessing IAPT, instead of summarising the entire data set. A data-driven, inductive approach was adopted rather than using a pre-existing coding frame. Latent themes were attempted, related to participants' experiences of living on a low income, MH difficulties and interactions with services. Analysis was performed using data analytic software NVivo.

Braun and Clarke's reflexive method (2019) was preferred over the approaches proposed by Fryer (2022) or Wiltshire and Ronkainen (2021). Although placed within a critical realist epistemological framework, these ultimately advocate for causal explanations, which was beyond the scope of this study. Reflexive TA is consistent with critical realism and has previously been used within this paradigm as critical realism supports researcher reflexivity and acknowledges the existence of both an objective and a socially constructed reality (Izon et al., 2021).

2.6. Ethical Considerations

The study has received ethical approval by UEL's School of Psychology Ethics Committee; the ethics application and the ethics review decision letter are available in Appendices G and H, respectively.

2.6.1. Study 1

There were no concerns regarding participant consent, wellbeing or confidentiality for Study 1, as the study used publicly available anonymised data.

2.6.2. Study 2

2.6.2.1. *Participant consent and wellbeing:* Prospective participants were offered the PIS (Appendix F) explaining what the study would involve, how data would be managed and likely avenues for dissemination of findings. Participants were informed that they could withdraw without explanation or consequence, within three weeks after the interview. Participants signed and returned a consent form before the interview (Appendix I); consent was revisited throughout the interview as required. Beginning the interview, participants were reminded of their right to pause or discontinue and were encouraged to only share what they felt comfortable with.

Interviews concluded with time for debrief, which allowed participants to reflect on the experience of the interview. After the interview, participants were offered a debrief sheet (Appendix J), which included a list of services offering support for MH, financial or other difficulties. This was in recognition that some participants had not been in contact with services. Participants were also provided with the contact details of the thesis supervisor and the chair of the Ethics Committee, so that they could raise any concerns. Study materials were developed in accordance with UEL templates and reviewed as part of obtaining ethical approval.

2.6.2.2. *Data management:* All participant information, recordings of interviews and transcriptions were pseudonymised, and held securely on UEL OneDrive. Recordings were transferred to OneDrive immediately after the interview and then deleted from other devices. The pseudonymisation log was held on OneDrive, separately to the rest of the data. Potentially identifiable information was removed or altered in transcriptions and demographic characteristics are presented at a group level here. As GDPR dictates, data have only been used and retained as necessary and in line with the purposes for which participant consent was obtained.

2.7. Quality Appraisal

The quality of the study was assessed with reference to trustworthiness and researcher reflexivity. These are outlined below and revisited in section 4.3.3.

2.7.1. Trustworthiness

Trustworthiness is a key quality indicator for qualitative studies (Nowell et al., 2017). It refers to the researcher’s effort to establish their study as valid and thus deserving of readers’ confidence in what is reported (Stahl & King, 2020). Lincoln and Guba (1985) defined four trustworthiness criteria, later revisited by Nowell et al. (2017), in relation to TA.

2.7.1.1. *Credibility:* refers to the congruence between the research findings and participants’ accounts (Lincoln & Guba, 1985). A credible study is one accurately representing participants’ experiences. It is acknowledged that there is an element of subjectivity in analysing qualitative data and producing a report, but also in evaluating a study’s credibility (Stahl & King, 2020).

2.7.1.2. *Transferability:* seen as akin to generalisability (Nowell et al., 2017), transferability relies on the researcher providing detailed descriptions of the research process and findings, so that they can be applied in new settings. Although exact replicability is not possible, good quality studies allow researchers to decide whether patterns from one setting are applicable elsewhere (Stahl & King, 2020).

2.7.1.3. *Dependability:* refers to the level of trust a study is afforded, based on whether adequate descriptions of the research steps and rationale are provided (Lincoln & Guba, 1985). After examining the research process, researchers and readers can judge whether the decisions and choices of a study are justified.

2.7.1.4. *Confirmability:* examines whether a study's findings and interpretations are derived from the data, rather than the researcher's views (Lincoln & Guba, 1985). Confirmability relies on the study meeting the three trustworthiness criteria above (Nowell et al., 2017).

2.7.2. Researcher Reflexivity

Turning the lens inwards is vital within a critical realist epistemological framework (Wiltshire & Ronkainen, 2021), as part of reflexive TA (Braun & Clark, 2019) and as a quality indicator in qualitative research (Berger, 2015). Researcher reflexivity refers to the process of continuously evaluating one's positioning in relation to the research topic and its implications for the research process (Willig, 2013). From formulating the research question to discussing the findings, this study has been shaped by my personal and professional values and experiences as the researcher. Rather than simply a source of bias, this is considered an inevitable, if not invaluable part of the research process (Le Gallais, 2008). Reflexivity while conducting this study was facilitated in supervision as well as using a reflective diary; a representative extract is available in Appendix K.

This study was born out of a firm belief in access to health care as a human right. Inequalities in access to care are considered an unacceptable transgression, requiring remedial action. Primary care is viewed as decisive in upholding people's right to access health care, when there is a public health system to provide the infrastructure necessary to improve population health, capture and address health inequalities and advocate for a health-in-all-policies agenda (Cabaj et al., 2019).

While this position may be criticised as merely an ideological stance, it is argued that not concerning oneself with social inequalities also represents an ideological stance.

Values of fairness and justice largely underpin this position. Personal experiences of growing up during the time of a severe economic recession in my home country are also relevant. These experiences highlighted the connections between poverty and distress, on a personal but also collective level. However, although not a “stranger in a strange land” as Berger phrased it (2015, p.227), in studying poverty I remain a researcher observing and analysing participants’ experiences from the outside in.

Being introduced to the NHS after moving to the UK and joining its workforce was transformative for me, opening new possibilities for what public health could achieve. Studying at UEL was similarly impactful. UEL emphasises the importance of the social context, power and inequality in understanding human distress. This ethos offered new language for personal and professional reflections, and alerted me to my identity as a White European woman and my position of privilege in moving to the UK to pursue further education. Such experiences collectively spawned interest in this study’s topic and shaped how it has been approached.

3. RESULTS

This chapter presents the results of the analyses performed, separately for each part of the research. Starting with Study 1, treatment outcomes are presented for the 10 IMD groups for the period 2018-2022, including the access rate, access gap and completion rate. Further analyses focus on the low-income group, compared to the least deprived group, and monitor changes after Covid-19 (SPSS output in Appendix L). The results of the TA completed for Study 2 are presented next. Three themes and ten further subthemes were developed. These are described and illustrated using representative quotes.

3.1. Study 1

3.1.1. All Group Analyses

3.1.1.1. *Referral sample:* A total of 6,544,536 referrals were received in IAPT across England between April 2018 and April 2022. Of these, 69% (N = 4,498,067) entered treatment. However, almost 1 in 3 referrals (N = 1,969,906; 30.2%) ended before treatment. Of those entering treatment, approximately 1 in 2 (N = 2,472,247; 54.96%) completed this. Subsequent analyses consider the 10 IMD groups separately. Table 1 displays the overall outcomes for each group. Referral, access and treatment rates are then presented per financial year, for different IMD groups.

Table 1

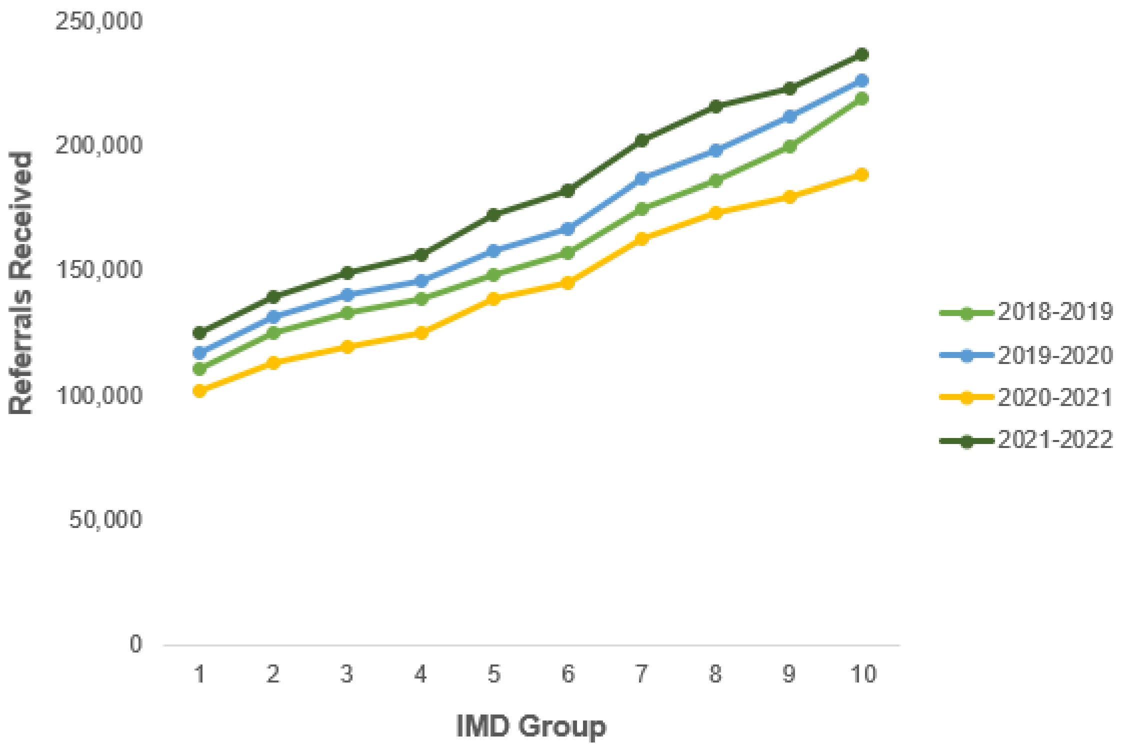
IAPT Referrals and Outcomes by Deprivation Decile, 2018-2022

Deprivation Decile	Referrals	Entered treatment (% of referrals)	Finished treatment (% of entered treatment)	Ended before treatment (% of referrals)
1-Least deprived	454,297	74.24	60.62	24.98
2	509,170	73.46	58.81	25.8
3	541,605	72.50	57.59	26.72
4	565,729	71.69	57.62	27.53
5	617,616	70.38	56.74	28.71
6	651,133	69.91	55.88	29.17
7	725,977	68.31	55.05	30.82
8	773,195	67.09	53.12	31.97
9	813,298	65.80	51.23	33.37
10-Most deprived	870,397	63.05	48.17	36.18

3.1.1.2. *Referrals received:* Those in the most deprived groups were referred to IAPT in greater numbers, with the number of referrals increasing incrementally with each group. This was a consistent pattern across the four years (Figure 1). The mean increase in referrals with each deprivation decile was 7.52% (*SD* = 2.76), moving from the least deprived to the most deprived group.

Figure 1

Referrals Received as a Function of IMD Group and Time of Measurement



Referrals dropped in 2020-2021, which roughly corresponds to the year after the first Covid-19 lockdown. Overall, 14.08% fewer referrals were received, compared to the year before. A decrease in referrals was observed across IMD groups, however the difference appears more pronounced for the most deprived group, where referrals dropped by 16.71% in 2020-2021 compared to 2019-2020.

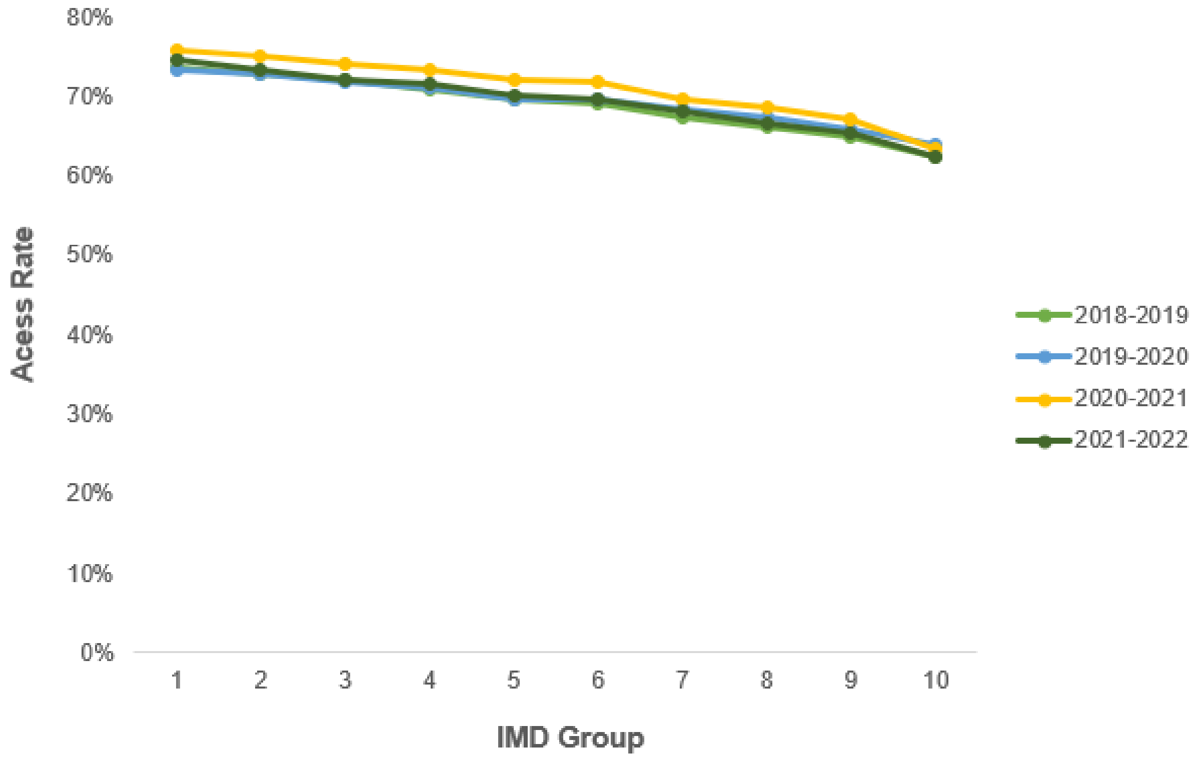
Referrals increased in 2021-2022, a pattern again consistent across IMD groups. There was a 24.59% increase in 2021-2022 compared to 2020-2021. This surge is smaller in comparisons with the pre-pandemic years; referrals in 2021-2022 were 13.09% higher than in 2018-2019 and 7% higher than 2019-2020.

3.1.1.3. *Access rate:* Overall, 69% of those referred to IAPT between April 2018 and April 2022 entered treatment. The access rate ranged from 74.24% for the least deprived group, to 63.05% for the most deprived one, a 11.19% difference (χ^2 (1) = 16878.36, p < .001, V = .11). The mean incremental decrease in the access rate was

1.24% (*SD* = 0.9) moving from the least deprived to the most deprived group. Those more deprived were consistently less likely to enter treatment in IAPT (Figure 2).

Figure 2

Access Rate as a Function of IMD Group and Time of Measurement



Note. Access rate = cases entering treatment/referrals.

The number of people entering treatment during Covid-19 was slightly increased compared to the year before, with the overall access rate rising from 68.81% in 2019-2020 to 70.37% in 2020-2021. Inspecting IMD groups individually, this increase is observed for all groups except the most deprived one, where the access rate decreased by 0.46%. The overall access rate returned to pre-pandemic levels (68.69%) in 2021-2022).

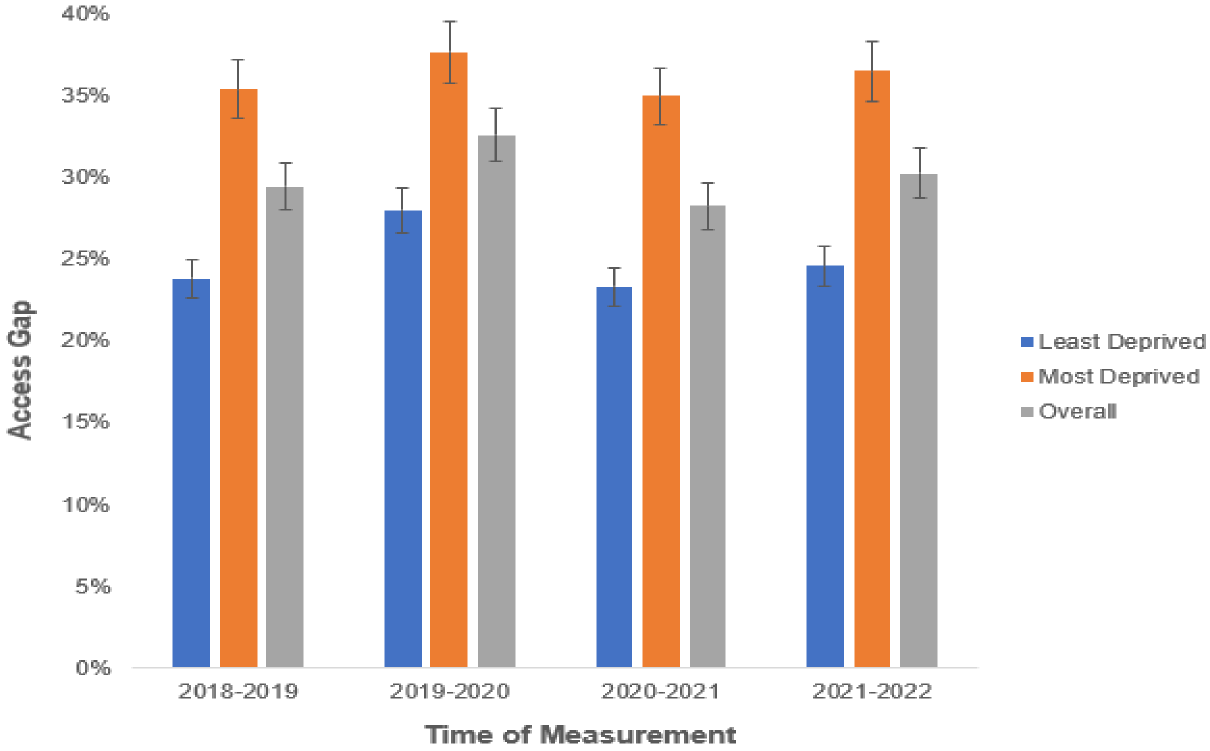
3.1.1.4. *Access gap:* Between April 2018 and April 2022, 30.2% of referrals received ended without treatment. The access gap was larger in more deprived groups, with a 1.24% mean (*SD* = 0.01) incremental increase in the access gap with each added deprivation decile, moving from the least to the most deprived group.

The access gap ranged from 24.98% in the least deprived group to 36.18% in the most deprived one, a 11.2% difference (χ^2 (1) = 125628.4, $p < .001$, $V = .27$).

Despite a higher overall access gap (32.56%), 2019-2020 marked the smallest percentage difference between the most deprived group and the least deprived one (9.69%) (χ^2 (1) = 3211.54, $p < .001$, $V = .1$), although across deprivation groups more referrals ended with no treatment (Figure 3). However, differences between the most and least deprived groups seem to have slightly widened in the two years that followed, rising to 11.66% (χ^2 (1) = 4215.19, $p < .001$, $V = .12$) in 2020-2021 and 11.9% (χ^2 (1) = 5291.03, $p < .001$, $V = .12$) in 2021-2022.

Figure 3

Access Gap as a Function of IMD Group and Time of Measurement



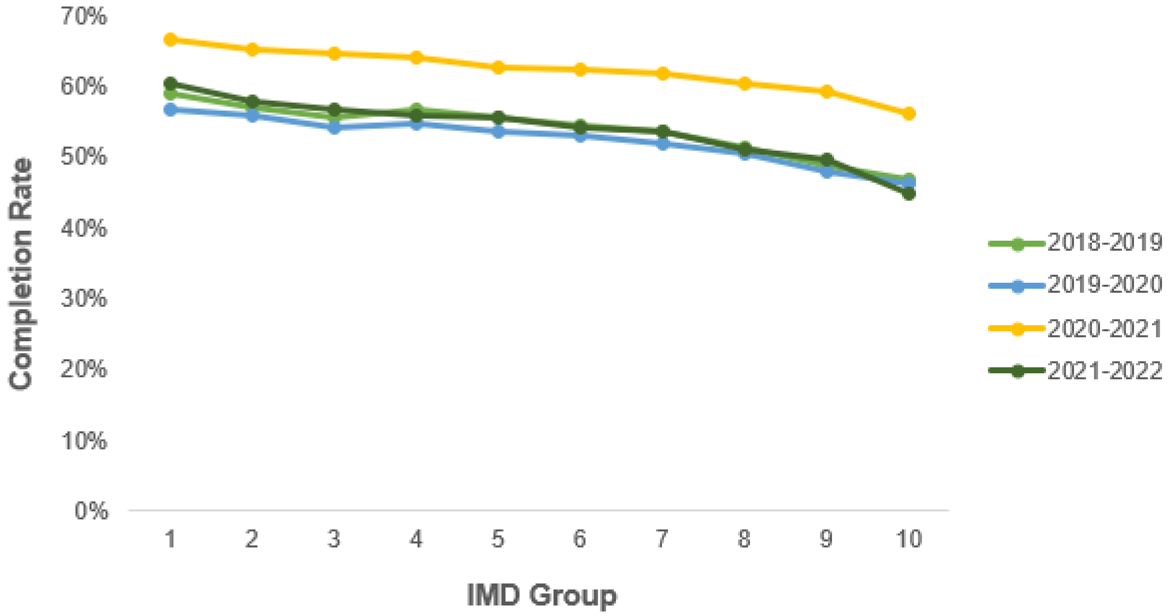
Note. Access gap = cases ended before treatment/referrals. Overall refers to total sample across IMD groups for each year. Error bars represent percentage.

Covid-19 saw a 4.32% decrease in the access gap across IMD groups compared to the year before; the overall access gap for 2020-2021 (28.24%) was the smallest one observed in the period examined, as fewer people were discharged without treatment that period. Smaller improvements were observed for the most deprived group; while the access gap dropped 4.69% for the least deprived group in 2020-2021 compared to 2019-2020, the deprived group recorded a 2.72% decrease in the same period. The following year (2021-2022) saw the overall access gap at 30.25%.

3.1.1.5. *Completion rate:* Overall, 54.96% of those entering treatment between April 2018 and April 2022 completed it. Completion rates ranged from 60.62% for the least deprived group to 48.17% for the most deprived one, a 12.45% difference (χ^2 (1) = 13007.01, $p < .001$, $V = .12$). Across the four years, those more deprived were consistently less likely to complete treatment (Figure 4), with a mean incremental decrease of 1.38% (*SD* = .01) in the completion rate for each added decile, moving from the least deprived to the most deprived group.

Figure 4

Completion Rate as a Function of IMD Group and Time of Measurement



Note. Completion rate = cases finishing treatment/cases entering treatment.

More people completed treatment during the pandemic than the year before. The overall completion rate rose from 52.02% in 2019-2020 to 61.95% in 2020-2021, a 9.75% increase. The completion rate returned to 53.4% in 2021-2022, which is similar to 2018-2019 (53.33%). Completion rates were slightly elevated in 2021-2022 than 2019-2020 for all IMD groups, except for the most deprived one, for which the completion rate in 2021-2022 (44.87%) was 1.53% lower than in 2019-2020 (46.4%).

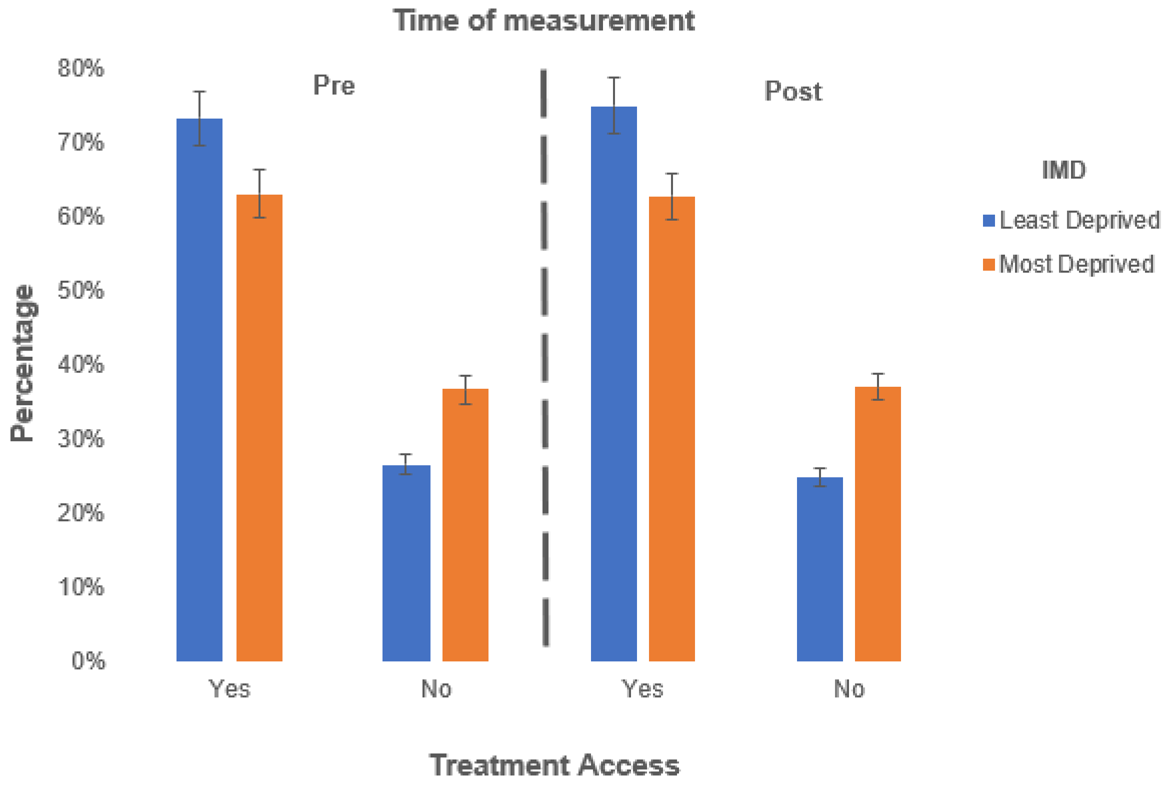
3.1.2. Loglinear Analysis

3.1.2.1. *Treatment access:* A three-way loglinear analysis was performed to explore the associations between IMD (most/least deprived), time of measurement (pre/post pandemic) and access to treatment (entered treatment/no treatment). The analysis produced a final model retaining all effects. Its likelihood ratio was χ^2 (0) = 0, $p < .001$, indicating that the highest-order interaction (time of measurement × IMD × treatment access) was significant, χ^2 (1) = 164.6, $p < .001$.

To break down this effect, separate chi-square tests were performed on the IMD and treatment access variables, separately for pre- and post-pandemic. Before Covid-19, there was a significant association between level of deprivation and treatment access following an IAPT referral, χ^2 (1) = 7007.82, $p < .001$, $V = .1$; this was also true after the pandemic, χ^2 (1) = 10010.19, $p < .05$, $V = .12$. Inspecting the two chi-square statistics, the one obtained after Covid-19 is stronger, suggesting larger between-group differences. Odds ratios indicated that the odds of being discharged without treatment were 1.6 times higher for the most deprived compared to the least deprived group before Covid-19, increasing to 1.79 after Covid-19. Therefore, as illustrated in Figure 5 and contrary to the null hypothesis of no difference between the groups compared, those most deprived were less likely to enter treatment than those least deprived, and the difference between the two groups grew after the pandemic.

Figure 5

Treatment Access Rate for the Most and Least Deprived IMD Groups, Before and After Covid-19



Note. Error bars represent percentage.

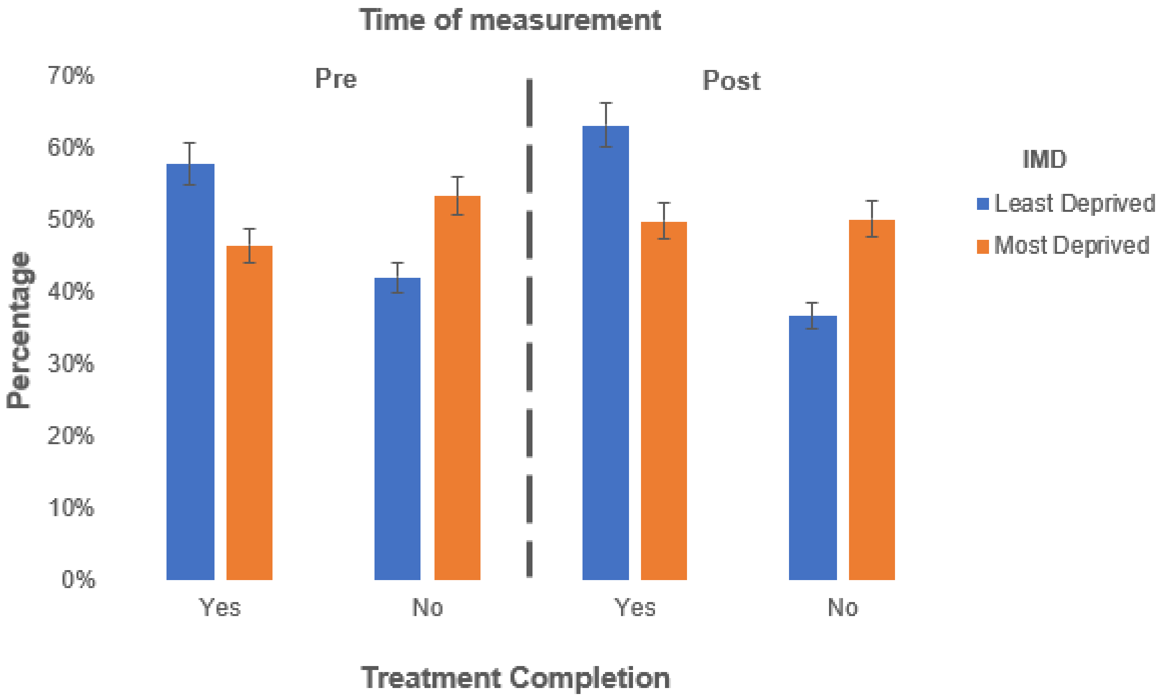
3.1.2.2. *Treatment completion:* A three-way loglinear analysis was performed to explore the associations between IMD (most/least deprived), time of measurement (pre/post pandemic) and treatment completion (completed treatment/disengaged). The analysis produced a final model retaining all effects. Its likelihood ratio was χ^2 (0) = 0, $p < .001$, indicating that the highest-order interaction (time of measurement × IMD × treatment completion) was significant, χ^2 (1) = 114.09, $p < .001$.

To break down this effect, separate chi-square tests were performed on the IMD and treatment completion variables, separately for pre- and post-pandemic. Before Covid-19, there was a significant association between IMD and treatment completion, χ^2 (1) = 5377.33, $p < .001$, $V = .11$; this was also true post-pandemic, χ^2 (1) = 7601.86, $p < .001$, $V = .13$. Inspecting the two chi-square statistics, the one obtained after Covid-19 is stronger, suggesting larger between-group differences.

Odds ratios indicated that the odds of treatment disengagement were 1.58 times higher for the most deprived group compared to the least deprived one before Covid-19, increasing to 1.72 after Covid-19. Therefore, as illustrated in Figure 6 and contrary to the null hypothesis of no difference between the groups compared, those most deprived were less likely to complete treatment than those least deprived, and the difference between the two groups grew after the pandemic.

Figure 6

Treatment Completion Rate for the Most and Least Deprived IMD Groups, Before and After Covid-19



Note. Error bars represent percentage.

3.2. Study 2

The analysis produced three main themes, and ten further subthemes. These are summarised in Table 2 and described in more detail below; representative quotes are included. An extract illustrating the coding process and an initial thematic map are available in Appendix M.

Table 2

Overview of Themes and Subthemes

Themes	Subthemes
A. Navigating the system	1. Practical barriers 2. Waiting and waiting 3. Lacking information 4. Referral and criteria
B. Us and Them	1. Coming forward 2. Disappointed and disempowered 3. Undeserving and excluded
C. Perceived mismatch between needs and available support	1. Personalised and holistic care 2. Not for me 3. Finding connection and support

3.2.1. Navigating The System

This theme captures pragmatic difficulties participants described in trying to receive support for their difficulties. Long waiting lists emerged as a fundamental barrier alongside practical factors. Participants also shared a sense that they had not received sufficient information about IAPT and what therapy entailed. Factors facilitating access are also discussed.

3.2.1.1. *Practical barriers:* Participants identified several practical factors impeding access to IAPT, starting with transportation and proximity to the service:

> Nora: *"if someone's clinic is far away from where they live and they're already living on a low budget it would be difficult for them to get from one place to another and back".*
>
> Lila: *"Having to find the mental health team in the local area. Sometimes there is something like far away".*

Alan highlighted language as a potential barrier, speaking to the intersectionality between low income and nationality/ethnicity:

> *"There is a lot of low-income families of quite a big proportion from under-represented ethnic communities, who have no or very little fluency in speaking and writing and reading English. So I think that's quite a fundamental barrier."*

On the other hand, flexibility around timing was important for Lila:

> *"[group sessions] are at a time that makes it impossible for me to attend. […] They have it early and I am not a morning person so I prefer it like in the afternoon or in the evening."*

Lila also discussed flexibility regarding ways of communicating with the service, while expressing a preference for face-to-face appointments to facilitate communication:

> *"it is about giving me the options, which way I would like to be contacted or get sorted […] because ultimately they could see whether I look like, maybe they might understand how I am feeling through my facial expressions? Or my irritability. Or staying quiet."*

3.2.1.2. *Waiting and waiting:* Among the barriers participants identified, long waiting times emerged as central. Many participants shared concerns about having to wait a long time before accessing support.

For Nora, anticipating that she would have to wait long to see her GP discouraged her from sharing her MH difficulties:

> *"It is difficult to like get an appointment with your doctors, never mind your own GP so I think it will be a lengthy process".*

For Simon and Susan, IAPT's long waiting list was decisive in terms of them not getting support from the service. "It's the waiting list, that's the big barrier", Susan explained, while also referencing the different stages at which waiting occurs:

> *"it would take a long time for the assessment to come through and then a long time to hear whether or not I would be eligible for IAPT […] it was an incredibly long waiting list […] whenever I try to go back to the GP he just says just wait, there is an incredibly high demand"*

The GP seems to play an important role in conversations around waiting times. Simon shared worries about having to wait a long time to get support, however it seems that he was also discouraged by his GP's warnings:

> *"it's quite off putting because you know, when the GP is even saying that the waiting lists for these sorts of things are very long. So it kind of deterred me from really pursuing that sort of thing, you know, wait for ages and then still feel like I was waiting and waiting and not being heard"*

Anticipated delays, at the point of seeing the GP or following an IAPT referral, could then prevent people from pursuing this option very early in the process. Moreover, waiting times are considered in the context of previous interactions with services participants may have had, which also involved a long wait. Lila provided an example:

> *"I wasn't receiving enough and I was so stressed. I wasn't receiving PIP yet because it took a very long time to get it processed".*

Consequently, experiences of having to wait for support may not be unfamiliar for people on low incomes, who might then expect long waiting times, particularly in the context of service restrictions and limited resources:

> Simon: *"they [low-income communities] feel more reluctant to access services because there is that sense of you know, if you actually get support or that you have to wait a long time for it […] that sort of group of people find it harder to actually get access in general, across the UK and services being very restricted in terms of their resources and how many people they can see at a certain time".*

3.2.1.3. *Lacking information:* Concerns about waiting times are potentially compounded by a lack of sufficient information regarding IAPT as a service and what therapy involves.

Alan explained how IAPT was described to him:

> *"Very generically. They just described verbally they gave me some information about how we would proceed but they didn't say what that would entail."*

This matches the experience Susan and Simon had, looking back at their discussion with their GP:

> Simon: *"it was more I don't know very brief really. It was just a short overview basically"*
>
> Susan: *"he [GP] just introduced it as a way of getting psychological therapy and he didn't say an awful lot apart from that. He was mainly talking about waiting lists [...] there was minimal information shared and it seemed as though the GP himself knew very little."*

Brief descriptions of IAPT services may include references to therapy, however, as Simon explained, what therapy is may be unclear:

> *"I have not had therapy before and so maybe there is that sense of I am not very sure what it entails."*

In the absence of sufficient information, people may not be prepared to continue:

> Alan: *"not knowing what would be delivered meant that I wasn't prepared and I ultimately didn't feel like it was for me. So having more information about what's going to be covered or facilitated would in some sense have been good, maybe it would have seemed more appropriate or useful to my circumstances at the time".*
>
> Simon: *"I guess just more information in terms of what the actual access to treatment would look like, like what each session, is there sort of a certain structure which you would have to follow or is it more just a week-by-week basis of what you feel like talking about […] what is it actually yeah, that would probably help".*

Participants suggested advertising the service to improve access to IAPT for low-income communities. This included using different means of advertising but also targeting a wider audience. For Nora, this would provide people with an opportunity to ask further questions:

> *"I guess just a general introduction to like what is IAPT, what they do and like what mental health difficulties and where you can go to and if there are any*

> *other websites for support. Just like a general introduction into it and that should give people the opportunity to ask more questions from professionals rather than keeping them to themselves.”*

Advertising could also offer reassurance that waiting for support is indeed worthwhile, according to Simon:

> *“advertising the service in a way which is reassuring and you know, in a way which is sort of like worth to be waiting for a long time if you need the support”.*

Susan agreed that this is important information, which she expected her GP to provide:

> *“they should have a better knowledge of when someone might be seen.”*

3.2.1.4. Referral and criteria: A specific area where information was potentially insufficient was the referral process and the GP’s role in this. Lila initially expected her GP to refer her to an appropriate MH team for the anxiety she was experiencing. Coupled with what seem like miscommunications within her network of support, this caused delays to her care:

> *“I was waiting for the key workers in the hostel I was in. Because I was waiting for them to refer me to the GP sorry I mean the mental health team. I was waiting for them, for the GP to send me.”*

It is noteworthy that IAPT services provide the option of self-referral, which allows a direct link to the service. This was decisive in Lila’s case, who found information on IAPT online and eventually decided to refer herself:

> *“I found about IAPT on my own, on Instagram. […] I sent an e-mail and they said they would call me. And they did”*

This seems to have been an important experience for Lila, who otherwise shared her frustration with the complexity and fragmentation of the MH system. In her experience of seeking support:

> *“They have certain criteria and you have to fit in. […] In a way it makes things complicated […] like you have to have certain mental health issues. […] So I*

> *am struggling and I am trying to find support and then I don't meet the criteria."*

A facilitator in Lila's case, the self-referral to IAPT was a barrier for Simon, who was expecting his GP to complete a referral for him but was instead asked to refer himself:

> *"I haven't put a referral forward for IAPT, because of that. I decided to look elsewhere for support."*

Simon explained that he was expecting his GP to be more "proactive":

> *"Language that was quite passive I guess. So like language that was kind of like you know, these are options that we could do rather than sort of options that we should be doing now in order to help you like in the immediate future."*

On the other hand, the inclusion and exclusion criteria services use, which Lila referenced, have potentially raised the bar for severity in a way that discourages people with less severe presentations from seeking support. Nora described significant difficulties that indicate that she would have benefited from support. However, she did not feel that people with difficulties like hers are seen in services:

> *" it just wouldn't go and it came to a point where I did want to seek something, something to at least clear that void out of my head […] obviously it wasn't like extreme, something extreme for example severe depression, self-harm or suicidal thoughts, it wasn't that extreme that I thought I needed to go out of my way and you know do something about it."*

3.2.2. Us and Them

This theme speaks to a sense of alienation between study participants and services. Beyond difficulties navigating the system, it seems that this sense of "us and them" dissuaded participants from accessing IAPT. Participants discussed difficulties with coming forward and seeking help, but also disappointing interactions with services, which left some of them feeling disempowered or hopeless about change. Participants also spoke to a sense of being excluded or feeling undeserving of support. In participants' accounts, IAPT services had replicated such experiences or were expected to do so.

3.2.2.1. *Coming forward:* Getting support often relies on the individual asking for it. Most study participants had felt able to do this in some way, for example by seeing their GP. Simon highlighted, however, that it might be very difficult for someone who struggles with their MH to ask for support:

> *"When I'm in depressive episodes I don't really feel like I can reach out for help or I am a lot more likely to not reach out for help. […] I think the worst part really is actually asking for the support in the first place. It takes a lot of strength to do that."*

Nora was equally reluctant to share her difficulties with professionals and shared an expectation of judgment, linked to seeking help as a sign of weakness:

> *"they [people] have the opportunity but they don't go for it in case they'll be judged or just thinking that you are not like strong as a person because you ask for help […] Obviously it's behind silent doors, I wouldn't tell anyone, I would just sit there and go through it thinking this will go away and will go back to normal."*

Nora also related her hesitation to her cultural background:

> *"Especially for people of my background whether that's Pakistani or Bengali it's just, when we are raised our mental health isn't, for example like your parents or whoever you live with they say that you'll get over it".*

Identity and intersectionality seem to be relevant here. In the above extract, Nora highlighted how growing up she had received a consistent message that MH difficulties need not be attended to. Positioning services as "outsiders" seems to have been another important cultural message, one that made Nora "defensive" when her friends suggested therapy might be helpful:

> *"maybe it's just my background, it's like you don't really get help from outsiders so when they said it it's like, honestly at first you'd be, I was defensive"*

Positioning services as outsiders draws a clear line between “us” and “them”, one that for Nora seemed difficult to cross; she did not proceed with an IAPT referral. A similar “us” and “them” distinction was present in Alan’s account. In suggesting that IAPT get to know the communities they serve for them to feel able to come forward and present in services, he communicated a sense that the two groups are separate:

> *“I think they [services] missed learning about people’s journeys and stories from every type of group […] I think services need to understand that rather than thinking that you have some of the answers.”*

In this context, seeking support from services is viewed as effortful, potentially only to be pursued as last resort:

> Nora: *“I just thought that everyone goes through that so I don’t need to go out of my way and ask for help. […] And then if it comes to it and I have no other option then I’ll seek I guess”*

3.2.2.2. *Disappointed and disempowered:* Participants further described disappointing interactions with services and shared experiencing professionals as inattentive or disinterested. This seems to have occurred in interactions with the GP, as part of seeking MH support. Simon shared feeling that he was not taken seriously:

> *“I think more of a seriousness from my GP in terms of her sort of attitude and compassion towards what I was going through. I feel that at the time it wasn’t taken as seriously when I first mentioned things about my mental health.”*

For Simon, attentiveness and compassion, or lack thereof, was first a felt sense:

> *“probably just feeling like I am being more listened to and like in an active way and more of just a serious concern in terms of the language that was used and I feel you can generally sense when someone is a bit more serious about your mental health or medical health just from their body language and their tone of voice.”*

However, attentiveness was also communicated though actions and omissions. For Simon, being invited by his GP to refer himself to IAPT and not being given a follow-up appointment with them also conveyed a sense that his concerns were not taken seriously, particularly given how hard it felt to share his MH difficulties:

> *“I think just the initial steps of actually making the referral would have been that sort of being a lot more seriously taken. It would probably make me feel a lot more cared for […] she could have offered a follow up appointment just to like check in, see how I’m doing”*

Susan also experienced the discussion with her GP about IAPT as unhelpful:

> *“I remember being overwhelmed by stress and anxiety […] the conversation didn’t really help, I was left feeling very isolated and alone. He [GP] seemed very busy.”*

Similarly disappointing experiences were shared by participants who did initially consider an IAPT referral, in their introductory interactions with the service:

> Lila: *It just wasn’t very engaging […] the IAPT person did not seem to be listening or to be understanding what the service user is saying. […] Just all the time she kept quiet and unsure what to say”.*
>
> Alan: *“He didn’t seem to listen in the initial appointment, in the introductory phone call. It didn’t’ seem very attentive.”*

Such interactions are again contextualised within wider and repeated experiences of disempowerment people on low incomes might have had in their contact with services. Lila offered an example when she described her move to a hostel:

> *“The ceiling was leaking, it has been leaking since March, the ceiling was leaking with water. And it was causing me issues, I had to report it. I reported it many times but the council weren’t taking any action against it.”*

In this context, people might either expect IAPT to replicate previous experiences of not being heard or taken seriously, or they might in fact experience the service as replicating these experiences. In either case, people may be actively deterred from accessing MH support. For example, Lila referred herself to IAPT but put the phone down during the assessment. She seemed to attribute this, at least partly, to a sense that she was not listened to:

> *“the person didn’t seem to show any emotions. I guess they didn’t listen to what I just said”*

Lila decided not to pursue the referral further following this telephone conversation. Simon explained how a different interaction with his GP could have resulted in a different outcome for him:

> *"if I am feeling like I am being taken more seriously then I feel that I would have probably been a lot more open when it comes to that [IAPT] so I think it would have made a difference, yeah, regardless of how long you are waiting for."*

At the same time, repeated experiences of not being offered support might leave people with a sense that they are left to manage their difficulties on their own:

> Lila: *"In fact today I went and bought some things that I need and paid for myself because I don't have anybody to talk to and even the staff members here or even the residents, they don't seem to be very approachable, or supportive."*
>
> Nora*: "I've always been the type of person to, whatever I go through I either keep to myself or I find it difficult to […] I wanna say I wanted to sort it out myself, I didn't want to ask that from someone else"*

Moreover, in the absence of more positive experiences of interacting with services, people might remain in a state of disempowerment and lose hope that things could change:

> Susan: *"I really gave up on the GP because you didn't know if he was texting you from the GP service or you know, at all. I kind of lost all faith in GPs."*
>
> Lila: *"it didn't work out. Which is not a surprise because many of the things I tried did not work for me. […] I always get my hopes up, whenever I get sent links to organisations to call or contact, thinking that something will be done and my situation will change for the better but sadly it never goes as planned."*

3.2.2.3. *Undeserving and excluded:* Services including IAPT may also be seen as potentially or actively replicating past experiences of discrimination and exclusion. This may be carried out relationally, in interactions, but also though processes and procedures.

Lila described experiences of being repeatedly told that she is a “benefit cheat”, eventually doubting herself:

> *“Sometimes I have been called a benefit cheat, saying that I am pretending to be mentally ill just to receive the income support. […] In a way they made me feel that I’m not worthy of it and I shouldn’t, I have no right to receive it, that I should be making more for work. […] I questioned myself whether I am a benefit cheat.”*

Lila also explained that such experiences had been re-enacted in her interaction with services, including IAPT:

> *“Many times when I need to fill in application forms and I was asked why I am receiving benefits, why I am not working. So that made me feel like guilty and like a criminal as well. […] Why are they asking this? I felt guilty. Are they thinking this?”*

Lila described a sense of undeservingness that led to her experiencing the questions asked in IAPT during her initial interaction with her local service as intrusive. Lila complained about being asked “*too many questions”,* which seems to have been another important factor in her decision to decline the service:

> *“But then [names local IAPT service] with all the questions. I was very disappointed. And annoyed. […] Just the whole asking questions, that’s all. I just felt that it just didn’t seem to be for me. So I decided that I didn’t want to go ahead anymore”*

Alan highlighted a different but equally powerful way services like IAPT might be experienced as exclusionary:

> *“I think the complexity of some of the words that IAPT uses would discourage people from low incomes. […] It creates stress, that they have difficulty in understanding and it creates isolation. I feel that if people from low-income backgrounds can’t relate to a service because they are not communicating in the same way, in the same language and then it can make them feel excluded from the service as they don’t seem on the same page.”*

Alan explained that this sense of isolation was part of his experience, as he felt that the conversation he had about IAPT was *"a bit more complex and less easy to follow at times",* and it was coupled with a sense that *"in IAPT they seemed quite professional and they wanted to almost see things professionally".* Perhaps he experienced this as a repeat of his experience of being socially excluded on the basis of his low-income background:

> *"Being on a low income and coming from a low-income background I was being socially excluded from certain people so that was affecting my mental health. […] People would intentionally not be my friend or they wouldn't befriend me or they would intentionally treat me as a lower class person to them. […] Just their attitude and the dialect or the tone. And just how they communicated with me. It was quite clear. It was a very unpleasant, arrogant approach to me".*

Simon, too, posed the question of whether services are relatable to low-income communities, and identified language as a means through which this is conveyed:

> *"the language being a lot more personal and relatable to what they are going through not just sort of a general this is IAPT and you can ask your GP to be referred to us"*

3.2.3. Perceived Mismatch Between Needs and Available Support.

This final theme illustrates the mismatch between the support participants were hoping to receive, and what they believed IAPT offered. It seems that participants related their MH difficulties to their life circumstances and expected to receive support that would address their needs holistically and be tailored to them. In this context, some saw therapy as irrelevant or unhelpful and concluded that IAPT was not for them. Participants also highlighted the value of establishing relationships of trust and connection.

3.2.3.1. *Personalised and holistic support:* Describing their MH difficulties, participants related those to external factors, predominantly living on a low income:

> Susan: *"I think it is a cyclical relationship. I think lower income can lead to greater stress, anxiety, depression and similarly greater stress, anxiety,*

> *depression can you know, lead to work difficulties, losing your job, not being able to find a new work etc so it can be a very vicious circle"*
>
> Simon: *"It is a big factor when you are obviously struggling financially and you know, having to really balance all of your different finances, your salary and stuff and obviously your job as well, being on the low paid job that I am in. [...] it just can, you know, add a lot of stress, so it is something which made me very depressed at times and very anxious in terms of what the future is going to look like short-term and long-term."*
>
> Lila: *"And now I am still miserable. There are many issues here as well. Especially with the room and their kitchens, that I have to share with the other residents. And my anxiety and my emotions are just detached and I lost, I couldn't sleep at all. Because of all the overthinking."*

This indicates that people understood their difficulties to be at least partly a response to their life conditions. Holding this frame of meaning making, some participants hoped for a change in the conditions fuelling their MH difficulties, expecting that this would bring about improvements in their MH:

> Alan: *"I wanted to focus more on my individual challenges and difficulties and looking at ways to do better or try and resolve them. [...] I wanted to be given support to help me with the issues I struggle, with the problems, challenges."*
>
> Simon: *"so maybe the IAPT service can help with financial hardship or anything like that, that could actually make a difference"*
>
> Lila: *"I wanted to tell the mental health team how much I was suffering at the hostel, by the residents and the staff members. I was hoping they would help me in a way escape from there into better accommodation."*

Participants thus seemed to wish for support that addressed their needs more holistically and was tailored to them. There was therefore a potential mismatch between what participants hoped support would look like, and the support that they felt was available in IAPT, which then contributed to them turning down the service. Alan clearly speaks to this discrepancy:

> *“I think IAPT services need to be more relatable to wider worries or struggles the patient might be going through. […] with life events, not just with a particular condition or illness, but with things that they might have planned for the future or any struggles that they have that is affecting their chances”.*

3.2.3.2. *Not for me:* Another discrepancy between participants and IAPT services seems to have been the extent to which therapy could be relevant or helpful. Some participants seemed to think that therapy would be unhelpful:

> Lila: “*Having a conversation with the person from IAPT just didn’t seem to I don’t know keep me grounded or interested in it […] they could improve their services so that they didn’t seem like unhelpful or boring or just unsupportive.”*
>
> Simon: *“I guess it seemed that talking therapy wouldn’t actually do much or it wouldn’t actually be sort of effective enough so having to wait obviously and then if it didn’t work it would have made me feel like it was a waste of time or you know like I have waited all this time and it has not really helped me.”*
>
> Alan: *“I just felt that the sessions would be too concentrated on emotions and feelings and then we didn’t talk about some of the other issues, they didn’t focus on those so that’s why thought that it wouldn’t be as valuable for me to engage in. […] I wanted more help or intervention to do with getting my job in a secure strong position and allowing me to achieve in my goals or interests. I didn’t really feel there was much importance to measuring and monitoring emotional being or yeah, in the depth of how far they wanted to go into that.”*

The number of sessions participants felt they could access is also relevant here. Simon’s shared some disbelief that significant change could be achieved in a limited number of sessions:

> *“really what could be achieved if I was only allowed to have like 10 sessions for example because once you get started, you’re kind of ending already so I feel like that was something which made me more reluctant”*

Once again, previous experiences in services seemed to shape participants’ experience in IAPT. Lila described that it was difficult for her to believe that IAPT would be different to services she had accessed in the past:

> *“I have tried many other services but I couldn’t trust that [names IAPT service] would be something different and would really help.”*

Personal perceptions and attitudes toward therapy may have discouraged participants from pursuing this option. Although unable to fully articulate why, participants shared a sense that therapy was not for them:

> Nora: *“when someone mentions therapy for me, I’ve always said to myself that you know what, it is not for me. […] it’s more about me being defensive, it’s the fact that I didn’t I wanna say I wanted to sort it out myself, I didn’t want to ask that from someone else, it was more just me and my own stubbornness.”*
>
> Simon: “*I think that generally just my own personal thoughts about having therapy like I was a little bit reluctant at the time”*

3.2.3.3. *Finding connection and support:* Participants in this study declined IAPT, however almost all of them described alternative sources of support. Alongside the support of family and friends, the role of charities and peer support seemed critical, as most participants explained that they had turned to such organisations:

> Lila: *“I know that a lot of the mental health services or charities they do like similar work with other organisations, like other organisations do. And I was trying to what’s the word? Reach out to as many as I could.”*
>
> Nora: *“I did like sign up to different mental health like campaigns or I guess like institutions that do like give other people the opportunity to I did it for like Anxiety UK, I did for Young Minds”*
>
> Simon: *“I decided to look elsewhere for support. My main support that I am kind of getting and still am getting is like sort of peer support really […] So like peer support groups and I’ve been part of like AA meetings and also like other peer support networks that you know the NHS just won’t and different charities as well.”*

In these spaces, participants recognise the value of peer support and lived experience:

> Lila: “*Expressing yourself and hearing what other clients have got to say and then if they are at the surgery, it would make the person feel safer and not afraid or ashamed to talk about the hardship that they are facing. Even like with the cost-of living and things.”*
>
> Nora: “*if you’ve gone through it personally it’s just better like for Young Minds they did this scheme of being an ambassador and that allowed to help other people”*
>
> Simon: “*Being able to relate to them, it kind of makes you feel like you are less alone and in turn it kind of makes me feel like my mood is sort of improved from you know, making connections and building relationships and with people that I feel like I can trust.”*

Participants highlighted the importance of feeling connected to others. Susan was hopeful this could be part of therapy in IAPT:

> Susan: *“I was well, you know [hoping for] counselling or psychological therapy. […] That kind of relational support”*
>
> Nora: *“you can talk about how you feel, especially in terms of your mental health and it’s something that’s just out there for you, that is provided for you, as way to talk about your feelings and talk about what you’re going through so you are not alone”*
>
> Lila: *“I was on my own and I’ve been lonely throughout my life and I wanted someone to be on my side”*

Simon also highlighted the importance of connecting with the therapist, while sharing his concern that this would not materialise:

> *“I think it depends on like the person you are talking to and how well you get on with them so that was probably a concern that I had it was at the time not knowing if I would have actually got on with the person and that sort of belief of if I don’t get on with them, then you know, what is the actual point of getting this sort of service”*

Considering such apprehension, IAPT services might have to work hard to earn people’s trust and spend time on building rapport. Alan declined IAPT, however he described a positive experience of having therapy as a young person, in Child and Adolescent Mental Health Services (CAMHS):

> *"The person [in CAMHS] used to check in with me about my personal and my school life, they used to be very social too and they were doing activities or setting the scene with someone that would get me talking openly in my own will."*

Alan therefore advocated for IAPT services to:

> *"Go out, visit or meet patients or individuals through face to face to understand and get to know them."*

4. DISCUSSION

This research explored changes in IAPT referral and treatment outcomes for people on low incomes after Covid-19 (Study 1), as well as barriers they face in accessing IAPT, and factors that could facilitate access to the service (Study 2). This chapter summarises the main findings in relation to the research questions and situates those in the literature. A critical review of the research is included, which considers important limitations and strengths, and revisits research quality and researcher reflexivity. The study's implications are then explored, in relation to clinical practice, service provision and policy, and future research. The chapter ends with important conclusions about the study's findings and their implications.

4.2. Study Findings: Summary And Location In The Literature

4.2.1. How Have The Referral And Treatment Rates In IAPT Changed For Low-Income Communities Since The Start Of Covid-19, Compared To Their Wealthier Counterparts?

4.2.1.1. *Referrals received:* This study demonstrated that IAPT referrals decreased during the first year of the pandemic (2020-2021). This finding confirms previous studies (Bauer-Staeb et al., 2021; Larsson et al., 2022; Verbist et al., 2023) and matches accounts in Fancourt et al.'s (2022) Covid-19 Social Study, which reported that 1 in 12 people in the UK experienced MH difficulties early in the pandemic, but did not discuss these with a professional for fear they would add pressure to the NHS.

The current study found that IAPT referrals increased in 2021-2022, exceeding pre-pandemic levels. This matches observations by Larsson et al. (2022) but contradicts predictions of an upsurge following the suppression of IAPT referrals during Covid-19; surges exceeding 50% were initially anticipated (The Strategy Unit, 2020). Covid-19 perhaps impacted the population's MH less than originally predicted, as population levels of depression and anxiety map onto Covid-19 waves and associated restrictions (Fancourt et al., 2022). The opposite is also possible, with people potentially presenting with more severe difficulties, warranting input from acute or secondary services rather than IAPT. Preliminary evidence suggests that more people have presented in crisis after Covid-19 (Mannion et al., 2023). It is also possible that people have struggled but not accessed services or that a delayed effect will occur, as with some natural disasters (Morganstein & Ursano, 2020).

While fewer referrals were observed across IMD groups during Covid-19, the drop appeared more pronounced for those most deprived. Referrals in more deprived groups were consistently higher over the period examined, in line with the higher prevalence of MH difficulties in more socio-economically disadvantaged areas (McManus et al., 2016) and the IAPT literature (Baker, 2021; Delgadillo et al., 2018; Green et al., 2012). However, with referrals in the most deprived group decreasing at a higher rate than in the least deprived group, the difference between the two narrowed during Covid-19. This is concerning given the increased MH needs of those more financially vulnerable during the pandemic (Fancourt et al., 2022).

The finding that referrals decreased more for those more deprived during Covid-19 seemingly contradicts Bauer-Staeb et al. (2021), who noted a rise in referrals for people living in higher deprivation. However, the two studies differ in their methodology. The current study used national data for April 2018-2022, looked at yearly changes and compared different IMD groups. In contrast, Bauer-Staeb et al. (2021) used data from five NHS trusts, collected between January 2019 and May 2020, and monitored changes monthly, examining average IMD. This index may have missed differential outcomes for those most deprived, as the mean describes trends across a data set. Moreover, the first two months of Covid-19, on which Baeur-Staeb et al. (2021) focused, may not reflect yearly trends, which this study explored. Indeed, Larsson et al. (2022) described a significant decrease in referrals between February and May 2020, followed by a short positive trend that in turn preceded another dip in August 2020; referrals returned to pre-pandemic levels in October 2020. This indicates considerable variation in the number of referrals within a single year, although the authors did not compare IMD groups.

4.2.1.2. *Access to treatment:* During Covid-19, the overall access rate slightly rose, indicating that more people entered IAPT treatment, attending at least one session. Similarly, the access gap decreased across IMD groups, with fewer referrals ending before treatment at this time, compared to the two years before. The overall access rate returned to pre-pandemic levels in 2021-2022, as did the number of referrals ending without treatment. Consequently, the gains observed during Covid-19, in terms of more people accessing therapy and fewer being discharged without treatment, do not appear to have been maintained.

There are several possible explanations for these findings. IAPT services quickly adapted to Covid-19 and the requirement for remote operation (Mannion et al., 2023). The furlough scheme, with the associated time off work, and the flexibility of working from home that was afforded to many people, may have facilitated treatment access. Taking time off work has previously been identified as a barrier to treatment (Binnie & Boden, 2016). Remote delivery potentially also facilitated access for people who would have otherwise struggled to attend sessions in person, for instance due to mobility or geographical restrictions (Simon et al., 2021).

Alongside IAPT treatment, many services and much of our daily activity operated remotely during Covid-19, which may have rendered therapy over the phone or video more acceptable; Capobianco et al. (2023) supported the acceptability and effectiveness of remote therapy. Due to restrictions implemented at the time, remote therapy was in many cases the only option, and perhaps matched what those referred to IAPT were expecting. Those not prepared or able to access therapy under the circumstances dictated by the pandemic potentially declined an IAPT referral, anticipating that there would be no alternative.

Furthermore, Covid-19 instigated and normalised conversations about MH, with discussions on anxiety, mood and wellbeing becoming more common (Snider & Flaherty, 2020). A reduction in the stigma surrounding MH and help-seeking could have facilitated access to IAPT treatment, particularly as other sources of support, such as social networks, were less available at the time. The decrease in IAPT referrals during the pandemic should also be factored, in terms of a reduced denominator potentially inflating the access rate as a ratio, but also because fewer referrals resulted in shorter waiting lists (Larsson et al., 2022). This may have boosted treatment access rates in IAPT during Covid-19 (2020-2021), as long waits hinder engagement with therapy (Binnie & Boden, 2016).

Those more deprived consistently accessed treatment at a lower rate across the period examined and were discharged without any treatment appointments more often, a finding supported by the IAPT literature (Baker, 2021; Delgadillo et al., 2016a, 2018, Sweetman et al., 2022). However, the most deprived group was the only one not to benefit from an increased access rate in 2020-2021, which was in fact lower than the year before. Several barriers could have been operating. First, major difficulties with therapy engagement identified in the literature include not being able to take time off work (Binnie & Boden, 2016), not addressing important underlying issues (Omylinska-Thurston et al., 2018) and practical problems, like debt and housing difficulties (Fairak, 2018). These are factors that are both more likely to impact low-income populations and less likely to have shifted during Covid-19. Moreover, those on lower incomes are more likely to be digitally excluded by not having access to the technology required to attend remote sessions (e.g., internet) (Holmes & Burgess, 2022). They are also more likely to live in crowded accommodation (Conway et al., 2016), without a private and safe space from which to engage in sessions. Finally, low-income individuals often have job roles that did not offer the opportunity of homeworking and many worked through the pandemic as essential workers (e.g., bus drivers) (Patel et al., 2020).

Directly comparing the most and least deprived IMD groups suggested that their difference in access to therapy was larger after Covid-19 than before. This supports the research hypothesis that the differences in treatment access between the two IMD groups would have increased during Covid-19 and indicates a persistent, widening disadvantage for those most deprived, potentially related to the fact that many IAPT services continued operating remotely during 2021-2022. Such findings add to Verbist et al.'s (2023) observation that unemployed SUs were less likely to access treatment both during and after the pandemic. They potentially indicate that a relative ICL (Cookson et al., 2021) not only continued to operate but has in fact been reinforced after Covid-19, with healthcare use increasing but not in proportion to need.

4.2.1.3. Treatment completion. Those more deprived finished treatment at consistently lower rates over the period studied, in line with previous research (Baker, 2021; Binnie & Boden, 2016; Smyth et al., 2022). However, completion rates rose by approximately 10% during Covid (2020-2021) compared to the previous year, across IMD groups. Unfortunately, this was not sustained following the pandemic, as completion rates returned to pre-pandemic levels in 2021-2022. For the most deprived group, the completion rate after Covid-19 was in fact lower than both 2018-2019 and 2019-2020.

Factors already discussed, facilitating access to treatment (e.g., homeworking) may have contributed to this finding, particularly as the completion rate is calculated as a proportion of those entering treatment; those who could not access treatment for reasons like digital exclusion are therefore not represented in the completion rates. The 2020-2021 SU cohort may have also benefited from therapy more than previous ones, as indicated by the slightly improved recovery rates in 2020-2021 (NHS Digital, 2021). Experiencing treatment as helpful potentially increased motivation to complete it, particularly in the absence of other sources of support given the Covid-19 restrictions. However, IAPT defines treatment completion as attending at least two treatment appointments. Those disengaging at later stages are not captured by this metric, completion rates therefore likely over-estimate the number of people who had a full course of therapy (Moller et al., 2019).

Direct comparisons between those most and least deprived before and after Covid-19 demonstrated that their difference in terms of treatment completion rates have widened. This is in line with the research hypothesis that the differences between the most and least socio-economically disadvantaged IMD groups would have grown during the pandemic, with regards to treatment completion in IAPT. This could be related to homeworking; working remotely is less often an option for low-income individuals (Patel et al., 2020) and its phased ending may have meant that they were the first to return to typical working conditions. Furthermore, it has been established that low-income communities have been hit the hardest by both the pandemic (McGowan & Bambra, 2022) and the ensuing cost-of-living crisis (Francis-Devine, 2023). This potentially resulted in increases in the prevalence, severity and complexity of the difficulties people in this group experienced, in their MH but also their lives. The lack of stability in financial and social circumstances has been associated with disengagement from treatment and prohibits people from making use of therapy (Omylinska-Thurston et al., 2019). As Covid-19 and the cost-of-living crisis destabilised people's lives, they may have further hindered treatment engagement and completion for low-income communities, adding to the treatment disadvantage observed before the pandemic.

4.2.2. What Barriers Do People On Low Incomes Face In Accessing IAPT? What Could Facilitate Access To The Service?

Alongside those who disengage from IAPT between assessment and treatment, captured by data on the access gap, numerous others do not complete the assessment stage or even get through IAPT's doors. Up to 40-45% (Jonker et al., 2020; Thomas et al., 2020) of those who have been recommended IAPT never present in the service. Their experiences are therefore not reflected in the IAPT dataset or the quantitative part of this study. Low-income communities may be over-represented in this group, as they are in the access gap statistics (Delgadillo et al., 2018). The qualitative part of the research thus included interviews with low-income individuals who had not accessed therapy in IAPT to better understand access barriers and facilitators. These are discussed below, with reference to the themes and subthemes developed.

4.2.2.1. *Navigating the system:* Participants described several challenges navigating the MH system and hindering access to IAPT. Transportation, language, restrictions around time of the sessions and other practical barriers were identified by participants in this study as well as previous research (Santiago et al., 2013). Such barriers hinder access to services or regular attendance to sessions. While such barriers may be relevant to many people considering IAPT, low-income individuals are perhaps more severely impacted by practical barriers. For example they are more likely to rely on public transport or worry about its affordability (Titheridge et al., 2014). IAPT services have historically offered remote sessions, an option made more available during Covid-19 (Mannion et al., 2023), which could help overcome some practical barriers. However, people on low incomes may simultaneously experience difficulties accessing resources like a phone (Thomas et al., 2020) and the digital access gap (Watts, 2020), making remote sessions equally inaccessible. It has been suggested that practical support with logistical barriers (e.g., offering transportation) improves access to services for low-income communities (Santiago et al., 2013).

Participants also expressed concerns about IAPT’s waiting list and provided examples of having to wait long for support, including struggling to access GP appointments. Concerns about waiting times have previously been discussed as discouraging engagement with therapy, in qualitative studies with SUs and practitioners (Binnie & Boden, 2016; Marshall et al., 2016; Omylinska-Thurston et al., 2018; Weir et al., 2022) and studies exploring how waiting times impact patient outcomes (Clark et al., 2018; Davis et al., 2020; Larsson et al., 2022). Once again, waiting times may be a concern of many IAPT service users, however this study highlights that people on low incomes may expect a long wait, based on a sense of lacking resources in their local area and previous experiences of interacting with services where delays have taken place, like applying for financial support.

The picture of waiting times in IAPT is complicated, due to local variations and service structure. While 89.4% of those referred entered treatment within six weeks in 2018-2019 (NHS Digital, 2020a), waiting times between referral and first treatment appointment across England ranged from 4 to 69 days during this period (Baker, 2020); between-area disparities from referral to second appointment ranged from 36 to 162 days. Communicating this complexity to SUs might be challenging, particularly for GPs, given the documented gaps in communication and information sharing between them and IAPT (Marshall et al., 2016). GPs might instead warn SUs that they will wait a long time to be seen, as was the case for some study participants. Websites of local IAPT services (e.g., iCope - Camden and Islington) offer similar warnings. This might reflect attempts at transparency, but can also be discouraging, as some participants shared.

Warnings around waiting times could be particularly impactful in the absence of other information about IAPT. Participants described lacking information about the service and some expressed uncertainty about what therapy is. Finazzi and MacBeth (2021) identified lacking knowledge and understanding of what treatment involves as a barrier to therapy access and acceptability. The current study emphasises that, without this information, people may not continue with an IAPT referral. Most study participants urged for greater advertisement of the service, to raise its profile with their local communities. Local attempts at this have indeed led to improvement in access to services (Poots et al., 2014). GPs' mediating role in providing appropriate information, previously highlighted in research (Jonker et al., 2020), re-emerged here, with one participant stating their GP themselves lacked a clear understanding of what IAPT offers.

A point of disagreement in the literature has been whether self-referral facilitates access to IAPT for low-income communities. While Brown et al. (2014) suggested that self-referrals support equitable access to IAPT for different population groups, including those unemployed and/or on benefits, Thomas et al. (2020) argued that self-referrals constitute a barrier for low-income communities; Jonker et al. (2020) also suggested that some SUs favour a GP referral. This study could be seen to support both positions. For one participant, the possibility of referring themselves to IAPT seemed an important experience, particularly given previous experiences of the MH system as fragmented and complex. Another participant, however, expected their GP to complete a referral and did not refer themselves when invited to do so.

4.2.2.2. *Us and them:* More than difficulties navigating the system, a sense of "us and them" seems to have prevented participants in this study from accessing IAPT support. This related first to the task of seeking help. Participants shared worries about being perceived as weak and described taking that first step as challenging, in the context of their MH difficulties. The literature on MH stigma is vast (Clement et al., 2015) and researchers like Finazzi and MacBeth (2021) highlight how difficult it can be for someone severely depressed to seek support. This study suggests, however, that in both cases seeking help from IAPT might be perceived as an "extraordinary act" (Stack & Meredith, 2018, p.238), pursued as last resort.

This has important implications for SUs on low incomes and IAPT services. The literature suggests that low-income individuals have more severe difficulties when starting IAPT treatment (Green et al., 2015; Stochl et al., 2021), which could indicate that they present in services at later stages. This is corroborated by evidence that low-income communities are over-represented in A&E attendances for MH reasons (Baracaia et al., 2020). Moreover, one participant in the current study referred to services as “outsiders”, highlighting a sense of mistrust preventing them from accessing IAPT. This is potentially related to documented perceived social class disparities between therapists and service users that often remain unacknowledged (Trott & Reeves, 2018). An intersectional analysis is crucial, as the literature has identified mistrust towards services as an access barrier for both low-income (Stack & Meredith, 2018) and racialised communities (Prajapati & Liebling, 2021). It is noted that participants who struggled to ask for help eventually did, which suggests that barriers other than challenges with initial help-seeking were operating.

One such barrier was a sense of professionals as disinterested, inattentive or unresponsive. This was a shared experience for participants and echoes previous research on the experiences of people on low incomes in mental health services (Abrams et al., 2009; Jonker et al., 2020; Omylinska-Thurston et al., 2019; Thomas et al., 2020). In the current study, participants described feeling that they were not listened to or taken seriously when discussing IAPT with the GP or during initial contact with IAPT services. In both cases, participants felt discouraged from pursuing an IAPT referral. The importance of being listened to shapes people’s experience of therapy (Finazzi & MacBeth, 2021) and the current study suggests that such features are present even at the point of considering a referral. The referral itself may constitute an act of care; not offered it, a participant explained, communicates dismissal. This corroborates Thomas et al.’s observations (2020) that suggesting a self-referral to IAPT can widen the disconnect between GPs and SUs.

While unhelpful interactions with professionals may not be unique to low-income communities, this study suggests that, for people on low incomes, such occurrences compound previous experiences of disempowerment within services, which IAPT either replicates or is expected to. Such experiences are also understood in a wider context of societal disenfranchisement of low-income individuals, that may leave them feeling powerless (Mattheys et al., 2018) and, as study participants shared, hopeless over the possibility of change. Not being listened to may thus be an experience people have had in their social encounters, interactions with services, discussions with the GP, and contact with IAPT.

Discourses around MH intersect with the narratives of undeservingness and exclusion shaping poverty as a lived experience (Lister, 2004). Participants described being discriminated, feeling excluded and worrying about being judged, based on their socio-economic background, an access barrier potentially specific to this population group. Again, such occurrences may inform people's expectations of IAPT or shape their experience with the service. This occurs relationally, in interactions with professionals, and through processes such as the language used and questions asked. For example, for one participant, being asked about benefits and their employment status, triggered past experiences of being called a "benefit cheat" and was experienced as insinuating that they were undeserving of financial support. Indeed, Thomas et al. (2019) warned that experiences of being made to feel underserving, through systems that question one's entitlement to support, informs how people from low-income backgrounds respond to their MH difficulties and their trust in seeking and accepting support.

The concept of epistemic trust (Fonagy et al., 2015) could be relevant here. Repeated experiences of feeling unsupported, judged or excluded, within and beyond MH services, could leave some low-income individuals questioning the intentions of professionals offering to help and whether they can be trusted as reliable. Such experiences may also shape people's relationship to help (Reder & Fredman, 1996), which is their construct of help and their stance towards those who offer it. These concepts are not invoked as mechanisms of individual pathology but rather to contextualise the sense of distance study participants described between low-income communities ("us") and professionals ("them") and highlight the continuity of experiences in IAPT, other MH services and beyond.

The questions of trust and the perceived "us and them" dichotomy may have been even more relevant for racialised participants in the study, for whom unhelpful interactions in services may have been compounded by experiences of racial discrimination and cultural insensitivity in interactions with services, including mental health services; three out of five participants in this study identified as Asian British.

4.2.2.3. *Perceived mismatch between needs and available support:* Another important consideration is the potential mismatch between what study participants were hoping for or expecting and what they felt was available in IAPT. Participants related their MH difficulties to their life conditions and made explicit links between living on a low income and their MH, in line with a bidirectional relationship between the two (Clark & Wenham, 2022; Read, 2010). Some therefore expected a change in their circumstances as part of the support offered, advocating for holistic and tailored care. However, it seems that they did not feel this would be offered in IAPT, based on what they knew of the service. Finazzi and MacBeth (2021) highlighted that perceiving treatment as impersonal or not adapted to individual needs and context contributes to negative therapeutic experiences. This study suggests that the actual or perceived lack of personalisation may constitute a barrier early in the process, at the point of considering an IAPT referral. For people on low incomes, personalisation may be related to a consideration of one's life conditions, in a way that is perhaps relevant to other groups of the population.

IAPT professionals have also raised concerns about not being able to support SUs with their practical needs and their own limitations in managing these, given service restrictions (Fairak, 2018). Binnie (2015) advocated for wider interventions to be considered in IAPT (e.g., securing safe housing before therapy for anxiety). There have been attempts to combine IAPT therapy with input from a money adviser; preliminary evidence indicates good acceptability by both SUs and professionals (Belcher et al., 2022). Participants in the current study would potentially favour such approaches but did not seem to expect them to be available.

Participants additionally expressed uncertainty around how therapy could be relevant or helpful to them. This scepticism seemed based on both pre-conceptions about therapy and information made available when discussing an IAPT referral. Some participants questioned the effectiveness of therapy in the context of what they wanted to focus on, others shared feeling reluctant or defensive towards therapy. Limitations around the number of available sessions were also important, with one participant wondering what could be achieved in a limited number of sessions in IAPT. This study supports Jonker et al.'s (2020) finding that a lack of belief in psychotherapy is a common reason for non-attendance in IAPT.

The meaning-making framework participants used may also be critical. To the extent that MH difficulties were attributed to external factors, including one's socioeconomic conditions, which participants believed would not be addressed in IAPT, the relevance of the service was understandably questioned. Several participants then concluded that therapy is "not for me", declining IAPT. Concerns have also been raised in the literature regarding the limitations of psychotherapy which does not consider distal causes of distress, such as the socio-economic climate (Harper, 2016). However, there is equally evidence that therapy can be beneficial for low-income individuals, in IAPT (Poots et al., 2014) and other settings (Behn et al., 2018), although recovery rates tend to be smaller for low-income communities (Firth et al., 2023) and adaptations that consider one's socio-economic background have been suggested (Finegan et al., 2019).

A final point of discrepancy between what participants wished for and what they felt was available in IAPT related to the importance of connecting with others. Participants talked about forming meaningful connections with people they could trust or feel safe with, friends and family but also peer support groups and charities; it is noted that participants were recruited through such organisations. Lived experience, with regards to both MH difficulties and living on a low income, also emerged as significant, with participants discussing the power of sharing their experiences or hearing those of others in similar situations. This finding matches Marshall et al.'s (2016) observations around the value of peer support and lived experience and complements studies like that of Firth et al. (2020), who noted that socio-economic similarity facilitated attendance at a group intervention in IAPT. While forming meaningful connections within IAPT did not feel possible for those interviewed for this study, who did not access the service, some found alternative sources of support. This coheres with research conducted by Mind (2017), suggesting that voluntary organisations offer some people a better experience of care than primary MH services. The opportunity to connect might be particularly important for people on low incomes, given the social exclusion participants described, and in the context of individualistic, blaming explanations of poverty (Shildrick & Rucell, 2015).

Many of the barriers discussed in this study can be seen to be relevant to population groups other than low-income communities and may therefore not be unique to people on low incomes. Based on the experiences study participants shared, however, it is argued that living on a low income influences how services and access barriers are perceived and experienced. Navigating the system may be harder in the context of limited resources, leaving people increasingly vulnerable to practical difficulties. A sense of "us and them" may be contextualised within previous experiences of disempowerment and othering on the basis of socioeconomic background, which inform interactions in IAPT. A mismatch between needs and available support may stem from a conceptualisation of one's mental health needs as related to their material conditions, and an understanding of these as beyond IAPT's remit. When examining IAPT access then and considering the findings of both Study 1 and Study 2, one's low-income background may shape their experiences of MH care of lack thereof.

4.3. Critical Review

4.3.1. Strengths

This project incorporated a quantitative study using national IAPT data and a qualitative study focusing on people on low incomes affected by inequalities in access to IAPT. This is in recognition that the voice of lived experience is often missing from academic research (Jones et al., 2021) and that people with lived experience of socio-economic disadvantage hold key information about the realities of poverty and inequality. Furthermore, a group of SUs was consulted in developing the project, their recommendations shaping its execution, including the terminology and materials used.

The study contributes to a developing area of research, by focusing on IAPT as a service and the experiences of low-income communities. Socio-economic disadvantage has been associated with mental ill health (McManus et al., 2016), poverty has been named a major driver of health inequalities (NHSE, 2020) and low-income communities have a poorer experience of IAPT care (Delgadillo et al., 2016a), yet they are under-represented in improving access initiatives and MH research (Thomas et al., 2021). The study joined existing literature on the experiences of this group in IAPT, but also attempted to hear from people who have not accessed the service, whose experiences are not captured in official data. Participants were recruited from the community rather than services and the sample, although small, is diverse, reflecting a range of experiences.

Capturing these experiences is critical in the aftermath of Covid-19 and the cost-of-living crisis. The evidence on the impact of the pandemic is only just emerging, and this study additionally attempted to explore the differential impact on low-income communities. To the researcher's knowledge, this is the first study investigating both the impact of Covid-19 and differences between IMD groups over an extended period, using national rather than regional data. The study's findings could improve understanding of IAPT outcomes post-pandemic and could add to ongoing efforts to re-imagine primary care provision (Marks, 2022).

The study's epistemological position also constitutes a strength. Although rarely explicitly stated, IAPT services and much of the relevant research have adopted a realist epistemological stance, one that asserts an external reality to be investigated and is based on a biomedical approach to distress (Binnie, 2015). This study was informed by a critical realist epistemology, acknowledging both the realities of living on a low income and the constructed nature of poverty and MH. In this context, consideration of power was seen as paramount in approaching the topic, engaging with the literature and interpreting the findings.

4.3.2. Limitations

The study's findings should be considered under the light of important limitations, discussed below separately for the quantitative (Study 1) and qualitative (Study 2) parts of the research.

4.3.2.1. *Study 1:* A major limitation relates to the study's cross-sectional design. While observed trends are described alongside hypotheses seeking to interpret them, conclusions around cause and effect are not possible. Another methodological limitation relates to the complete cases analysis performed, which relies on the assumption that data are missing at random (Little et al., 2022). This was not verified, and potential differences between cases included and cases excluded were not explored. However, only 0.3% of cases, for which IMD was unknown, were excluded from analyses.

Limitations of the statistical tests employed are also important. Although elegant and frequently used, the chi-square statistic is sensitive to sample size, such that small differences between groups can still emerge as statistically significant if the sample is large enough (Field, 2009). This could be the case for this study, as the use of national data resulted in a large sample of observations. This is further compounded by the small effect sizes obtained, although it has been suggested that Cramer's V tends to produce low correlation measures even when the results are highly significant (McHugh, 2012). At the same time, complementing the chi-square tests performed with a log-linear analysis may have not added sufficient nuance, as the test requires parsimony with regards to the number of variables included and it still conceptualises the outcome variable in dichotomous terms. The relative contribution of variables included in the model, important factors such as ethnicity and significant nuance, for example in relation to time of measurement, may have been missed. The statistical plan selected reflects the study's focus on low-income communities and changes post-covid; alternative options, like a logistic regression, were considered but discounted, as not fully addressing the research question. It is acknowledged, however, that a different statistical plan could have allowed additional comparisons, for example by incorporating all 10 IMD groups, or explored potentially important covariates, for example by using individual-level data rather than data extracted from the publicly available IAPT dataset. Limitations around the analyses performed highlight that the results of the study need to be interpreted with caution and in conjunction with other research findings, particularly with regards to their clinical significance.

Interpretations about the impact of Covid-19 on the experiences of people on low incomes in IAPT are also limited by the definitions used and comparisons made. First, as a measure, IMD captures a wider set of indicators, one of which is income, at the level of small areas rather than individual people (McLennan et al., 2019). This study used the terms "low-income communities" and "people on low incomes", which overlap with but are not identical to IMD. For example, the experiences of low-income individuals living in areas of relative wealth are not captured.

Moreover, the study explored outcomes in IAPT services for low-income communities by comparing the two ends of the IMD spectrum. While comparisons were limited to the most and least deprived groups, initial observations and the literature (Poots et al., 2014) indicate that there is a socio-economic gradient in IAPT outcomes across IMD deciles. Comparisons with groups in the middle range of the spectrum are warranted, while expanding the definition of low income beyond the most deprived group would align with estimates that 22% of the population is in relative low income after housing costs (DWP, 2023).

An intersectional exploration of socio-economic and sociodemographic factors is also lacking, despite evidence for differential outcomes based on factors like age or ethnicity, potentially exacerbated by Covid-19 (Laake et al., 2021a). Factors such as gender (Sharland et al., 2023), disability (Dagnan et al., 2022), age (Laake et al., 2021b), religion (Mir et al., 2019), sexuality (Rimes et al., 2019) have been highlighted in the IAPT literature as related to inequalities in access and treatment outcomes, although many relevant studies have examined such factors separately rather an in conjunction. Such factors have also been associated with higher poverty rates (Maroto et al., 2019). As such, incorporating those in the analysis as confounders would have been warranted. This was not possible in this study, as the national IAPT dataset does not provide breakdowns combining IMD and other sociodemographic variables. The only selections that are currently possible are age group/gender and ethnic group/gender. Individual level data were not available for this study, thus making individual level analyses impossible. Care should therefore be taken when interpreting the results of this study, particularly in light of the small effect sizes obtained.

At the same time, the study compared outcomes before and after Covid-19, by grouping together data for April 2018-2020 (pre) and April 2020-2022 (post). The time period selected therefore roughly corresponds to the two years before and the two years after the pandemic, with data from 2018-2019 and 2019-2020 serving as the baseline against which changes were estimated. However, 2018-2019 and 2019-2020 differed regarding key variables, including referral rates and the access gap. For example, 2019-2020 marked an increase in the number of cases ended before treatment across IMD groups compared to the year before, although this difference was not assessed in terms of its significance. It was not possible to establish which year best represented the average performance of IAPT services. Grouping the two years together perhaps did not provide a fully accurate baseline, to explore the impact of Covid-19 and may have resulted in important information being obscured by the data aggregation. Including data prior to 2018-2019 or establishing averages for different IMD groups since 2015-2016, when IMD was first documented in IAPT reports, represent alternative methodological options.

Moreover, it is worth noting that while the first national lockdown was imposed on the 23rd of March 2020, the first cases of Covid-19 in the UK were officially announced on the 29th of January and other European countries imposed lockdown as early as February of that year. Such developments may have impacted outcomes in IAPT, for example by slowing down new referrals to the service in anticipation of an imminent lockdown in the UK. However, data from this period were included in the baseline period (pre), which could have clouded comparisons made; the reader is reminded that IAPT annual reports cover the period from 1st April of one year to 31st March of the following year. Using monthly rather than annual data could have been more appropriate. Similarly, 2020-2021 and 2021-2022 differed in terms of the socio-political environment, Covid-19 regulations and service provision. For instance, there were three national lockdowns in the financial year 2020-2021, but none after April 2021. The study's descriptive analyses would support that outcomes were different for 2020-2021 compared to 2021-2022, however the research design did not allow more nuanced comparisons. It is noted that Covid-19 was still considered a pandemic at the time of writing (WHO, 2023).

4.3.2.2. *Study 2:* Limitations of the qualitative study relate first to its small sample. Although people on low incomes who have not accessed IAPT likely constitute a large population, only five participants were interviewed. This is less than the recruitment target of six participants (see section 2.5.1.). Guest et al. (2012) suggested that data saturation occurs after 6-12 interviews, although they warned against using this as a rule without considering data quality. Given the study's aim, analytic method and quality of dialogue, it is reasonable to believe that more participants would be required to achieve satisfactory information power (Malterud et al., 2016). Reservations around data sufficiency are therefore warranted, with implications for the study's validity and generalisability, with regards to service provision both at a local level and across the country. All recommendations based on this study's findings are offered tentatively and in the context of existing literature around access to mental health services for people on low incomes.

Limitations relevant to the recruitment process are also considered. It may have been difficult for people to come forward as participants, given the narratives of blame and shame attached to poverty (Thomas et al., 2019), compounded by the stigma surrounding MH (Clement et al., 2015). Building links with the community would have been preferable and was attempted but not sufficiently achieved. As participants were recruited mostly through charities and community centres, recruitment potentially missed people not in contact with any kind of services. Study participants may thus not represent the wider population, which includes people who remain very isolated, whose experiences may not be reflected in the findings.

At the same time, recruitment heavily, although not exclusively, relied on digital means, with participants invited to make contact over e-mail or the phone and study materials (e.g., PIS) shared predominantly over e-mail. This may have excluded people without access to a phone, a computer, or the internet, or those uncomfortable using them. Digital means were also used to conduct the interviews, although the in-person option was available. The literature on whether remote interviews facilitate or hinder engagement has been mixed (Thunberg & Arnell, 2022); this might be particularly pertinent to this study, given the sensitivity of the topic explored.

The terminology used is also important, regarding recruitment and generalisability of findings. People potentially eligible for participation were perhaps missed because of the terminology used to advertise the study. There is significant variation in the names of local IAPT services. For instance, the IAPT service in Camden and Islington is called iCope, that in Merton is named Uplift. People may have therefore been unfamiliar with IAPT as a term; indeed, several people who made contact to register their interest in the study had in fact received IAPT therapy, but were unaware that the service they had accessed was an IAPT one. The study advertisement also defined eligibility for the study using descriptors like facing unemployment or housing problems, potentially equating populations that overlap but are not identical. It is important to consider this in terms of identifying who is affected by inequalities in access to IAPT and who these findings are relevant to.

The reader is further reminded that for Study 2, access to IAPT was defined in terms of whether one received psychological therapy. This is in line with IAPT’s foundational aim to improve access to therapy, a holistic understanding of access to health care (Gullliford et al., 2002), as discussed in the introduction, and other studies in the field (e.g., Finegan et al., 2019). Within IAPT’s Key Performance Indicators, access to the service is defined as attending one treatment appointment. This number is then used as the numerator to calculate access rates in relation to the estimated prevalence of mental health presentations relevant to IAPT (i.e., depression and anxiety disorders), based on the figures provided by the Adult

Psychiatric Morbidity Survey (NHS Digital, 2020b). To the extent that an assessment is recorded as first treatment appointment, people who disengage in between assessment and therapy may be counted as accessing IAPT. One participant in this study was offered an assessment, which they did not complete as they put the phone down. Another study participant reported having an introductory call with the service, after which they decided not to go further with an assessment. Both cases represent people who did not access therapy, and thus did not access IAPT based on the definition of access this study has adopted. It is acknowledged, however, that such cases may be counted as accessing IAPT in the context of national definitions employed, if these interactions were recorded as first treatment appointments.

With regards to generalising this study's findings, it is also important to consider that three out of five participants identified as Asian British. The study focused on the experiences of people on low incomes, with limited opportunities to explore how ethnicity may have shaped participants' experiences. For example, Harwood et al. (2023) suggested that racialised groups are less likely to self-refer to IAPT compared to the White British group. In contrast, Clark et al. (2009) supported self-referrals as facilitating access to IAPT for racialised communities. This study did discuss referral routes in relation to access to IAPT for low-income communities, however fully appreciating how referral routes may act as a barrier or a facilitator would require an appreciation of the intersection between income and ethnicity. An intersectional analysis is crucial given the over-representation of racialised communities in estimates of relative poverty (Edmiston, 2022), but was not possible in this study. It is important to hold in mind, however, that socio-demographic variables seem to reduce but not to eliminate treatment disparities for racialised groups in IAPT services (Amati et al., 2023), indicating that ethnicity and socioeconomic background also operate independently.

4.3.3. Quality Appraisal

Research quality was assessed with reference to the concept of trustworthiness, centred around four criteria: credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985; Nowell et al., 2017).

4.3.3.1. *Credibility:* To increase research credibility, I devoted time to engaging with the data, reading and re-reading the transcribed interviews. Familiarisation with the data was further facilitated by transcribing the interviews myself, rather than using a transcription software. Reviewing and defining themes included returning to the interviews several times, to check for inconsistencies between the dataset and the thematic framework produced, which was further reviewed in supervision. Careful consideration was given to including representative quotes across the dataset. Moreover, findings were located within the literature, addressing points of similarity and divergence with previous studies. My position as a researcher was outlined in the methodology section, while the methodology chosen was defined, justified and contextualised within the epistemological position adopted.

4.3.3.2. *Transferability:* Consideration was given to adequately describe: the context of the study; the inclusion and exclusion criteria; the recruitment strategy; the analysis performed; the study's findings; its strengths and limitations. This allows interested researchers to track the research process, draw conclusions about the study's generalisability and decide on how or whether to transfer the findings to their own setting or replicate the study. Section 4.5.1. further discusses clinical applications of the study's findings.

4.3.3.3. *Dependability:* To enhance research dependability, all steps of the study were clearly presented, including the procedure and analysis followed. To illustrate the coding process, Appendix M provides an extract of an anonymised transcribed interview, alongside the codes and an initial thematic map. Choices made about the analysis were discussed in thesis supervision and documented in supervision minutes, which thus serve as a decision trail (Nowell et al., 2017). It is acknowledged, in line with a reflexive approach to TA (Braun & Clarke, 2019), that as a researcher and due to personal and professional views and experiences, I have shaped the analysis in a way that prohibits an identical replication.

4.3.3.4. *Confirmability*: To strengthen confirmability, interview transcripts were made available to the thesis supervisor, themes and subthemes were described in detail, using representative quotes by every participant, and subsequently summarised in relation to the research question. The importance of researcher reflexivity, facilitated by a reflective log, was highlighted in the methodology section and is revisited in the section below.

4.3.4. Researcher Reflexivity

The importance of reflecting on one's position has already been highlighted, for every study and particularly in relation to critical realism as an epistemological position (Wiltshire & Ronkainen, 2021) and reflexive TA as an analytic method (Braun & Clarke, 2019). Personal and professional experiences that have shaped this project have been discussed and were considered at each stage of the research, especially the process of conducting interviews and interpreting the data collected. Throughout this process, I have tried to remain aware of my perceptions of reality and how these have informed my understanding of the experiences participants shared.

I was particularly aware of my identity as a White middle class trainee who does not share many of the experiences participants described. When participants positioned services as "outsiders", I wondered whether I was an outsider too in my role as a researcher, how participants experienced that and whether I was sufficiently attuned to experiences of multiple disadvantage, particularly at the intersection of poverty and race. I wondered about the extent to which my identity and inexperience as a researcher translated in lost opportunities to curiously encourage richer descriptions and accounts or exacerbated blind spots.

I was also mindful of the framework of mental illness dominant in psychology teaching (Bentall, 2013) and MH services (Handerer et al., 2020) I have also been a part of. Recognising psychiatric terminology in participants' accounts (e.g., "depressive episodes") I wondered whether I am contributing to this framework being upheld and the implications for people whose MH difficulties are exacerbated by (or attributable to) significant pragmatic challenges, like unemployment. I wondered whether this study has positioned not accessing IAPT services as a negative outcome. It can be argued that this is not always the case, given the documented limitations of IAPT's current structure and concerns raised about its underpinning values (e.g., Cotton, 2018; Rahim & Cooke, 2019; Timini, 2018). Relevant to this, I wondered about the ethical implications of advocating for increased access to therapy, if this is offered reactively, after suffering has occurred and in the absence of changes in the contextual factors that cause or maintain distress.

These ideas were processed in a reflective diary (Appendix K), in conversations with the thesis supervisor and with colleagues and peers. These discussions supported reflexivity, as did returning to the data multiple times after taking breaks from the research and intentionally checking for misrepresentations attributable to my own oversensitivity to particular accounts.

4.4. Research Implications

Research implications are discussed with reference to clinical practice, service provision and wider policy, as well as future research. The reader is again reminded of important study limitations (see section 4.3.2.) which ought to be considered in relation to the transferability of the findings in clinical contexts, at a local and national level.

4.4.1. Clinical Practice

The findings of the quantitative and qualitative parts of the research are jointly considered in relation to clinical practice, in light of the documented under-representation of low-income communities in IAPT services. Participants' testimonies are seen as complementing the quantitative research part and existing literature, could enrich our understanding of the factors that contribute to service inaccessibility and patient disengagement, and offer ideas around improvement.

First, participants questioned the relevance of therapy and shared a sense that the support available did not match their needs. This needs to be considered in the context of the information people have when they consider an IAPT referral. Given the current pressure on GPs (Salisbury, 2023), it should perhaps fall on each IAPT service to offer the local community an outline of what type of support they offer, what being in therapy means and how it can be relevant to people's conditions. Transparency around waiting times is also important, although information provided should not be limited to warnings about long waits. This is a recommendation for GPs as well, given their mediating role between SUs and IAPT. While advertisements and leaflets could be helpful, participants in this study emphasised the importance of getting to know the needs of the local community. Poots et al. (2014) supported this approach, by combining traditional promotional means (e.g., leaflets) with engagement with social networks (e.g., churches, community groups) to increase referrals to the local IAPT service.

Establishing good links with third-sector organisations is key, given their role in supporting people who do not access statutory services. These connections are also important for addressing the range of difficulties people on low incomes might experience. This is considered relevant to the work of IAPT practitioners, in terms of facilitating access but also retention, improving treatment outcomes, and providing compassionate and responsive care (Delgadillo, 2018). Participants in the study were aware of the complexities of their difficulties and expected the support offered to address those.

Given these complexities and holding in mind that psychological therapy can have negative effects and that its benefit cannot be assumed (Crawford et al., 2016), it would be important for IAPT practitioners to be explicit about how therapy in IAPT can be relevant and in fact helpful for SUs on low incomes. This is particularly significant given additional life pressures people might be facing, which they might consider relevant to their MH difficulties. SUs' expectations and perceptions of therapy should be explored in this context. Relationship to help (Reder & Fredman, 1996) and epistemic trust (Fonagy et al., 2015) are potentially useful concepts to consider and attend to, for a sense of trust and safety to be fostered. These conversations should form part of discussing an IAPT referral, initial contact with SUs, and assessment, and be revisited in subsequent therapy sessions.

It is important that the context of one's MH difficulties is acknowledged and named, in formulations as well as interventions, team discussions, supervision, reflective spaces and service delivery. Financial difficulties but also people's intersectional identities should be considered. Decontextualising distress and pathologising natural responses to adversity causes harm (Thomas et al., 2019). It is therefore important to consider distress as occurring within a complex nexus of needs and experiences. This implies some deviation from treatment protocols to meet individual needs and flexibility around the duration and delivery of therapy. As Binnie (2015) suggested, a wider range of interventions should be considered to address practical problems, like offering support with housing or debt. It has been recommended that IAPT services screen for debt and financial difficulties (NCCMH, 2021); this study would support such practices, if the process and its rationale is clearly explained to SUs, with consideration of how it might be experienced.

The pressure on IAPT clinicians to meet targets around access and recovery may be hindering consideration of SUs’ experiences and the therapeutic relationship, known to determine engagement with therapy (Marshall et al., 2016). The current study supports that this connection is important even in one’s first interactions with IAPT. For low-income communities, these interactions are contextualised within previous experiences with services, where people may have felt disbelieved, let down or excluded. Clinicians need to be aware that such experiences and wider discourses around poverty shape interactions with SUs and reflect on how they engage with such narratives personally and professionally; both SUs and professionals hold beliefs about what help looks like, when it is warranted and how it is offered (Reder & Fredman, 1996).

4.4.2. Service Provision And Policy

In the context of expansion plans included in the NHS Long Term Plan (NHSE, 2019) and developments including the introduction of primary care networks and the transformation of community MH care, it is important to attend to those IAPT has left behind, including low-income communities (Walker et al., 2018). Already an imperative within a human rights-informed approach to health and the NHS constitution (2012), this is more urgent after Covid-19, considering potentially widening inequalities along the lines of poverty in IAPT outcomes that this study has illustrated, and ongoing financial pressures on the population (Corlett & Try, 2022).

Alongside increases in service provision to reduce waiting times, participants’ experiences support holistic approaches to care, which consider individual needs and provide an opportunity to feel heard, understood and supported. These may be difficult to achieve within the current IAPT structure, given concerns raised around the emphasis on protocolised interventions, throughput and targets (Binnie, 2015, 2018; Martin et al., 2022; Timimi, 2018). Some level of cultural shift is therefore required to allow for flexibility, connection and an appreciation of people’s context and its impact on their MH. IAPT clinicians would require time, resources and, crucially, permission, to place individual needs at the core of their practice, create a sense of trust and safety, and work creatively with SUs to identify where and how these can be met.

Convincing people to come through IAPT's doors and engage in interventions offered also requires careful consideration of how the service can be relevant to low-income communities. Clarity over what a psychological intervention would target is essential (Thomas et al., 2019), in the face of sources of distress that therapy would not address, such as housing problems. Construction of a wider web of support would be important, made available in or through IAPT. Assistance with financial difficulties, offered alongside psychological therapy, may be of value (Belcher et al., 2022; Egan & Robison, 2019), although previous efforts to do this have suffered from low uptake and implementation challenges (Steadman & Thomas, 2015). Supporting links with social infrastructures, other statutory services and community organisations could address the needs of low-income individuals that IAPT cannot meet and foster a sense of community and wrap-around support. A wider package of care, acknowledging the range of needs people on low incomes might have at the point of considering IAPT could increase the service's acceptability.

In rethinking existing structures and implementing changes all key stakeholders should be involved. This includes GPs, many of whom are acutely aware of the impact of social circumstances on MH and dissatisfied with support options (Thomas et al., 2019), yet tasked with the responsibility of offering SUs a positive experience of help-seeking and adequate information around available services. Crucially, conversations should include those affected by inequalities in access to IAPT, low-income individuals with MH difficulties who require support. This could not only be a powerful experience for people often marginalised due to their socio-economic background (Pantazis, 2016), it would also allow a better understanding of what support is relevant and helpful and consequently increase its acceptability. To date and to the researcher's knowledge, IAPT services have not undertaken discussions of this kind beyond local projects, and the IAPT manual (NCCMH, 2021) references but does not engage with the impact of social deprivation.

Furthermore, data on referrals ended without treatment, where low-income communities are over-represented, must be examined alongside recovery rates, figures on the number of people disengaging during therapy and data on longer-term outcomes for those who complete treatment, at both a national and a local level. Making services more available does not necessarily mean that they are appropriate (Thomas et al., 2021), which needs to be contemplated as part of widening access initiatives. If IAPT services replicate experiences of disappointment, exclusion and disempowerment, whether improving access causes more harm than good ought to be carefully considered. Such interactions could discourage people from seeking help or engaging in therapy in the future (Martin et al., 2022), while alienating people from services may further their marginalisation (Walker et al., 2018). Improving access to IAPT therefore should not replace other important aspects of service provision, like the therapeutic experience, and succumb to the tunnel vision that has previously characterised performance measurement in the NHS (Mannion & Braithwaite, 2012) or distract from the values that targets reflect (Binnie, 2015).

This study joins calls for poverty-aware practice, embedded in IAPT and MH services more widely, at the level of clinical practice but also training, service provision and commissioning. Rather than considering poverty a variable in the background, this relies on a thorough understanding of its strong links with MH and views poverty as the product of social and structural injustices rather than individual behaviour (Krumer-Nevo, 2020). This is essential in minimising disappointing experiences for low-income individuals who consider or present in IAPT services. Understanding this link also invites a reconsideration of the role of CP. Supply will never meet demand for therapy, Harper (2016) observed; resources should therefore be redirected to preventing suffering, a position that is both ethically and pragmatically convincing.

Both research and clinical practice support that poverty is deleterious for people’s MH; there is an ethical imperative for CP to disseminate this knowledge when contributing to policy. It can be argued that this has not been the case with IAPT, which in many ways has been the product of professional interests around expanding our sphere of influence aligning with political interests related to people returning or staying in work (Walker et al., 2018). Across settings, CP has been criticised for replicating individualistic accounts of poverty and MH in research (Harper, 2003); for contributing to poverty and class being disregarded through models that view individuals as unable to cope, engaging in negative thinking or not resilient enough (Smith, 2010); for not advocating for interventions targeting issues known to contribute to distress, like access to adequate financial support (Hagan & Smail, 1997); for failing to acknowledge social inequalities in the therapy room (Delgadillo, 2018). Mills (2015) is firmer in accusing the discipline for being complicit with the medicalisation of misery and the psychiastrisation of poverty.

Ongoing developments in the restructuring of primary and community MH care represent a unique opportunity to rectify this, one that CP cannot afford to miss (Durcan, 2020). The British Psychological Society has recently engaged in a campaign named “From Poverty to Flourishing”, advocating for poverty to be treated as a systemic crisis and highlighting its impact on MH. The Society has further campaigned for social class to be included as a protected characteristic under the 2010 Equalities Act. Professional interest in primary care has also been reignited in recent years, acknowledging existing gaps in service provision and the potential of CP to contribute to improved outcomes. This culminated in the establishment of the Faculty of Primary Care in September 2022. These ideas ought to be transferred to IAPT services. Evidently, alongside looking outwards, it is imperative for the profession to look inwards, to address the lack of diversity (Marks, 2023) that contributes to the sense of alienation many people on low incomes experience in their interactions with IAPT and shapes their perception of therapy as irrelevant.

4.4.3. Future Research

Future research could address some of this study’s limitations and further the understanding of its findings. First, this study only described patterns of service use during and after Covid-19, as is the case for other studies on this topic (Bauer-Staeb et al., 2021, Larrson et al., 2022; Verbist et al., 2023). Research employing more robust designs (e.g., multilevel modelling) should complement initial observations. This study suggested that the difference between the most and least deprived IMD groups in treatment access and completion is widening. It would be important to continue monitoring these patterns, potentially expanding comparisons to a larger range of socio-economic groups. Exploring regional differences would also be useful, to identify good practice examples and learn from services with improved outcomes.

Covid-19 may have long-term implications for the NHS and population MH (Mannion et al., 2023), potentially exacerbated by the cost-of-living crisis, given the documented effect of recessions on MH and treatment outcomes (Barr et al., 2015). Preliminary evidence suggests that there has not been a surge in IAPT referrals, however the possibility of an after wave should be explored. IAPT outcomes should also be juxtaposed with outcomes in other services, like emergency care. It is possible that people presented in services other than IAPT or that longer waiting lists for other services will later put pressure on IAPT. IAPT outcomes should also be juxtaposed with prescription rates for psychiatric drugs, as studies in other countries have demonstrated increases in the use of antidepressants and anxiolytics during Covid-19 (Milani et al., 2021; Tiger et al., 2023). This is particularly relevant for low-income communities, where prescription rates and use of psychoactive drugs were already elevated (Taylor et al., 2019).

At the same time, further research is required to better understand the experience of low-income communities in IAPT services. For example, the improved completion rates observed in 2020-2021 were a positive development; understanding what facilitated this could inform IAPT practice and help maintain the gains achieved. Beyond Covid-19, our understanding of what makes services appropriate and relevant for people at the intersection of mental ill health and poverty is still growing (Thomas et al., 2021). Hearing from those directly affected is key for service design and delivery, to ensure that the support services offer matches the needs of the population. This should include reaching out to people in the community not seen in statutory services, as this study has attempted.

4.5. Conclusions

This study joins previous research documenting inequalities for low-income communities in IAPT services. The study supports that Covid-19 has impacted service provision in IAPT and that the effect was in some ways different for people on low incomes compared to their wealthier counterparts. It seems that the anticipated upsurge in the demand for IAPT services has not materialised but should be monitored. This study also suggests that the gap between low-income communities and those most socio-economically privileged has widened following Covid-19, in relation to both treatment access and completion.

People interviewed for this study, who identified as low-income and had not accessed IAPT therapy, described difficulties navigating the system, but also shared feelings of alienation towards services, including IAPT, as well as a sense that what they needed and they felt was available in IAPT were not aligned, which contributed to them declining the service. Their experiences are contextualised within past interactions with services, which IAPT replicated or was expected to replicate, and wider narratives shaping the experience of living on a low income.

Although further research is required to confirm the study's findings and holding in mind its limitations, this study encourages IAPT services to explore SUs' MH difficulties alongside their socio-economic circumstances, attend to the multiple needs of low-income communities and consider ways to address those. It is argued that, to some extent, a cultural shift would be required for IAPT services to meaningfully engage with issues of poverty. This includes a consideration of how IAPT therapy can be helpful for people on low incomes and whether improving access to the service for low-income communities should indeed constitute a target. CPs hold an important role in highlighting the link between poverty and MH to inform service provision and policy that alleviates but also prevents distress.

REFERENCES

Abrams, L. S., Dornig, K., & Curran, L. (2009). Barriers to service use for postpartum depression symptoms among low-income ethnic minority mothers in the United States. *Qualitative Health Research, 19*(4), 535 – 551. https://doi.org/10.1177/1049732309332794

Acheson, D., Barker, D., Chambers, J., Graham, H., Marmot, M., & Whitehead, M. (1998). *Independent Inquiry into Inequalities in Health Report.* Department of Health and Social Care. https://www.gov.uk/government/publications/independent-inquiry-into-inequalities-in-health-report

Acton, R. (2016). *The missing link. How tackling financial difficulty can boost recovery rates in IAPT.* Money and Mental Health Policy Institute. https://www.moneyandmentalhealth.org/the-missing-link/

Agerbo, E., Trabjerg, B. B., Børglum, A. D., Schork, A. J., Vilhjálmsson, B. J., Pedersen, C. B., Hakulinen, C., Albiñana, C., Hougaard, D. M., Grove, J., McGrath, J., Bybjerg-Grauholm, J, Mors, O., Plana-Ripoll, O., Werge, T., Wray, N. R., Mortensen, P. B., & Musliner, K. L. (2021). Risk of early-onset depression associated with polygenic liability, parental psychiatric history, and socioeconomic status. *JAMA psychiatry, 78*(4), 387-397. https://doi.org/10.1001/jamapsychiatry.2020.4172

Alston, P. (2018, November 16). *Statement on visit to the United Kingdom, by Professor Philip Alston, United National Special Rapporteur on extreme poverty and human rights* [statement]. United Nations. https://www.ohchr.org/en/statements/2018/11/statement-visit-united-kingdom-professor-philip-alston-united-nations-special

Amati, F., Green, J., Kitchin, L., Watt, H., Jones, S., AlRubaye, N., McCann, L., & Greenfield, G. (2023). Ethnicity as a predictor of outcomes of psychological therapies for anxiety and depression: a retrospective cohort analysis. *Behavioural and Cognitive Psychotherapy, 51*(2), 164-173. https://doi.org/10.1017/S1352465822000558

Amoretti, S., Mezquida, G., Rosa, A. R., Bioque, M., Cuesta, M. J., Pina-Camacho, L., Garcia-Rizo, C., Barcones, F., González-Pinto, A., Merchán-Naranjo, j., Corripio, I., Vieta, E., Baeza, I., Cortizo, R., Bonnín, C., Torrent, C., Bernardo, M., & PEPs Group. (2021). The functioning assessment short test (FAST) applied to first-episode psychosis: psychometric properties and severity thresholds. *European Neuropsychopharmacology, 47*, 98-111. https://doi.org/10.1016/j.euroneuro.2021.02.007

Bacchi, C. (2009). *Analysing Policy: What's the problem represented to be?* (1st ed.). Pearson Education Australia.

Baker, C. (2021). *Mental Health Statistics (England).* House of Commons Library. https://researchbriefings.files.parliament.uk/documents/SN06988/SN06988.pdf

Bambra, C., Riordan, R., Ford, J., & Matthews, F. (2020). The COVID-19 pandemic and health inequalities. *Journal of Epidemiology & Community Health, 74(*11), 964-968. https://doi.org/10.1136/jech-2020-214401

Banks, J., & Xu, X. (2020). The mental health effects of the first two months of lockdown during the COVID-19 pandemic in the UK. *Fiscal Studies, 41*(3), 685-708. https://doi.org/10.1111/1475-5890.12239

Baracaia, S., McNulty, D., Baldwin, S., Mytton, J., Evison, F., Raine, R., Giacco, D., Hutchings, A., & Barratt, H. (2020). Mental health in hospital emergency departments: cross-sectional analysis of attendances in England 2013/2014. *Emergency Medicine Journal, 37*(12), 744 – 751. https://doi.org/10.1136/emermed-2019-209105

Barr, B., Kinderman, P., & Whitehead, M. (2015). Trends in mental health inequalities in England during a period of recession, austerity and welfare reform 2004 to 2013. *Social Science & Medicine, 147*, 324-331. http://dx.doi.org/10.1016/j.socscimed.2015.11.009

Bauer-Staeb, C., Davis, A., Smith, T., Wilsher, W., Betts, D., Eldridge, C., Griffith, E., Faraway, J. & Button, K. S. (2021). The early impact of COVID-19 on primary care psychological therapy services: A descriptive time series of electronic healthcare records. *EClinicalMedicine, 37*, 1 - 11. https://doi.org/10.1016/j.eclinm.2021.100939

Bearman, M. (2019). Eliciting rich data: A practical approach to writing semi-structured interview schedules. *Focus on Health Professional Education: A Multi-disciplinary Journal, 20*(3), 1-11. https://doi.org/10.11157/fohpe.v20i3.387

Beck, A., Naz, S., Brooks, M., & Jankowska, M. (2019). *Black, Asian and Minority Ethnic service user positive practice guide.* British Association for Behavioural and Cognitive Psychotherapies. https://lewishamtalkingtherapies.nhs.uk/wp-content/uploads/2021/10/IAPT-BAME-PPG-2019.pdf

Behn, A. J., Errázuriz, P. A., Cottin, M., & Fischer, C. (2018). Change in symptomatic burden and life satisfaction during short-term psychotherapy: Focusing on the role of family income. *Counselling and Psychotherapy Research, 18*(2), 133-142. https://doi.org/10.1002/capr.12158

Belcher, H. L., Evans, J., Bond, N., Darcy, C., Hatch, M., Preece, G., & Wykes, T. (2022). Views of services users and staff on a combined money advice and psychological therapy service within IAPT. *Journal of Mental Health,* 1-9. https://doi.org/10.1080/09638237.2022.2069718

Belle, D. (1990). Poverty and women's mental health. *American Psychologist, 45(*4), p. 385 – 389. https://doi.org/10.1037/0003-066X.45.3.385

Bellis, M. A., Lowey, H., Leckenby, N., Hughes, K., & Harrison, D. (2014). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of Public Health, 36*(1), 81-91. https://doi.org/10.1093/pubmed/fdt038

Bellù, L. G., & Liberati, P. (2005). *Impacts of policies on poverty: The definition of poverty*. Food and Agriculture Organization of the United Nations. https://mpra.ub.uni-muenchen.de/44644/

Bentall, R. P. (2013). Foreword. In J. Cromby, D. Harper & P. Reavey (Eds.) *Psychology, Mental Health and Distress* (xxiv-xxv). Palgrave Milligan.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234. https://doi.org/10.1177/1468794112468475

Bergin, M., Wells, J. S., & Owen, S. (2008). Critical realism: a philosophical framework for the study of gender and mental health. *Nursing Philosophy, 9*(3), 169-179. https://doi.org/10.1111/j.1466-769X.2008.00358.x

Berzins, S., Babins-Wagner, R., & Hyland, K. (2018). Relationship of employment status and socio-economic factors with distress levels and counselling outcomes during a recession. *Counselling and Psychotherapy Research, 18*(2), 122-132. https://doi.org/10.1002/capr.12164

Bhaskar, R. (1978). *A realist theory of science*. Harvester Press.

Binnie, J. (2015). Do you want therapy with that? A critical account of working within IAPT. *Mental Health Review Journal, 20*(2), 79-83. https://doi.org/10.1108/MHRJ-11-2014-0044

Binnie, J., & Boden, Z. (2016). Non-attendance at psychological therapy appointments. *Mental Health Review Journal, 21*(3), p. 231-248. https://doi.org/10.1108/MHRJ-12-2015-0038

Bramley, G., Treanor, M., Sosenko, F., & Littlewood, M. (2021). *State of hunger. Building the evidence on poverty, destitution, and food insecurity in the UK*. The Trussel Trust. https://www.trusselltrust.org/wp-content/uploads/sites/2/2021/05/State-of-Hunger-2021-Report-Final.pdf

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative research in sport, exercise and health, 11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021). *Thematic Analysis: A Practical Guide*. Sage.

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13*(2), 201-216. https://doi.org/10.1080/2159676X.2019.1704846

Braveman, P. & Gottlieb, L. (2014). The social determinants of health: it’s time to consider the causes of the causes. *Public Health Reports, 129*(2), 19 – 31. https://doi.org/10.1177/00333549141291S206

Brewer, M., Fry, E., & Try, L. (2023). *The Living Standards Outlook 2023*. The Resolution Foundation. https://www.resolutionfoundation.org/app/uploads/2023/01/Living-Standards-Outlook-2023.pdf

Brown, D. W., Balluz, L. S., Ford, E. S., Giles, W. H., Strine, T. W., Moriarty, D. G., Croft, J., & Mokdad, A. H. (2003). Associations between short-and long-term unemployment and frequent mental distress among a national sample of men and women. *Journal of Occupational and Environmental Medicine, 45*(11), 1159-1166. https://doi.org/10.1097/01.jom.0000094994.09655.0f

Brown, J. S. L., Ferner, H., Wingrove, J., Aschan, L., Hatch, S. L., & Hotopf, M. (2014). How equitable are psychological therapy services in South East London now? A comparison of referrals to a new psychological therapy service with participants in a psychiatric morbidity survey in the same London borough. *Social Psychiatry and Psychiatric Epidemiology, 49*(12), 1893-1902. https://doi.org/10.1007/s00127-014-0900-6

Brown, T. H., Richardson, L. J., Hargrove, T. W., & Thomas, C. S. (2016). Using multiple-hierarchy stratification and life course approaches to understand health inequalities: The intersecting consequences of race, gender, SES, and age. *Journal of Health and Social Behavior, 57*(2), 200-222. https://doi.org/10.1177/0022146516645165

Bullock, H. E., Fraser Wyche, K., & Williams, W. R. (2001). Media images of the poor. *Journal of Social Issues, 57*(2), 229-246. https://doi.org/10.1111/0022-4537.00210

Buzelli, L., Cameron, G., Duxbury, K., Gardner, T., Rutherford, S., Williamson, S., & Alderwick, H. (2022). *Public perceptions of health and social care. What the new government should know*. The Health Foundation. https://www.health.org.uk/sites/default/files/upload/publications/2022/What%20the%20new%20government%20should%20know_RGB_WEB.pdf

Byrne, A., Barber, R., & Lim, C. H. (2021). Impact of the COVID-19 pandemic–a mental health service perspective. *Progress in Neurology and Psychiatry, 25*(2), 27-33. https://doi.org/10.1002/pnp.708

Cabaj, J. L., Musto, R., & Ghali, W. A. (2019). Public health: who, what and why? *Canadian Journal of Public Health, 110*(3), 340 – 343. https://doi.org/10.17269/s41997-019-00207-2

Cambridge Econometrics. (2018). *The impact of Brexit on poverty in the UK.* Joseph Rowntree Foundation. https://www.camecon.com/wp-content/uploads/2018/09/FINAL-REPORT-The-impact-of-Brexit-on-poverty-in-the-UK.pdf

Capobianco, L., Verbist, I., Heal, C., Huey, D., & Wells, A. (2023). Improving access to psychological therapies: Analysis of effects associated with remote provision during COVID-19. *British Journal of Clinical Psychology, 62*(1), 312-324. https://doi.org/10.1111/bjc.12410

Carr, S. (2019). 'I am not your nutter': a personal reflection on commodification and comradeship in service user and survivor research. *Disability & Society, 34*(7-8), 1140-1153. https://doi.org/10.1080/09687599.2019.1608424

Chandola, T., Kumari, M., Booker, C. L., & Benzeval, M. (2022). The mental health impact of COVID-19 and lockdown-related stressors among adults in the UK. *Psychological Medicine, 52*(14), 2997-3006. https://doi.org/10.1017/S0033291720005048

Chung, H., Taylor-Gooby, P., & Leruth, B. (2018). Political legitimacy and welfare state futures: Introduction. *Social Policy & Administration, 52*(4), 835-846. https://doi.org/10.1111/spol.12400

Clark, D. & Whittington, A. (2023, January 16). What's in a name? NHS Talking Therapies, for anxiety and depression – the new name for IAPT services. *NHS England Blogs.* https://www.england.nhs.uk/blog/whats-in-a-name-nhs-talking-therapies-for-anxiety-and-depression-the-new-name-for-iapt-services/

Clark, D. (2019, February 13). IAPT at 10: Achievements and challenges. *NHS England blogs*. https://www.england.nhs.uk/blog/iapt-at-10-achievements-and-challenges/

Clark, D., Canvin, L., Green, J., Layard, R., Pilling, S., & Janecka, M. (2018). Transparency about the outcomes of mental health services (IAPT approach): an analysis of public data. *The Lancet, 391*(10121), 679-686. https://doi.org/10.1016/S0140-6736(17)32133-5

Clark, D., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy, 47*(11), 910-920. https://doi.org/10.1016/j.brat.2009.07.010

Clark, T., & Wenham, A. (2022). *Anxiety nation? Economic insecurity and mental distress in 2020s Britain*. Joseph Rowntree Foundation. https://www.jrf.org.uk/report/anxiety-nation-economic-insecurity-and-mental-distress-2020s-britain

Clarke, V., & Braun, V. (2018). Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling and Psychotherapy Research, 18*(2), 107-110. https://doi.org/10.1002/capr.12165

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C., Rusch, N., Brown, J. S. L., & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*(1), 11-27. https://doi.org/10.1017/S0033291714000129

Collishaw, S., Furzer, E., Thapar, A., & Seller, R. (2019). Brief report: a comparison of child mental health inequalities in three UK population cohorts. *European Child & Adolescent Psychiatry, 28(*11), 1547 – 1549. https://doi.org/10.1007/s00787-019-01305-9

Conway, R., Byrne, D., O’Riordan, D., Cournane, S., Coveney, S., & Silke, B. (2016). Influence of social deprivation, overcrowding and family structure on emergency medical admission rates. *QJM: An International Journal of Medicine, 109*(10), 675-680. https://doi.org/10.1093/qjmed/hcw053

Cookson, R., Doran, T., Asaria, M., Gupta, I., & Mujica, F. P. (2021). The inverse care law re-examined: a global perspective. *The Lancet, 397*(10276), 828-838. https://doi.org/10.1016/S0140-6736(21)00243-9

Corlett, A., & Try, L. (2022). *In at the deep end. The living standards crisis facing the new Prime Minister.* Resolution Foundation. https://www.resolutionfoundation.org/app/uploads/2022/09/In-at-the-deep-end.pdf

Cotton, E. (2018). The future of mental health services: the organising challenge ahead. *Soundings, 70,* 149-172. https://www.muse.jhu.edu/article/710449.

Crawford, M. J., Thana, L., Farquharson, L., Palmer, L., Hancock, E., Bassett, P., Clarke, J., & Parry, G. D. (2016). Patient experience of negative effects of psychological treatment: results of a national survey. *The British Journal of Psychiatry, 208*(3), 260-265. https://doi.org/10.1192/bjp.bp.114.162628

Crenshaw, K. (1989). Demarginalising the intersection or race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1*(8), 139 – 167. https://chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=uclf

Crouch, E., Jones, J., Strompolis, M., & Merrick, M. (2020). Examining the association between ACEs, childhood poverty and neglect, and physical and mental health: Data from two state samples. *Children and Youth Services Review, 116,* 1-7. 105155. https://doi.org/10.1016/j.childyouth.2020.105155

Curtis, S., Copeland, A., Fagg, J., Congdon, P., Almog, M., & Fitzpatrick, J. (2006). The ecological relationship between deprivation, social isolation and rates of hospital admission for acute psychiatric care: a comparison of London and New York City. *Health & Place, 12*(1), 19-37. https://doi.org/10.1016/j.healthplace.2004.07.002

Curtis, S., Cunningham, N., Pearce, J., Congdon, P., Cherrie, M., & Atkinson, S. (2021). Trajectories in mental health and socio-spatial conditions in a time of economic recovery and austerity: A longitudinal study in England 2011–17. *Social Science & Medicine,* 270(113654), 1-11. https://doi.org/10.1016/j.socscimed.2020.113654

Dagnan, D., Rodhouse, C., Thwaites, R., & Hatton, C. (2022). Improving Access to Psychological Therapies (IAPT) services outcomes for people with learning disabilities: national data 2012–2013 to 2019–2020. *The Cognitive Behaviour Therapist, 15,* e4. https://doi.org/10.1017/S1754470X21000404

Davey, F., McGowan, V., Birch, J., Khun, I., Lahiri, A., Gkiouleka, A., Arora, A., Sowden, S., Bambra, C., & Ford, J. (2022). Levelling up health: A practical, evidence-based framework for reducing health inequalities. *Public Health in Practice, 100322*(4), 1 - 18. https://doi.org/10.1016/j.puhip.2022.100322

Davis, A., Smith, T., Talbot, J., Eldridge, C., & Betts, D. (2020). Predicting patient engagement in IAPT services: a statistical analysis of electronic health records. *BMJ Mental Health, 23*(1), 8-14. http://dx.doi.org/10.1136/ebmental-2019-300133

Decerf, B. (2021). Combining absolute and relative poverty: income poverty measurement with two poverty lines. *Social Choice and Welfare, 56*(2), 325-362. https://doi.org/10.1007/s00355-020-01279-7

Delgadillo, J. (2018). Worlds apart: Social inequalities and psychological care. *Counselling & Psychotherapy Research, 18*(2), 111–113. https://doi.org/10.1002/capr.12168

Delgadillo, J., Asaria, M., Ali, S., & Gilbody, S. (2016a). On poverty, politics and psychology: The socioeconomic gradient of mental healthcare utilisation and outcomes. *British Journal of Psychiatry, 209*(5), 429 – 430. https://doi.org/10.1192/bjp.bp.115.171017

Delgadillo, J., Farnfield, A., & North, A. (2018). Social inequalities in the demand, supply and utilisation of psychological treatment. *Counselling and Psychotherapy Research, 18*(2), 114-121. https://doi.org/10.1002/capr.12169

Delgadillo, J., Kellett, S., Ali, S., McMillan, D., Barkham, M., Saxon, D., Donohoe, G., Stonebank, H., Mullaney, S., Eschoe, P., Thwaites, R., & Lucock, M. (2016b). A multi-service practice research network study of large group psychoeducational cognitive behavioural therapy. *Behaviour Research and Therapy, 87*, 155 – 161. https://doi.org/10.1016/j.brat.2016.09.010.

Dembling, B. P., Rovnyak, V., Mackey, S., & Blank, M. (2002). Effect of geographic migration on SMI prevalence estimates. *Mental Health Services Research*, *4*(1), 7 – 12. https://doi.org/10.1023/A:1014041024787

Department for Levelling Up, Housing and Communities. (2022). *Levelling Up the United Kingdom.* https://www.gov.uk/government/publications/levelling-up-the-united-kingdom

Department for Work and Pensions. (2023). *Households Below Average Income: an analysis of the UK income distribution: FYE 1995 to FYE 2022.* https://www.gov.uk/government/statistics/households-below-average-income-for-financial-years-ending-1995-to-2022/households-below-average-income-an-analysis-of-the-uk-income-distribution-fye-1995-to-fye-2022

Department of Health and Social Care. (2012). *The NHS Constitution for England*. https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england

Department of Health and Social Care. (2022). *Build Back Better: Our Plan for Health and Social Care*. https://www.gov.uk/government/publications/build-back-better-our-plan-for-health-and-social-care/build-back-better-our-plan-for-health-and-social-care

Department of Health. (2003). *Tackling Health Inequalities: A Programme for Action.* http://www.bris.ac.uk/poverty/downloads/keyofficialdocuments/Tackling%20HE%20program%20for%20action.pdf

Department of Health. (2008). *Health Inequalities: Progress and Next Steps.* https://www.choiceforum.org/docs/inequalities.pdf

Department of Health. (2011). *No health without mental health. A cross-government mental health outcomes strategy for people of all ages.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Department of Health. (2012). *IAPT three-year report. The first million patients.* https://www.mhinnovation.net/sites/default/files/downloads/innovation/reports/Three-year-report.pdf

Durcan, G. (2020). *Clinical psychology in primary care*. Centre for Mental Health. https://www.centreformentalhealth.org.uk/publications/clinical-psychology-primary-care

Edmiston, D., Begum, S., & Kataria, M. (2022). *Falling faster amidst a cost-of-living crisis: Poverty, inequality and ethnicity in the UK.* The Runnymede Trust. https://assets.website-files.com/61488f992b58e687f1108c7c/633d8007a3bfa49bd4cd0fa8_Runnymede%20Briefing%20Cost%20of%20Living%20FINAL.pdf

Egan, J., & Robison, O. (2019). *Integrating money advice workers into primary care settings: an evaluation*. Glasgow Centre for Population Health. https://ihub.scot/media/5713/gcph-integrating-money-advice-workers-into-primary-care-settings-an-evaluation.pdf

Elliott, I. (2016). *Poverty and Mental Health: a review to inform the Joseph Rowntree Foundation's Anti-Poverty Strategy.* Mental Health Foundation. https://www.bl.uk/collection-items/poverty-and-mental-health-a-review-to-inform-the-joseph-rowntree-foundations-antipoverty-strategy

Elwell-Sutton, T., Marshall, L., Bibby, J., & Volmert, A. (2019). *Briefing: Reframing the conversation on the social determinants of health.* The Health Foundation. https://www.health.org.uk/sites/default/files/upload/publications/2019/Reframing%20the%20conversation%20on%20social%20determinants.pdf

Equality Act 2010 (c. 31). https://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

Evans, G., Wells, N. M., & Moch, A. (2003). Housing and mental health: a review of the evidence and a methodological and conceptual critique. *Journal of Social Issues, 59*(3), 475-500. https://doi.org/10.1111/1540-4560.00074

Faheem, A. (2023). 'It's been quite a poor show'–exploring whether practitioners working for Improving Access to Psychological Therapies (IAPT) services are culturally competent to deal with the needs of Black, Asian and Minority Ethnic (BAME) communities. *The Cognitive Behaviour Therapist, 16*(6), 1-23. https://doi.org/10.1017/S1754470X22000642

Fairak, A. (2018). *The roadblock to recovery. How mental health practitioners deal with people's practical problems in England*. Citizens Advice. https://www.citizensadvice.org.uk/Global/CitizensAdvice/Public%20services%20publications/FINAL%20-%20Roadblock%20to%20Recovery.pdf

Falconnier, L. (2009). Socioeconomic status in the treatment of depression. *American Journal of Orthopsychiatry, 79*(2), 148-158. https://doi.org/10.1037/a0015469

Fancourt, D., Steptoe, A., & Bradbury, A. (2022). *Tracking the Psychological and Social Consequences of the COVID-19 Pandemic across the UK Population: Findings, Impact, and Recommendations from the COVID-19 Social Study (March 2020 – April 2022).* University College London. https://www.covidsocialstudy.org/_files/ugd/064c8b_fa25a87fd1ba4e99b7d069e7af76c64a.pdf

Ferrari, R. (2015). Writing narrative style literature reviews. *Medical Writing, 24*(4), 230-235. https://doi.org/10.1179/2047480615Z.000000000329

Field, A. (2009). *Discovering Statistics Using SPSS* (3rd ed.). Sage.

Finazzi, E., & MacBeth, A. (2021). Service users experience of psychological interventions in primary care settings: A qualitative meta-synthesis. *Clinical Psychology & Psychotherapy, 29*(2), 1 – 24. https://doi.org/10.1002/cpp.2650

Finegan, M., Firth, N., & Delgadillo, J. (2019). Adverse impact of neighbourhood socioeconomic deprivation on psychological treatment outcomes : the role of area-level income and crime. *Psychotherapy Research, 30*(4). https://doi.org/10.1080/10503307.2019.1649500

Firth, N., Barkham, M., Delgadillo, J., Bell, A., & O'Cathain, A. (2023). The role of socioeconomic deprivation in explaining neighborhood and clinic effects in the effectiveness of psychological interventions. *Journal of Consulting and Clinical Psychology, 91*(2), 82-94. https://psycnet.apa.org/doi/10.1037/ccp0000784

Firth, N., Delgadillo, J., Kellett, S., & Lucock, M. (2020). The influence of socio-demographic similarity and difference on adequate attendance of group psychoeducational cognitive behavioural therapy. *Psychotherapy Research, 30*(3), 362-374. https://doi.org/10.1080/10503307.2019.1589652

Fitch, C., Hamilton, S., Bassett, P., & Davey, R. (2011). The relationship between personal debt and mental health: A systematic review. *Mental Health Review Journal, 16*(4), 153–166. https://doi.org/10.1108/13619321111202313

Fonagy, P., Luyten, P., & Allison, E. (2015). Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment. *Journal of Personality Disorders, 29*(5), 575–609. https://doi.org/10.1521/pedi.2015.29.5.575

Ford, J., Knight, J., Brittain, J., Bentley, C., Sowden, S., Castro, A., Doran, T., & Cookson, R. (2022). Reducing inequality in avoidable emergency admissions: Case studies of local health care systems in England using a realist approach. *Journal of Health Services Research & Policy, 27*(1), 31-40. https://doi.org/10.1177/13558196211021618

Francis-Devine, B. (2023). *Poverty in the UK: statistics*. House of Commons Library. https://commonslibrary.parliament.uk/research-briefings/sn07096/

Friedli, L. (2009). *Mental health, resilience and inequalities*. World Health Organisation – Regional Office for Europe. https://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

Fryer, T. (2022). A critical realist approach to thematic analysis: producing causal explanations. *Journal of Critical Realism, 21*(4), 365-384. https://doi.org/10.1080/14767430.2022.2076776

Gabbay, M., Shiels, C., & Hillage, J. (2015). Factors associated with the length of fit note-certified sickness episodes in the UK. *Occupational and Environmental Medicine, 72*(7), 467 – 475. http://dx.doi.org/10.1136/oemed-2014-102307

Generaal, E., Timmermans, E. J., Dekkers, J. E., Smit, J. H., & Penninx, B. W. (2019). Not urbanization level but socioeconomic, physical and social neighbourhood characteristics are associated with presence and severity of depressive and anxiety disorders. *Psychological Medicine, 49*(1), 149-161. https://doi.org/10.1017/s0033291718000612

Giebel, C., Corcoran, R., Goodall, M., Campbell, N., Gabbay, M., Daras, K., Barr, B., Wilson, T. & Kullu, C. (2020). Do people living in disadvantaged circumstances receive different mental health treatments than those from less disadvantaged backgrounds?. *BMC Public Health, 20*(1), 1-10. https://doi.org/10.1186/s12889-020-08820-4

Gilmer, W. S., Trivedi, M. H., Rush, A. J., Wisniewski, S. R., Luther, J., Howland, R. H., Yohanna, D., Khan, A., & Alpert, J. (2005). Factors associated with chronic depressive episodes: a preliminary report from the STAR-D project. *Acta Psychiatrica Scandinavica, 112*(6), 425 – 433. https://doi.org/10.1111/j.1600-0447.2005.00633.x

Gornick, J. C. (2022*). Income inequality and income poverty in a cross-national perspective.* Institute for Fiscal Studies. https://ifs.org.uk/inequality/wp-content/uploads/2022/10/Income-inequality-and-income-poverty-in-a-cross-national-perspective-IFS-Deaton-Review-of-Inequalities-1.pdf

Grant, K., McMeekin, E., Jamieson, R., Fairfull, A., Miller, C., & White, J. (2012). Individual therapy attrition rates in a low-intensity service: a comparison of cognitive behavioural and person-centred therapies and the impact of deprivation. *Behavioural and Cognitive Psychotherapy, 40*(2), 245 – 249. https://doi.org/10.1017/S1352465811000476

Grassroots Poverty Action Group. (2022, October 18th). Lived experience is key to designing compassionate policy response. *Joseph Rowntree Foundation Blogs*. https://www.jrf.org.uk/blog/lived-experience-key-designing-compassionate-policy-response

Green, S. A., Honeybourne, E., Chalkley, S. R., Poots, A. J., Woodcock, T., Price, G., Bell, D., & Green, J. (2015). A retrospective observational analysis to identify patient and treatment-related predictors of outcomes in a community mental health programme. *BMJ Open, 5*(5), 1 – 11. http://dx.doi.org/10.1136/bmjopen-2014-006103

Green, S., Poots, A., Marcano-Belisario, J., Samarasundera, E., Green, J., Honeybourne, E., & Barnes, R. (2012). Mapping mental health service access: achieving equity through quality improvement. *Journal of Public Health, 35*(2), 286 – 292. https://doi.org/10.1093/pubmed/fds071

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough?: An experiment with data saturation and variability. *Field Methods, 18*(1), 59 – 82. https://doi.org/ 10.1177/1525822X05279903

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does' access to health care' mean?. *Journal of Health Services Research & Policy, 7*(3), 186-188. https://doi.org/10.1258/135581902760082517

Gupta, A. E., & Huston, A. C. (2009). Depressive symptoms and economic outcomes of low-income women: A review of the social causation, social selection, and interactionist hypotheses. *Social Issues and Policy Review, 3*(1), 103-140. https://doi.org/10.1111/j.1751-2409.2009.01012.x

Hagan, T., & Smail, D. (1997). Power-Mapping – I. Background and basic methodology. *Journal of Community and Applied Social Psychology, 7*(4)*,* 257-267. https://doi.org/10.1002/(SICI)1099-1298(199709)7:4%3C257::AID-CASP428%3E3.0.CO;2-P

Handerer, F., Kinderman, P., Timmermann, C., & Tai, S. J. (2020). How did mental health become so biomedical? The progressive erosion of social determinants in historical psychiatric admission registers. *History of Psychiatry, 32*(1), 37-51. https://doi.org/10.1177/0957154X20968522

Harper, C. (2003). Poverty and Discourse. In C. Carr & T. Sloan (Eds.), *Poverty and Psychology: From global perspective to local practice,* (pp. 185-203). Kluwer-Plenum.

Harper, D. (2016). Beyond individual therapy. *Psychologist, 29*(6), 440-445. https://repository.uel.ac.uk/item/850qy

Harwood, H., Rhead, R., Chui, Z., Bakolis, I., Connor, L., Gazard, B., Hall., J., MacCrimmon, S., Rimes, K. A., Woodhead, C., & Hatch, S. L. (2023). Variations by ethnicity in referral and treatment pathways for IAPT service users in South London. *Psychological Medicine, 53*(3), 1084-1095. https://doi.org/10.1017/S0033291721002518

Hastings, P. D., Serbin, L. A., Bukowski, W., Helm, J. L., Stack, D. M., Dickson, D. J., Ledingham, J., & Schwartzman, A. E. (2020). Growing up in poverty increases risk of developing psychosis-spectrum disorders in adulthood. *Epidemiology, 51*(8), 941-950. https://poverty.ucdavis.edu/sites/main/files/file-attachments/hastings_psychosisspectrum_brief.pdf

Health and Care Act 2022 (c. 31). https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted

Health and Social Care Act 2012 (c. 7). https://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf

HM Treasury. (2022). *The Growth Plan.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1105989/CCS207_CCS0822746402-001_SECURE_HMT_Autumn_Statement_2022_BOOK_Web_Accessible.pdf

Holmes, H., & Burgess, G. (2022). Digital exclusion and poverty in the UK: How structural inequality shapes experiences of getting online. *Digital Geography and Society, 3,* 100041. https://doi.org/10.1016/j.diggeo.2022.100041

Hudson, C. (2005). Socioeconomic status and mental illness: tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry, 75*(1), 3 – 18. https://doi.org/10.1037/0002-9432.75.1.3

Human Rights Act 1998 (c. 42). https://www.legislation.gov.uk/ukpga/1998/42/pdfs/ukpga_19980042_en.pdf

International Monetary Fund. (2023). *GDP per capita, current prices.* https://www.imf.org/external/datamapper/NGDPDPC@WEO/WEOWORLD/GBR

Iob, E., Frank, P. & Steptoe, A. (2020). Levels of severity of depressive symptoms among at-risk groups in the UK during the Covid-19 pandemic. *JAMA Network Open, 3*(10), 1-13. https://doi.org/10.1001/jamanetworkopen.2020.26064

Izon, E., Berry, K., Law, H., & French, P. (2021). ‘If he feels better I'll feel better’ relationships with individuals at high-risk of developing psychosis. *Early Intervention in Psychiatry, 16*(3), 231-238. https://doi.org/10.1111/eip.13146

Joffe, J. (1988). The cause of the causes. In G. Albee, J. Joffe, & L. Dusenbury (Eds.), *Prevention, powerlessness and politics: Readings on social change* (pp. 57-79). Sage Publications.

Joinson, C., Kounali, D., & Lewis, G. (2017). Family socioeconomic position in early life and onset of depressive symptoms and depression: a prospective cohort study. *Social Psychiatry and Psychiatric Epidemiology, 52*(1), 95-103. https://doi.org/10.1007/s00127-016-1308-2

Jones, N., Atterbury, K., Byrne, L., Carras, M., Brown, M., & Phalen, P. (2021). Lived experience, research leadership, and the transformation of mental health services: building a researcher pipeline. *Psychiatric Services, 72*(5), 591-593. https://doi.org/10.1176/appi.ps.202000468

Jonker, L., Thwaites, R., & Fisher, S. J. (2020). Patient referral from primary care to psychological therapy services: a cohort study. *Family Practice, 37*(3), 395-400. https://doi.org/10.1093/fampra/cmz094

Joseph Rowntree Foundation. (2021). *UK poverty 2020/21. The leading independent report.* https://www.jrf.org.uk/report/uk-poverty-2020-21

Joseph Rowntree Foundation. (2022). *UK poverty 2022. The essential guide to understanding poverty in the UK*. https://www.jrf.org.uk/report/uk-poverty-2022

Kerr, W. C., Kaplan, M. S., Huguet, N., Caetano, R., Giesbrecht, N., & McFarland, B. H. (2017). Economic recession, alcohol, and suicide rates: comparative effects of poverty, foreclosure, and job loss. *American Journal of Preventive Medicine, 52*(4), 469-475. https://doi.org/10.1016/j.amepre.2016.09.021

Kim, P., Neuendorf, C., Bianco, H., & Evans, G. W. (2015). Exposure to childhood poverty and mental health symptomatology in adolescence: A role of coping strategies. *Stress and Health, 32*(5), 494 – 502. https://doi.org/10.1002/smi.2646

Knapp, M. & Iemmi, V. (2014). The economic case for better mental health. In S. Davies (Ed.), *Annual Report of the Chief Medical Officer 2013. Public Mental Health Priorities: Investing in the Evidence* (pp. 147-156). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/413196/CMO_web_doc.pdf

Knapstad, M., Nordgreen, T. & Smith, O. (2018). Prompt mental health care, the Norwegian version of IAPT: clinical outcomes and predictors of change in a multicenter cohort study. *BMC Psychiatry, 18*(260), 1-16. https://doi.org/10.1186/s12888-018-1838-0

Kraus, M. W., Tan, J. J., & Tannenbaum, M. B. (2013). The social ladder: A rank-based perspective on social class. *Psychological Inquiry, 24*(2), 81-96. https://doi.org/10.1080/1047840X.2013.778803

Kroenke, C., Spitzer, R., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606-613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Krumer-Nevo, M. (2020). *Radical hope: Poverty-aware practice for social work*. Policy Press.

Laake, J. P., Majeed, N., & Walters, K. (2021a). Realising the potential of Improving Access to Psychological Therapies for older adults. *British Journal of General Practice, 71*(702), 8-9. https://doi.org/10.3399/bjgp21X714365

Laake, J. P., Parratt, J., & Majeed, N. (2021b). Improving Access to Psychological Therapies for older adults: auditing management of newly diagnosed mild and moderate depression in six general practices within the Birmingham and Solihull CCG. Postgraduate Medical Journal, 97(1144), 89-92. https://doi.org/10.1016/j.jad.2021.06.084

Lacey, R. E., Howe, L. D., Kelly-Irving, M., Bartley, M., & Kelly, Y. (2022). The clustering of adverse childhood experiences in the Avon Longitudinal Study of Parents and Children: are gender and poverty important?. *Journal of Interpersonal Violence, 37*(5), 2218-2241. https://doi.org/10.1177/0886260520935096

Larsson, P., Lloyd, R., Taberham, E., & Rosairo, M. (2022). An observational study on IAPT waiting times before, during and after the COVID-19 pandemic using descriptive time-series data. *Mental Health Review Journal*, 27(4), 455-471. https://doi.org/10.1108/MHRJ-04-2022-0023

Le Gallais, T. (2008). Wherever I go there I am: reflections on reflexivity and the research stance. *Reflective Practice, 9*(2), 145 – 155. https://doi.org/10.1080/14623940802005475

Lee, S. C., DelPozo-Banos, M., Lloyd, K., Jones, I., Walters, J. T., Owen, M. J., O’Donovan, M., & John, A. (2020). Area deprivation, urbanicity, severe mental illness and social drift—A population-based linkage study using routinely collected primary and secondary care data. *Schizophrenia Research, 220*, 130-140. https://doi.org/10.1016/j.schres.2020.03.044

Lewer, D., King, E., Bramley, G., Fitzpatrick, S., Treanor, M. C., Maguire, N., Bullock, M., Hayward, A., & Story, A. (2020). The ACE Index: mapping childhood adversity in England. *Journal of Public Health, 42*(4), 487-495. https://doi.org/10.1093/pubmed/fdz158

Lewis, O. (1961). *The children of Sanchez.* Random House.

Lillywhite, E. (2022). *Shaping social mobility: education and employment*. Cumberland Lodge. https://www.cumberlandlodge.ac.uk/sites/default/files/social_mobility_briefing_document_-_screen.pdf

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry.* SAGE.

Lister, R. (2004). *Poverty.* Polity Press.

Little, R. J., Carpenter, J. R., & Lee, K. J. (2022). A comparison of three popular methods for handling missing data: complete-case analysis, inverse probability weighting, and multiple imputation. *Sociological Methods & Research,* 00491241221113873, 1 – 31. https://doi.org/10.1177/00491241221113873

London School of Economics. (2006). *The depression report: a new deal for depression and anxiety disorders.* Centre for Economic Performance’s Mental Health Policy Group, London School of Economics. http://eprints.lse.ac.uk/818/

Lorenc, T., Petticrew, M., Welch, V., & Tugwell, P. (2012). What types of interventions generate inequalities? Evidence from systematic reviews. *Journal of Epidemiology and Community Health*, *67*(2), 190-193. http://dx.doi.org/10.1136/jech-2012-201257

Lorimer, B., Delgadillo, J., Kellett, S. & Lawrence, J. (2021). Dynamic prediction and identification of cases at risk of relapse following completion of low-intensity cognitive behavioural therapy. *Psychotherapy Research, 31*(1), 19-32. https://doi.org/10.1080/10503307.2020.1733127

Lund, C., Breen, A., Flisher, A. J., Kakuma, R., Corrigall, J., Joska, J., Swartz, L., & Patel, V. (2010). Poverty and common mental disorders in low and middle income countries: A systematic review. *Social Science and Medicine, 71*(3), 517 - 528. https://doi.org/10.1016/j.socscimed.2010.04.027

MacDonald, R., Shildrick, T., & Furlong, A. (2014). In search of ‘intergenerational cultures of worklessness’: Hunting the Yeti and shooting zombies. *Critical Social Policy, 34*(2), 199-220. http://dx.doi.org/10.1177/0261018313501825

Maconick, L., Sheridan Rains, L., Jones, R., Lloyd-Evans, B., & Johnson, S. (2021). Investigating geographical variation in the use of mental health services by area of England: a cross-sectional ecological study. *BMC Health Services Research, 21*(1), 1-10. https://doi.org/10.1186/s12913-021-06976-2

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research, 26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Mangalore, R., Knapp, M., & Jenkins, R. (2007). Income-related inequality in mental health in Britain: the concentration index approach. *Psychological medicine, 37*(7), 1037 – 1045. https://doi.org/10.1017/S003329170600969X

Mannion, R., & Braithwaite, J. (2012). Unintended consequences of performance measurement in healthcare: 20 salutary lessons from the English National Health Service. *Internal Medicine Journal, 42*(5), 569-574. https://doi.org/10.1111/j.1445-5994.2012.02766.x

Mannion, R., Konteh, F. H., & Jacobs, R. (2023). Impact of COVID-19 in mental health trusts. *Journal of Health Services Research & Policy, 28*(2), 119-127. https://doi.org/10.1177/13558196221116298

Marks, D. F. (2018). IAPT under the microscope. *Journal of Health Psychology, 23*(9), 1131-1135. https://doi.org/10.1177/1359105318781872

Marks, D. F. (2023). A catalogue of shame: the British Psychological Society as a Dysfunctional Organisation. *Journal of Educational and Psychological Research, 5*(1), 575-587. https://doi.org/10.31234/osf.io/yx59h

Marks, L. (2022). *Clinical Psychology in Primary Care – how can we afford to be without it? Guidance for Clinical Commissioners and Integrated Care Systems*. The British Psychological Society. https://doi.org/10.53841/bpsrep.2022.rep165

Marmot, M., Allen, J., Boyce, T., Goldblatt, P., & Morrison, J. (2020). *Health equity in England: the Marmot review 10 years on*. Institute of Health Equity. https://www.health.org.uk/publications/reports/the-marmot-review-10-years-on

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M.., & Geddes, I. (2010). *Fair Society, Health Lives. The Marmot Review.* Institute of Health Equity. https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review

Maroto, M., Pettinicchio, D., & Patterson, A. C. (2019). Hierarchies of categorical disadvantage: economic insecurity at the intersection of disability, gender, and race. *Gender & Society, 33*(1), 64-93. https://doi.org/10.1177/0891243218794648

Marshall, D., Quinn, C., Child, S., Shenton, D., Pooler, J., Forber, S., & Byng, R. (2016). What IAPT services can learn from those who do not attend. *Journal of Mental Health, 25*(5), 410-415. https://doi.org/10.3109/09638237.2015.1101057

Martin, C., Iqbal, Z., Airey, N., & Marks, L. (2022). Improving Access to Psychological Therapies (IAPT) has potential but is not sufficient: How can it better meet the range of primary care mental health needs? *British Journal of Clinical Psychology, 61*(1), 1-18. https://doi.org/10.1111/bjc.12314

Mattheys, K., Warren, J., & Bambra, C. (2018). “Treading in sand”: A qualitative study of the impact of austerity on inequalities in mental health. *Social Policy & Administration, 52*(7), 1275-1289. https://doi.org/10.1111/spol.12348

McArthur, D., & Reeves, A. (2019). The rhetoric of recessions: how British newspapers talk about the poor when unemployment rises, 1896–2000. *Sociology, 53*(6), 1005-1025. https://doi.org/10.1177/0038038519838752

McCay, L. (2022). Why a health inequalities white paper is still so vital and should not be scrapped. *The BMJ, 378*, 1-2. http://dx.doi.org/10.1136/bmj.o2369

McGowan, V. J., & Bambra, C. (2022). COVID-19 mortality and deprivation: pandemic, syndemic, and endemic health inequalities. *The Lancet Public Health, 7*(11), 966-975. https://doi.org/10.1016/S2468-2667(22)00223-7

McHugh, M. L. (2012). The Chi-square test of independence. *Biochemia Medica, 23*(2), 143–149. https://doi.org/10.11613/BM.2013.018

McKee, M., Karanikolos, M., Belcher, P., & Stuckler, D. (2012). Austerity: a failed experiment on the people of Europe. *Clinical Medicine, 12*(4), 346 – 350. https://doi.org/10.7861/clinmedicine.12-4-346

McKendrick, J., Sinclair, S., Irwin, A., O'Donnell, H., Scott, G., & Dobbie, L. (2008). *The media, poverty and public opinion in the UK.* Joseph Rowntree Foundation. https://www.jrf.org.uk/report/media-poverty-and-public-opinion-uk

McLennan, D., Noble, S., Noble, M., Plunkett, E., Wright, G., & Gutacker, N. (2019). *The English Indices of Deprivation 2019. Technical report. Ministry of Housing, Communities & Local Government.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/833951/IoD2019_Technical_Report.pdf

McManus S., Beddington, P., Jenkins, R., & Brugha, T. (2016). *Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014.* NHS Digital. https://openaccess.city.ac.uk/id/eprint/23646/1/

Meltzer, H., Bebbington, P., Brugha, T., Farrell, M., & Jenkins, R. (2013). The relationship between personal debt and specific common mental disorders. *The European Journal of Public Health, 23*(1), 108-113. https://doi.org/10.1093/eurpub/cks021

Meneses, E., Kinslow, K., McKenney, M., & Elkbuli, A. (2021). Post-traumatic stress disorder in adult and pediatric trauma populations: a literature review. *Journal of Surgical Research, 259*, 357-362. https://doi.org/10.1016/j.jss.2020.09.023

Mental Health Policy Group (2015). *A manifesto for better mental health.* https://www.mind.org.uk/media-a/4404/a-manifesto-for-better-mental-health.pdf

Milani, S. A., Raji, M. A., Chen, L., & Kuo, Y. F. (2021). Trends in the use of benzodiazepines, Z-hypnotics, and serotonergic drugs among US women and men before and during the COVID-19 pandemic. *JAMA Network Open, 4*(10), 1-12. https://doi.org/10.1001/jamanetworkopen.2021.31012

Mills, C. (2015). The Psychiatrization of Poverty: Rethinking the Mental Health-Poverty Nexus. *Social and Personality Psychology Compass, 9*(5), 213 – 222. https://doi.org/10.1111/spc3.12168

Mind. (2017). *Big Mental Health Survey 2017: Headline Findings.* https://www.mind.org.uk/media-a/4368/mind-big-mental-health-survey-headlines-2017.pdf

Mir, G., Ghani, R., Meer, S., & Hussain, G. (2019). Delivering a culturally adapted therapy for Muslim clients with depression. *The Cognitive Behaviour Therapist, 12*(26), 1-14. https://doi.org/10.1017/S1754470X19000059

Moher. D., Liberati, A., Tetzlaff, J., Altman, D. G., & The PRISMA Group. (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *Annals of Internal Medicine, 151*(4), 264-269. https://doi.org/10.1371/journal.pmed.1000097

Moller, N. P., Ryan, G., Rollings, J., & Barkham, M. (2019). The 2018 UK NHS Digital annual report on the Improving Access to Psychological Therapies programme: a brief commentary. *BMC Psychiatry, 19*(1), 1-5. https://doi.org/10.1186/s12888-019-2235-z

Morganstein, J. C., & Ursano, R. J. (2020). Ecological disasters and mental health: causes, consequences, and interventions. *Frontiers in Psychiatry, 11*(1), 1-15. https://doi.org/10.3389/fpsyt.2020.00001

Nadeem, E., Lange, J. M., & Miranda, J. (2008). Mental health care preferences among low-income and minority women. *Archives of Women's Mental Health, 11*(2), 93 – 102. https://doi.org/10.1007/s00737-008-0002-0

National Collaborating Centre for Mental Health (2021). *The Improving Access to Psychological Therapies Manual*. https://www.england.nhs.uk/wp-content/uploads/2018/06/the-nhs-talking-therapies-manual-v6.pdf

National Health Service Act 1946 (c. 81). https://www.legislation.gov.uk/ukpga/1946/81/pdfs/ukpga_19460081_en.pdf

National Institute for Health and Care Excellence. (2004a). *Anxiety: Management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care.* NICE quality standard CG22. https://www.nice.org.uk/guidance/cg22

National Institute for Health and Care Excellence. (2004b). *Depression: management of depression in primary and secondary care.* Clinical guideline CG23. https://www.nice.org.uk/guidance/cg23

NHS Digital. (2020a). *Psychological Therapies, Annual report on the use of IAPT services, 2018-2019.* https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2018-19

NHS Digital. (2020b). *Psychological Therapies. A guide to IAPT data and publications*. https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/service-standards/

NHS Digital. (2021). *Psychological Therapies, Annual report on the use of IAPT services, 2021-2022.* https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2021-22

NHS Digital. (2022). *Psychological Therapies: Annual report on the use of IAPT services 2020-21.* https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services/annual-report-2021-22

NHS England (2020). *Advancing Mental Health Equalities Strategy.* https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/

NHS England. (2019). *The NHS long-term plan.* https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*(1), 1-13. https://doi.org/10.1177/1609406917733847

Nyasulu, G. (2010). Revisiting the definition of poverty. *Journal of Sustainable Development in Africa, 12*(7), 147 – 158. https://jsd-africa.com/Jsda/V12No7_Winter2010_A/article12_7.htm

O'Connor, R. C., Wetherall, K., Cleare, S., McClelland, H., Melson, A. J., Niedzwiedz, C. L., O'Carroll, R. E., O'Connor, D. B., Platt, S., & Robb, K. A. (2021). Mental health and well-being during the COVID-19 pandemic: longitudinal analyses of adults in the UK COVID-19 Mental Health & Wellbeing study. *The British Journal of Psychiatry, 218*(6), 326-333. https://doi.org/10.1192/bjp.2020.212

O’Shea, N. (2021). *Now or never: a systemic investment review of mental health care in England.* Centre for Mental Health. https://www.centreformentalhealth.org.uk/sites/default/files/publication/download/CentreforMH_NowOrNever_PDF.pdf

Omylinska-Thurston, J., McMeekin, A., Walton, P., & Proctor, G. (2019). Clients' perceptions of unhelpful factors in CBT in IAPT serving a deprived area of the UK. *Counselling and Psychotherapy Research, 19*(4), 455 – 464. https://doi.org/10.1002/capr.12249

Owen, E., Massazza, A., Roberts, B., Lokot, M., & Fuhr, D. C. (2022). “Nothing about us, without us”? A qualitative study of service user involvement in the development of lay-delivered psychological interventions in contexts affected by humanitarian crises. *Journal of Migration and Health, 5*, 1-8. https://doi.org/10.1016/j.jmh.2022.100087

Pantazis, C. (2016). Policies and discourses of poverty during a time of recession and austerity. *Critical Social Policy, 36*(1), 3-20. https://doi.org/10.1177/0261018315620377

Parry, G., Barkham, M., Brazier, J., Dent-Brown, K., Hardy, G., Kendrick, T., Rick, J., Chambers, E., Chan, T., Connell, J., Hutten, R., de Lusignan, S., Mukuria, C., Saxon, D., Bower, P., & Lovell, K. (2011). *An evaluation of a new service model: Improving Access to Psychological Therapies demonstration sites 2006-2009.* National Institute for Health and Care Research - Service Delivery and Organisation Programme. https://eprints.whiterose.ac.uk/149148/1/3008822-3.pdf

Patel, J. A., Nielsen, F. B. H., Badiani, A. A., Assi, S., Unadkat, V. A., Patel, B., Ravindrane, R., & Wardle, H. (2020). Poverty, inequality and COVID-19: the forgotten vulnerable. *Public health, 183,* 110-111. https://doi.org/10.1016/j.puhe.2020.05.006

Pickett, K., & Wilkinson, R. (2015). Income inequality and health: A causal review. *Social Science and Medicine, 128*, 316 – 326. https://doi.org/10.1016/j.socscimed.2014.12.031

Pieh, C., Budimir, S., Delgadillo, J., Barkham, M., Fontaine, J. R., & Probst, T. (2021). Mental health during COVID-19 lockdown in the United Kingdom. *Psychosomatic Medicine, 83*(4), 328-337. https://doi.org/10.1097/PSY.0000000000000871

Pierce, M., Hope, H., Ford, T., Hatch, S., Hotopf, M., John, A., Kontopantelis, E., Webb, R., Wessely, S., McManus, S., & Abel, K. M. (2020). Mental health before and during the COVID-19 pandemic: a longitudinal probability sample survey of the UK population. *The Lancet Psychiatry, 7*(10), 883-892. https://doi.org/10.1016/S2215-0366(20)30308-4

Pierce, M., McManus, S., Hope, H., Hotopf, M., Ford, T., Hatch, S. L., John, A., Kontopantelis, E., Webb, R. T., Wessely, S., & Abel, K. M. (2021). Mental health responses to the COVID-19 pandemic: a latent class trajectory analysis using longitudinal UK data. *The Lancet Psychiatry, 8*(7), 610-619. https://doi.org/10.1016%2FS2215-0366(21)00151-6

Pilgrim, D., & Bentall, R. (1999). The medicalisation of misery: A critical realist analysis of the concept of depression. *Journal of Mental Health, 8*(3), 261 – 274. https://doi.org/10.1080/09638239917427

Pomerantz, J. M. (2003). The Relationship Between Psychosis and Poverty. *Drug Benefit Trends, 15*(3), 31–32. https://psycnet.apa.org/record/2003-00351-001

Poots, A. J., Green, S. A., Honeybourne, E., Green, J., Woodcock, T., Barnes, R., & Bell, D. (2014). Improving mental health outcomes: achieving equity through quality improvement. *International Journal for Quality in Health Care, 26*(2), 198-204. https://doi.org/10.1093/intqhc/mzu005

Prajapati, R., & Liebling, H. (2021). Accessing mental health services: A systematic review and meta-ethnography of the experiences of South Asian Service users in the UK. *Journal of Racial and Ethnic Health Disparities*, *9,* 598-619. https://doi.org/10.1007/s40615-021-00993-x

Prowse, M. (2007). *The poverty and inequality debate in the UK: thoughts on terminology and approaches*. Oversees Development Institute. https://portal.research.lu.se/en/publications/the-poverty-and-inequality-debate-in-the-uk-thoughts-on-terminolo

Pulok, M. H., van Gool, K., Hajizadeh, M., Allin, S., & Hall, J. (2020). Measuring horizontal inequity in healthcare utilization: a review of methodological developments and debates. *The European Journal of Health Economics, 21*(2), 171 – 180. https://doi.org/10.1007/s10198-019-01118-2

Rahim, M., & Cooke, A. (2019). Should clinical psychologists be political?. In W. Curvis (Ed.), *Professional issues in Clinical Psychology* (pp. 81-91). Routledge.

Read, J. (2010). Can poverty drive you mad?' Schizophrenia', socio-economic status and the case for primary prevention. *New Zealand Journal of Psychology, 39*(2), 7-19. https://www.psychology.org.nz/journal-archive/NZJP-Vol392-2010-2-Read.pdf

Reder, P., & Fredman, G. (1996). The relationship to help: Interacting beliefs about the treatment process. *Clinical Child Psychology and Psychiatry, 1*(3), 457-467. https://doi.org/10.1177/1359104596013012

Redhead, C. A., Fovargue, S., Frith, L., Chiumento, A., Draper, H., & Baines, P. B. (2022). Relationships, Rights, and Responsibilities: (Re)viewing the NHS Constitution for the post-pandemic 'new normal'. *Medical Law Review*, *00*(0), 1 - 26. https://doi.org/10.1093/medlaw/fwac028

Regidor, E. (2006). Social determinants of health: a veil that hides socioeconomic position and its relation with health. *Journal of Epidemiology and Community Health, 60*(10), 896 – 901. http://dx.doi.org/10.1136/jech.2005.044859

Reilly, S., Planner, C., Hann, M., Reeves, D., Nazareth, I., & Lester, H. (2012). The role of primary care in service provision for people with severe mental illness in the United Kingdom. *PLoS ONE, 7*(5), p. 1 – 10. https://doi.org/10.1371/journal.pone.0036468

Reisinger-Walker, E., & Druss, B. (2017). Cumulative burden of comorbid mental disorders, substance use disorders, chronic medical conditions, and poverty on health among adults in the USA. *Psychology, Health & Medicine, 22*(6), 727-735. http://dx.doi.org/10.1080/13548506.2016.1227855

Rickett, B., Easterbrook, M., Sheehy-Skeffington, J., Reavey, P., & Woolhouse, M. (2022). *Psychology of social class-based inequalities. Policy implications for a revised (2010) UK Equality Act*. The British Psychological Society. https://cms.bps.org.uk/sites/default/files/2022-07/BPS%20Report%20-%20Psychology%20of%20social%20class-based%20inequalities%20-%20Policy%20implications%20for%20a%20revised%20%282010%29%20UK%20Equality%20Act.pdf

Rimes, K. A., Ion, D., Wingrove, J., & Carter, B. (2019). Sexual orientation differences in psychological treatment outcomes for depression and anxiety: National cohort study. *Journal of Consulting and Clinical Psychology, 87*(7), 577-589. https://psycnet.apa.org/doi/10.1037/ccp0000416

Rittel, H. W., & Webber, M. M. (1973). Dilemmas in a general theory of planning. *Policy Sciences, 4*(2), 155-169. https://doi.org/10.1007/BF01405730

Rizq, R. (2012). The ghost in the machine: IAPT and organizational melancholia. *British Journal of Psychotherapy, 28*(3), 319-335. https://doi.org/10.1080/14753634.2012.640161

Roscoe, J. (2019). Has IAPT become a bit like Frankenstein's monster? *CBT Today, 47*(1), 16-17. http://insight.cumbria.ac.uk/id/eprint/6535

Rose, D. (2014). Patient and public involvement in health research: ethical imperative and/or radical challenge?. *Journal of Health Psychology, 19*(1), 149-158. https://doi.org/10.1177/1359105313500249

Rosso, A., Pacurariou, A., Cave, A.., Hernandez Garcia, C., Donegan, K., Pasmooij, M., & Nyeland, M. E. (2021). *Observational Data (Real World Data).* European Medicines Agency. https://www.ema.europa.eu/en/documents/report/observational-data-real-world-data-subgroup-report_en.pdf

Rowntree, B. S. (1902). *Poverty: a study of town life* (centennial ed.). Policy Press.

Russell Jonsson, K., Taylor-Robinson, D. C., Schultz Straatmann, V., Melis, G., & Adjei, N. K. (2023). Health behaviors and subsequent mental health problems during the COVID-19 pandemic: A longitudinal analysis of adults in the UK. *Frontiers in Public Health, 10*, 1064677. https://doi.org/10.3389/fpubh.2022.1064677

Saleh, E. (2013). *The right to health care in international law*. [Doctoral dissertation, University of Glasgow]. Glasgow Theses Service. https://theses.gla.ac.uk/4293/1/2013elzuwayphd.pdf

Salisbury, H. (2023). Helen Salisbury: The new GP contract doesn't deliver. *BMJ,* 380, 590. https://doi.org/10.1136/bmj.p590

San Giorgi, M. (2012). *The human right to equal access to health care.* Erasmus University Medical Centre.

Santiago, C., Kaltman, S., & Miranda, J. (2013). Poverty and mental health: how do low-income adults and children fare in psychotherapy?. *Journal of Clinical Psychology, 69*(2), 115-126. https://doi.org/10.1002/jclp.21951

Saraceno, B., Levav, I., & Kohn, R. (2005). The public mental health significance of research on socio-economic factors in schizophrenia and major depression. *World Psychiatry, 4*(3), 181-185. https://europepmc.org/article/pmc/pmc1414773

Savage, M., Devine, F., Cunningham, N., Taylor, M., Li, Y., Hjellbrekke, J., Le Roux, B., Friedman, S., & Miles, A. (2013). A new model of social class? Findings from the BBC's Great British Class Survey experiment. *Sociology, 47*(2), 219-250. https://doi.org/10.1177/0038038513481128

Saxon, D., Barkham, M., Bee, P., Gellatly, J., Faija, C., & Bower, P. (2023). Telephone treatments in Improving Access to Psychological Therapies services: an analysis of use and impact on treatment uptake. *BMC Psychiatry, 23*(1), 1-12. http://dx.doi.org/10.1186/s12888-022-04404-1

Saxon, D., Fitzgerald, G., Houghton, S., Lemme, F., Saul, C., Warden, S., & Ricketts, T. (2007). Psychotherapy provision, socioeconomic deprivation, and the inverse care law. *Psychotherapy Research, 17*(5), 515-521. https://doi.org/10.1080/10503300601063246

Schoeyen, H. K., Birkenaes, A. B., Vaaler, A. E., Auestad, B. H., Malt, U. F., Andreassen, O. A., & Morken, G. (2011). Bipolar disorder patients have similar levels of education but lower socio-economic status than the general population. *Journal of Affective Disorders, 129*(1-3), 68 – 74. https://doi.org/10.1016/j.jad.2010.08.012

Scott, M. (2021). Ensuring that the Improving Access to Psychological Therapies (IAPT) programme does what it says on the tin. *The British Journal of Clinical Psychology, 60*(1), 38 – 40. https://doi.org/10.1111/bjc.12264

Sen, A. (1983). Poor, relatively speaking. *Oxford Economic Papers, 35*(2), 153-169. http://www.jstor.org/stable/2662642

Sen, A. (2008). Why and how is health a human right? *The Lancet, 372*(9655), 2010-2010. http://dx.doi.org/10.1016/S0140-6736(08)61784-5

Seng, J., Lopez, W., Sperlich, M., Hamama, L., & Reed Meldrum C. (2012). Marginalized identities, discrimination burden, and mental health: Empirical exploration of an interpersonal-level approach to modelling intersectionality. *Social Science and Medicine, 75*(2), 2437 – 2445. https://doi.org/10.1016/j.socscimed.2012.09.023

Sengupta, A. (2010). Human rights and extreme poverty. *Economic and Political Weekly, 45*(17), 85-93. https://www.jstor.org/stable/25664389

Sharland, E., Rzepnicka, K., Schneider, D., Finning, K., Pawelek, P., Saunders, R., & Nafilyan, V. (2023). Socio-demographic differences in access to psychological treatment services: evidence from a national cohort study. *Psychological Medicine,* 1-12. https://doi.org/10.1017/S0033291723001010

Sharma, M., Pinto, A. D., & Kumagai, A. K. (2018). Teaching the social determinants of health: a path to equity or a road to nowhere?. *Academic medicine, 93*(1), 25-30. http://dx.doi.org/10.1097/ACM.0000000000001689

Shildrick, T., & Rucell, J. (2015). *Sociological perspectives on poverty*. Joseph Rowntree Foundation. https://www.jrf.org.uk/report/sociological-perspectives-poverty

Skapinakis, P., Lewis, G., Araya, R., Jones, K., & Williams, G. (2005). Mental health inequalities in Wales, UK: Multi–level investigation of the effect of area deprivation. *The British Journal of Psychiatry, 186*(5), 417 – 422. https://doi.org/10.1192/bjp.186.5.417

Skilbeck, L., Spanton, C., & Roylance, I. (2020). Beyond the COVID-19 pandemic: 'Learning the hard way'–adapting long-term IAPT service provision using lessons from past outbreaks. *The Cognitive Behaviour Therapist, 13*(34), 1-12. https://doi.org/10.1017/S1754470X20000379

Smith, H. J., Ryan, D., Jaurique, A., & Duffau, E. (2020). Personal relative deprivation and mental health among university students: Cross-sectional and longitudinal evidence. *Analyses of Social Issues and Public Policy, 20*(1), 287 – 314. https://doi.org/10.1111/asap.12201

Smith, L. (2010). *Psychology, poverty and the end of social exclusion: putting our practice to work.* Teachers College Press.

Smith, L., Jacob, L., Yakkundi, A., McDermott, D., Armstrong, N. C., Barnett, Y., López-Sánchez, G. F., Martin, S., Butler, L., & Tully, M. A. (2020). Correlates of symptoms of anxiety and depression and mental wellbeing associated with COVID-19: a cross-sectional study of UK-based respondents. *Psychiatry Research, 291*, 1-7. https://doi.org/10.1016/j.psychres.2020.113138

Smyth, N., Buckman, J. E., Naqvi, S. A., Aguirre, E., Cardoso, A., Pilling, S., & Saunders, R. (2022). Understanding differences in mental health service use by men: an intersectional analysis of routine data. *Social Psychiatry and Psychiatric Epidemiology,* 57, 2065 – 2077. https://doi.org/10.1007/s00127-022-02256-4

Snider, C. J., & Flaherty, M. P. (2020). Stigma and mental health: The curious case of COVID-19. *Mental Health: Global Challenges Journal, 3*(1), 27-32. https://doi.org/10.32437/mhgcj.v1i2.60

Sosenko, F., Bramley, G., & Bhattacharjee, A. (2022). Understanding the post-2010 increase in food bank use in England: new quasi-experimental analysis of the role of welfare policy. *BMC Public Health, 22(1),* 1-10. https://doi.org/10.1186/s12889-022-13738-0

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7*. Archives of Internal Medicine, 166*(10), 1092-1097. https://doi.org/10.1001/archinte.166.10.1092

Sreeharan, V., Madden, H., Lee, J. T., Millett, C., & Majeed, A. (2013). Improving access to psychological therapies and antidepressant prescribing rates in England: a longitudinal time-series analysis. *British Journal of General Practice, 63*(614), 649-653. https://doi.org/10.3399/bjgp13X671641

Stack, R. J., & Meredith, A. (2018). The impact of financial hardship on single parents: An exploration of the journey from social distress to seeking help. *Journal of Family and Economic Issues, 39*, 233-242. https://doi.org/10.1007/s10834-017-9551-6

Stahl, N. A., & King, J. R. (2020). Expanding approaches for research: Understanding and using trustworthiness in qualitative research. *Journal of Developmental Education, 44*(1), 26-28. https://www.jstor.org/stable/45381095

Steadman, K., & Thomas, R. (2015). *An evaluation of the 'IPS in IAPT' psychological wellbeing and work feasibility pilot.* The Work Foundation. https://www.base-uk.org/sites/default/files/knowledge/Evaluation%20of%20IPS%20alongside%20IAPT%20services/ips_in_iapt_report.pdf

Stochl, J., Soneson, E., Stuart, F., Fritz, J., Walsh, A. E., Croudace, T., Hodgekins, J., Patel, U., Russo, D. A., Knight, C., Jones, P. B., & Perez, J. (2021). Determinants of patient-reported outcome trajectories and symptomatic recovery in Improving Access to Psychological Therapies (IAPT) services. *Psychological Medicine, 52*(14), 3231-3240. https://doi.org/10.1017/S0033291720005395

Stroud, I., & Gutman, L. M. (2021). Longitudinal changes in the mental health of UK young male and female adults during the COVID-19 pandemic. *Psychiatry Research, 303*, 114074. https://doi.org/10.1016/j.psychres.2021.114074

Sweetman, J., Knapp, P., McMillan, D., Fairhurst, C., Delgadillo, J., & Hewitt, C. (2022). Risk factors for initial appointment non-attendance at Improving Access to Psychological Therapy (IAPT) services: A retrospective analysis. *Psychotherapy Research,* 1-16. https://doi.org/10.1080/10503307.2022.2140616

Taylor, B. (2015). The last asylum: a memoir of madness in our times. Penguin.

Taylor, S., Annand, F., Burkinshaw, P., Greaves, F., Kelleher, M., Knight, J., Perkinsm C., Tran, A., White, M., & Marsden J. (2019). *Dependence and withdrawal associated with some prescribed medicines: an evidence review.* Public Health England. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/940255/PHE_PMR_report_Dec2020.pdf

The Strategy Unit. (2020). *Estimating the impacts of COVID-19 on mental health services in England*. https://www.strategyunitwm.nhs.uk/sites/default/files/2020-11/Modelling%20covid-19%20%20MH%20services%20in%20England_20201109_v2.pdf

Thomas, F., Hansford, L., Ford, J., Hughes, S., Wyatt, K., McCabe, R., & Byng, R. (2019). *Poverty, pathology and pills: DeStress Project Final report.* http://destressproject.org.uk/wp-content/uploads/2019/05/Final-report-8-May-2019-FT.pdf

Thomas, F., Hansford, L., Ford, J., Wyatt, K., McCabe, R., & Byng, R. (2020). How accessible and acceptable are current GP referral mechanisms for IAPT for low-income patients? Lay and primary care perspectives. *Journal of Mental Health, 29*(6), 706-711. https://doi.org/10.1080/09638237.2019.1677876

Thomas, F., Hansford, L., Wyatt, K., Byng, R., Coombes, K., Finch, J., Finnerty, K., Ford, J., Guppy, K., Guppy, R., Hughes, S., McCabe, R., Richardson, H., Roche, D., & Stuteley, H. (2021). An engaged approach to exploring issues around poverty and mental health: A reflective evaluation of the research process from researchers and community partners involved in the DeStress study. *Health Expectations, 24*, 113-121. https://doi.org/10.1111/hex.13065

Thorpe, W. J. R., & Gutman, L. M. (2022). The trajectory of mental health problems for UK emerging adults during COVID-19. *Journal of Psychiatric Research, 156*, 491-497. https://doi.org/10.1016/j.jpsychires.2022.10.068

Thunberg, S., & Arnell, L. (2022). Pioneering the use of technologies in qualitative research–A research review of the use of digital interviews. *International Journal of Social Research Methodology, 25*(6), 757-768. https://doi.org/10.1080/13645579.2021.1935565

Tiger, M., Wesselhoeft, R., Karlsson, P., Handal, M., Bliddal, M., Cesta, C. E., Skurtveit, S., & Reutfors, J. (2023). Utilization of antidepressants, anxiolytics, and hypnotics during the COVID-19 pandemic in Scandinavia. *Journal of Affective Disorders, 323*, 292-298. https://doi.org/10.1016/j.jad.2022.11.068

Timimi, S. (2018). The diagnosis is correct, but National Institute of Health and Care Excellence guidelines are part of the problem not the solution. *Journal of Health Psychology, 23*(9), 1148-1152. https://doi.org/10.1177/1359105318766139

Titheridge, H., Mackett, R. L., Christie, N., Oviedo Hernández, D., & Ye, R. (2014). *Transport and poverty: a review of the evidence*. University College London. https://discovery.ucl.ac.uk/id/eprint/1470392/1/transport-poverty[1].pdf

Tomaney, J., & Pike, A. (2020). Levelling up?. *The Political Quarterly, 91*(1), 43-48. https://doi.org/10.1111/1467-923X.12834

Townsend, P. (1979). *Poverty in the United Kingdom. A survey of household resources and standards of living.* Penguin.

Tranchese, A. (2019). Getting off benefits or escaping poverty? Using corpora to investigate the representation of poverty in the 2015 UK general election campaign. *Journal of Corpora and Discourse Studies, 2,* 65-93. http://dx.doi.org/10.18573/jcads.9

Trott, A., & Reeves, A. (2018). Social class and the therapeutic relationship: The perspective of therapists as clients. A qualitative study using a questionnaire survey. *Counselling and Psychotherapy research, 18*(2), 166-177. https://doi.org/10.1002/capr.12163

Tudor-Hart, J. (1971). The inverse care law. *The Lancet, 297*(7696), 405 – 412. http://dx.doi.org/10.1016/S0140-6736(71)92410-X

UK Drug Policy Commission. (2012). *A fresh approach to drugs.* https://www.ukdpc.org.uk/wp-content/uploads/a-fresh-approach-to-drugs-the-final-report-of-the-uk-drug-policy-commission.pdf

United Nations General Assembly. (1948). *Universal Declaration of Human Rights.* https://www.un.org/sites/un2.un.org/files/2021/03/udhr.pdf

United Nations General Assembly. (1966). *International Covenant on Economic, Social and Cultural Rights.* https://www.ohchr.org/sites/default/files/cescr.pdf

United Nations General Assembly. (1989). *Convention on the Rights of the Child*. https://www.ohchr.org/sites/default/files/crc.pdf

Verbist, I. L., Fabian, H., Huey, D., Brooks, H., Lovell, K., & Blakemore, A. (2023). Exploring access and engagement with Improving Access to Psychological Therapies (IAPT) services, before, during, and after the COVID-19 lockdown: A service evaluation in the Northwest of England. *Psychotherapy Research*, 1-12. https://doi.org/10.1080/10503307.2023.2184285

Veseth, M., Binder, P. E., Borg, M., & Davidson, L. (2017). Collaborating to stay open and aware: service user involvement in mental health research as an aid in reflexivity. *Nordic Psychology, 69*(4), 256-263. https://doi.org/10.1080/19012276.2017.1282324

Wadsworth, M., & Achenbach, T. M. (2005). Explaining the Link Between Low Socioeconomic Status and Psychopathology: Testing Two Mechanisms of the Social Causation Hypothesis. *Journal of Consulting and Clinical Psychology, 73*(6), 1146–1153. https://doi.org/10.1037/0022-006X.73.6.1146

Waite, P., Pearcey, S., Shum, A., Raw, J. A., Patalay, P., & Creswell, C. (2021). How did the mental health symptoms of children and adolescents change over early lockdown during the COVID-19 pandemic in the UK?. *JCPP Advances, 1*(1), 1-10. https://doi.org/10.1111/jcv2.12009

Wakefield, S., Kellett, S., Simmonds-Buckley, M., Stockton, D., Bradbury, A., & Delgadillo, J. (2021). Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *British Journal of Clinical Psychology, 60*(1), 1-37. https://doi.org/10.1111/bjc.12259

Walker, C., Speed, E., & Taggart, D. (2018). Turning psychology into policy: a case of square pegs and round holes?. *Palgrave Communications, 4*(1), 1-4. https://doi.org/10.1057/s41599-018-0159-8

Walsh, D., McCartney, G., Smith, M., & Armour, G. (2019). Relationship between childhood socioeconomic position and adverse childhood experiences (ACEs): a systematic review. *Journal of Epidemiology & Community Health*, *73*(12), 1087-1093. https://doi.org/10.1136/jech-2019-212738

Watt, G. (2018). The inverse care law revisited: a continuing blot on the record of the National Health Service. *British Journal of General Practice, 68*(677), 562-563. https://doi.org/10.3399/bjgp18X699893

Watts, G. (2020). COVID-19 and the digital divide in the UK. *The Lancet Digital Health, 2*(8), 395-396. https://doi.org/10.1016/S2589-7500(20)30169-2

Weich, S., McBride, O., Twigg, L., Duncan, C., Keown, P., Crepaz-Keay, D., Cyhlarova, E., Parsons, H., Scott, J., & Bhui, K. (2017). Variation in compulsory psychiatric inpatient admission in England: a cross-classified, multilevel analysis. *The Lancet Psychiatry, 4*(8), 619-626. https://doi.org/10.1016/S2215-0366(17)30207-9

Weir, B., Struthers, R., Reid, L., Wild, C., & Robinson, L. (2022). Psychological recovery in a step 4 service: a qualitative study exploring the views of service users and clinicians. *Journal of Mental Health, 31*(2), 220-226. https://doi.org/10.1080/09638237.2021.1922640

White, J., Gutacker, N., Jacobs, R., & Mason, A. (2014). Hospital admissions for severe mental illness in England: changes in equity of utilisation at the small area level between 2006 and 2010. *Social Science & Medicine, 120*, 243-251. https://doi.org/10.1016/j.socscimed.2014.09.036

Wiles, E. (2006). Aspirational Principles or Enforceable Rights? The Future for Socio-Economic Rights in National Law. *American University International Law Review, 22*(1), 35-64. https://digitalcommons.wcl.american.edu/cgi/viewcontent.cgi?article=1112&context=auilr

Wilkinson, R., & Pickett, K. (2010). *The Spirit Level. Why Equality is Better for Everyone.* Penguin Books.

Willig, C. (2013). *Introducing Qualitative Research in Psychology* (2nd ed.). Open University Press.

Wiltshire, G., & Ronkainen, N. (2021). A realist approach to thematic analysis: making sense of qualitative data through experiential, inferential and dispositional themes. *Journal of Critical Realism, 20*(2), 159-180. https://doi.org/10.1080/14767430.2021.1894909

Woodhead, C., Khondoker, M., Lomas, R., & Raine, R. (2017). Impact of co-located welfare advice in healthcare settings: prospective quasi-experimental controlled study. *The British Journal of Psychiatry, 211*(6), 388-395. https://doi.org/10.1192/bjp.bp.117.202713

Working group on inequalities in health. (1980). *Inequalities in Health: Report of a Research Working Group.* Department of Health and Social Security. https://navigator.health.org.uk/theme/black-report-health-inequalities

World Health Organisation. (2001). *World Health Report 2001. Mental Health: new understanding, new hope.* https://apps.who.int/iris/handle/10665/42390

World Health Organisation. (2014). *Social determinants of mental health.* https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf

World Health Organisation. (2018). *Health inequities and their causes.* https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes

World Health Organisation. (2023). *Coronavirus disease (Covid-19) pandemic.* https://www.who.int/europe/emergencies/situations/covid-19

Zachariadis, M., Scott, S., & Barrett, M. (2013). Methodological implications of critical realism for mixed-methods research. *MIS quarterly*, *37*(3), 855-879. https://www.jstor.org/stable/43826004

Zivin, K., Yosef, M., Miller, E. M., Valenstein, M., Duffy, S., Kales, H. C., Vijan, S. & Kim, H. M. (2015). Associations between depression and all-cause and cause-specific risk of death: a retrospective cohort study in the Veterans Health Administration. *Journal of Psychosomatic Research, 78*(4), 324-331. http://dx.doi.org/10.1016/j.jpsychores.2015.01.014

APPENDIX A: Literature Review Search Terms And Exclusion Criteria

Search terms

“IAPT” OR “improving access to psychological therapies”

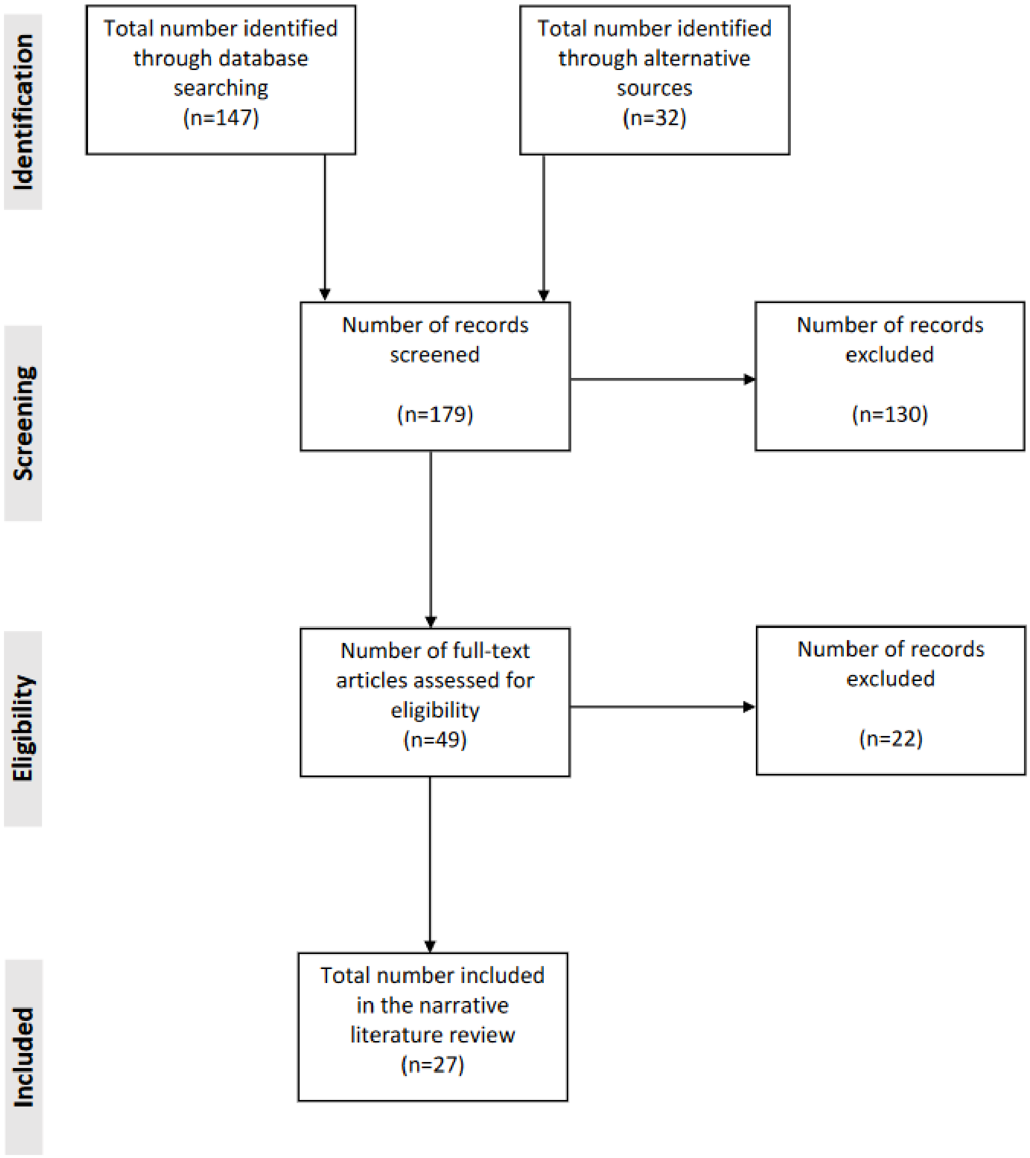
AND

“low income” OR “low-income” OR “poor” OR “poverty” OR disadvantage* OR depriv* OR “social class” OR “SES” OR “socioeconomic” OR “socio-economic” OR “social status” or “financial” OR “money” OR “IMD”

Exclusion criteria

- Exclude if the study is about services other than IAPT
- Exclude if the study refers to other under-represented population groups but does not make reference to income or socioeconomic status
- Exclude if the study focuses on children and adolescents
- Exclude if study attempts to calculate the cost of the IAPT programme
- Exclude if the study is not in English language

APPENDIX B: Literature Review Flow-Diagram



APPENDIX C: Table of Definitions

Study Variable	**Name in IAPT data set**	**Definition**
Number of referrals received	CountReferralsReceived	Count of referrals with a referral request received date in the year.
Number of cases that started treatment	CountFirstTreatment	Count of referrals with a first attended treatment appointment (entered treatment) in the year.
Number of cases that finished treatment	CountFinishedCourseTreatment	Count of referrals with an end date in the year that had at least two attended treatment appointments (excluding follow up).
Number of ended referrals	CountEndedReferral	Count of referrals with an end date in the year.
Number of referrals ended before treatment	CountEndedBeforeTreatment	Count of referrals with an end date in the year having no treatment appointments.
Socioeconomic group	IndicesOfDeprivationDecile	Derived English Indices of Deprivation decile of the patient, based on their Lower Level Super Output Area (LSOA). Linked to patient’s residence.

APPENDIX D: Interview Schedule

Demographic Characteristics

Age ____

Gender:

- Male
- Female
- Non-binary
- Other, please specify: _______________

Ethnicity:

- White British
- White Other: ______________
- Black British
- Black Other: ______________
- Asian British
- Asian Other: ______________
- Other, please specify: _______________
- Mixed, please specify: _______________

Employment status:

- Employed
- Unemployed and seeking work
- Long-term sick or disabled, or in receipt of benefit payments
- Unpaid voluntary work
- Retired

- Student

I have experienced mental health problems related to:

- Anxiety and stress-related difficulties
- Depression and mood-related difficulties
- Other, please specify: _______________

I have experienced challenges related to living on a low income:

- Financial problems
- Job insecurity/Unemployment
- Poor housing
- Limited access to services and resources
- Social isolation
- Other, please specify: __________________

1. Introduction

Thank participant for coming

Setting the scene, explaining the process and what will be involved

Acknowledge it might be difficult to talk about personal experiences, invite to only share what they feel comfortable with, remind they can ask for break / to stop

Ask participant how they feel about the interview and if there is anything I can do to make them feel more comfortable

Complete demographics

2. Main Part

a. History of mental health difficulties and seeking help

- When did you first see your GP for support for your mental health? What kind of difficulties were you having at the time?
- To what extent do you think the mental health difficulties you have experienced are related to living on a low income?
- What were you hoping or expecting when you sought help for your mental health?
- How was it for you when IAPT was suggested as a possibility? (What information did your GP share with you about IAPT? Did they offer to put in a referral or did they invite you to self-refer?)

b. Barriers and facilitators

- What was helpful about the conversation you had around IAPT and what would you like to have been different?
- What stopped you from accessing IAPT? (What do you think got in the way for you? What are some of the barriers you think people face when it comes to getting support from IAPT?)
- What would have made accessing the service easier for you?

c. Service provision

- What advice would you offer to mental health professionals who want to make sure their services are accessible to people on low incomes? (What do you think services can do improve in terms of their accessibility?)

- Is there anything else you would like to add about this conversation?

3. Debrief

Invite questions, reflections, any concerns

Thank participant for their participation, explain next steps

Offer participant debrief sheet and voucher

APPENDIX E: Study Poster

Barriers and facilitators to accessing psychological services for people on low incomes

University of East London

Are you experiencing:

- **Challenges like unemployment, low pay, and poor housing?**

and

- **Mental health problems, like anxiety or low mood?**

Research Study

What: one 1:1 interview, up to an hour

Where: a local community centre, the UEL Startford campus or remotely

When: a date and time that work for you

To thank you for your time, participants will receive a **£10 Amazon voucher.**

If your GP has suggested Improving Access to Psychological Therapies (IAPT) but you have **not accessed** the service, we want to hear about your experience.

Please contact me, Zeny Melissourgaki:

✉ u2075216@uel.ac.uk

☎ 07726961633

This study aims to examine inequalities in access to IAPT services.

Your participation can help us understand what barriers people on low incomes face and how to address these.

APPENDIX F: Participant Information Sheet

Version: 1

Date: 19/07/2022

Participant Information Sheet

Understanding barriers and facilitators to accessing IAPT for people on low incomes: a mixed methods study.

Contact person: Zeny Melissourgaki

E-mail: u2075216@uel.ac.uk

Thank you for considering taking part in this research study!

I am a Trainee Clinical Psychologist at the University of East London (UEL) and I am carrying out this study as part of my Doctorate in Clinical Psychology.

This document offers additional information on the study, why it is important and what it involves, to help you decide whether to take part. Please read it carefully. You are welcome to discuss this information with other people, friends and family. If you have questions or for further information, please do not hesitate to contact me.

➢ What is this study about and why is it important?

Research suggests that people on low incomes are more likely to experience mental health difficulties and that these tend to be more severe or last longer. Research has also shown that people on low incomes may be more likely to need mental health support but often cannot access it. Researchers call this the treatment access gap.

One of the services where this access gap has been identified is Improving Access to Psychological Therapies (IAPT). This is the main service providing mental health support in primary care in the UK and it was set up to make therapy available to more people. The evidence indicates that low-income communities are under-represented in IAPT, which would reflect inequalities in access to mental health care.

It is important to ensure that everyone who needs support for their mental health can access it. To remove the barriers people face when they seek support, we first need to understand what these are. This study aims to hear from people who have experienced economic adversity and mental health difficulties but were not able to access IAPT for support. By listening to those directly affected, the study aims to better understand their experiences and what got in the way of them accessing help, as well as to contribute to current efforts to make services more accessible.

- **What does taking part involve?**

If you decide to participate, you will be invited to one research interview of about an hour. This will be with me as the researcher and we can meet in a confidential space (eg. community centre) in your local area or at the UEL campus. Alternatively, , we can have a video call over Microsoft Teams or speak on the phone. Interviews will be recorded on a digital recorder. I will ask you some questions about your experience of seeking support for your mental health, the difficulties you faced in trying to access IAPT and your ideas about what would have been helpful for you and how services can become more accessible. You will not be asked to disclose personal details and you can skip questions that you do not feel comfortable answering. To thank you for your time, you will receive a £10 Amazon voucher.

- **What happens to what I say?**

Interviews will be held in a private space, with one participant at a time. Interviews will be recorded on a digital recorder to be transcribed. This is so that I can look for common themes across participants as part of data analysis. Any identifiable information will be altered in the transcripts to protect your identity. For example, if your name is mentioned during the interview, I will change it in the transcription. Every recording will be deleted once transcribed. I will be the only one with access to your personal details and I will store all information collected or produced as part of this study securely on OneDrive, a cloud service provided by UEL that benefits from multi-factor authentication.

I will have access to this information while working on this project. My research supervisor at UEL will have access to the transcripts, but not the recordings or personal information. The examiners who will assess this study may request access to the transcripts to assess the quality of my work. If I need to share information with them, this will be pseudonymised and it will be shared via secure channels like UEL e-mail or One Drive. I will delete all the information I hold related to this study once it has been examined. My thesis supervisor will keep the transcripts and group-level demographic information for three years, to be used for disseminating the results of this study, following which all data will be deleted.

The final research will include brief quotes from interviews and demographic information on participants as a group. The study will be written up as a thesis, which will be uploaded on UEL's online repository and available to the public. I also intend to share the findings will other professionals, for example by submitting an article to academic journals or presenting to people who work in mental health care. In all material produced, your identity will be protected with the use of a pseudonym and it will not be possible to identify you personally. You can also ask to receive a summary of the research findings once the study has been completed.

Please note that if I am concerned about your safety or the safety of someone else following the interview, I might need to share information with others to ensure yours and other people's safety. I will make every effort to discuss this fully with you first, however I am legally required to act on this information even without your consent.

For the purposes of data protection, UEL is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection.

- **Who has reviewed this research?**

This study has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society. If you have any concerns about how this study is conducted, please contact my research supervisor, Dr. Lorna Farquharson. You will find her details below.

- **Do I have to take part? What if I change my mind later?**

It is completely up to you to decide whether you would like to take part in this study. Your decision to not take part will not disadvantage you in any way.

If you decide to participate, you can choose not to answer a question if you do not want to. You can also choose to stop the interview while it is taking place, at which point the recording will be deleted. You do not have to explain your reasons for not answering a question or for asking for the interview to stop.

If you change your mind about participating after the interview has taken place, please contact me within three weeks. You can withdraw without explanation or consequence. Your interview data will be destroyed and will not be used for the study. Three weeks after your interview, the data will be moved to data analysis, after which it will not be possible to remove your data. Please see the section above (What happens to what I say?) for information on how your identity will be protected.

- **What are the advantages and the risks of taking part?**

If you decide to take part in this study, you will help us better understand why low-income communities are under-represented in services, what barriers people face when they try to access support for their mental health and what services can do to be more accessible. Improving existing services will make it possible for more people to get the support they need for the mental health difficulties they experience.

Sometimes people find it distressing to talk about their experiences of seeking help. While care has been taken to minimise this risk and if you find any of the topics difficult, please remember that you can ask for the interview to pause or stop. After the interview, you will also be given some information on services that can offer support with mental health and other problems, in case this is helpful to you.

- **What are the next steps?**

If you decide that you would like to participate in this study, an interview will be arranged at a time convenient to you. You will be given a consent form to sign before the interview takes place. There will be time for questions or concerns before and after the interview. Please retain this information sheet for your reference.

If you are unsure about taking part, you are more than welcome to contact me and discuss this further. If you have decided that you would not like to participate, please feel free to discard this information sheet.

- **Who can I contact if I have any questions or concerns?**

If you would like further information about this study or have any questions or concerns, please do not hesitate to contact me: Zeny Melissourgaki, Trainee Clinical Psychologist

E-mail: u2075216@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor: Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ,

(Email: l.farquharson@uel.ac.uk)

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet!

APPENDIX G: Ethics Application

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2021)

FOR BSc RESEARCH;

MSc/MA RESEARCH;

PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form (please read carefully)	
1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.

1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login

	You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details		
2.1	**Your name:**	Zaneta-Eleni Melissourgaki
2.2	**Your supervisor's name:**	Dr. Lorna Farquharson
2.3	**Name(s) of additional UEL supervisors:**	Dr. Trishna Patel 3rd supervisor (if applicable)
2.4	**Title of your programme:**	Professional Doctorate in Clinical Psychology
2.5	**UEL assignment submission date:**	22/05/2023 Re-sit date (if applicable)

Section 3 – Project Details		
Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.		
3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	Understanding barriers and facilitators to accessing IAPT for people on low incomes: a mixed methods study.

3.2	**Summary of study background and aims (using lay language):**	The literature has unveiled a strong association between socio-economic adversity and mental ill health, as people on low incomes are more likely to experience mental health difficulties and these tend to be more severe or long-lasting. At the same time, evidence suggests that low-income communities are under-represented in psychological services and thus less likely to access support. This includes Improving Access to Psychological Therapies (IAPT) services, which is the main provider of mental health support in primary care in the UK. Delgadillo et al. (2018) talk about a treatment access gap in IAPT. The literature on barriers to accessing mental health services has discussed supply factors, like long waiting lists and the lack of healthcare resources, however research focusing on low-income communities has been limited. Moreover, research on IAPT tends to target those who engaged; little is known about those who were not able to access the service and barriers they may have faced. This study aims to address this gap in the literature, by focusing on the barriers and facilitators to accessing IAPT for people on low incomes. A mixed method design will be adopted. First, publicly available national data on IAPT services will be examined to compare referral and treatment rates between different socio-economic groups of the population and

		track changes since the start of the Covid-19 pandemic (Study 1). Furthermore, interviews will be conducted with people who self-identify as experiencing economic adversity and have been unable to access IAPT to better understand the barriers they faced (Study 2). It is hoped that this study will contribute to efforts to improve equity of access in primary mental healthcare.
3.3	**Research question(s):**	Study 1: Have the referral and treatment rates in IAPT changed for different socio-economic groups since the start of the Covid-19 pandemic? Study 2: a. What barriers do people on low incomes face in accessing IAPT? b. What could facilitate access to the service?
3.4	**Research design:**	The study will attempt a mixed methods design which consists of two studies. Study 1: This part of the study will address the first research question and thus aims to compare referral and treatment rates across different socio-economic groups and monitor changes over time. The study will use national data on IAPT services, publicly available on NHS digital. Study 2: This part of the study will address the second research question and thus aims to hear from people on low incomes who have not been able to access IAPT about the barriers they faced and what would have facilitated access. Data will be collected through semi-structured interviews.
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	Study 1: The study will use publicly available national data on IAPT service use for the years 2018 – 2022. Data will be collected on number of referrals, number of cases entering treatment and number of cases closed before treatment

		was offered, per socio-economic group. In the IAPT database, socio-economic groups are defined based on the Index of Multiple Deprivation decile, with service users classified in 10 groups (1= least deprived; 10 = most deprived). Study 2: Inclusion criteria: adults, English-speaking; self-identifying as having experienced challenges like low pay, unemployment and poor housing; have seen their GP for mental health concerns, like anxiety and low mood; have considered self-referral or have been referred to IAPT but have subsequently not accessed the service.
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	Study 1: The data used for the study is publicly available on NHS digital. Annual and monthly reports are available on the website for every CCG in the country since 2012. The annual report for the period from 01/04/2021 to 31/03/2022 is expected in November 2022. Study 2: The study advertisement will be shared with the researcher's network, partnering and community organisations and on social media. Prospective participants will be invited to contact the researcher by e-mail or text to express their interest in taking part. The researcher will confirm eligibility and arrange the interview at a data, time and location convenient to the participant.
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely	Study 1: The data used for the study is publicly available on NHS digital. Data will be analysed using Excel and IBM SPSS Statistics 26; UEL provides access to both. Study 2: The interview schedule has been created by the researcher after consultation with a service user group and

	available, permissions required, etc.	is included with this form. The researcher will also need a Dictaphone and access to Teams, NVivo and the UEL One Drive which are available through UEL.
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Study 1: National data on the annual use of IAPT is publicly available on NHS digital: https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services. Data on variables of interest will be collected from separate annual reports and collated in a single excel spreadsheet. Data will then be moved onto SPSS for data analysis. Study 2: Prospective participants will contact the researcher to express their interest in taking part in the study in response to the study advertisement. The researcher will confirm eligibility for the study before arranging an interview; the date, time and location will be negotiated with the participant. Consent forms will be collected on the day of the interview. The participant information sheet will be shared over e-mail before the interview with participants who have access to and use e-mail or, alternatively, it will be sent by post or shared on the day of the interview, if that is more accessible to the participant. Demographic data will be collected as part of the interview process. Interviews will be conducted in person, in spaces were privacy and confidentiality can be ensured. For participants who do not wish to meet in person, a video or a telephone call will be offered as an alternative. All interviews will be audio recorded.

		Recordings will be saved in WAV format for the purposes of transcription. Recordings will be transcribed as word documents (.docx) and subsequently deleted. Participants will be offered the participant debrief sheet at the end of the interview.	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?		
3.10	**Will participants be reimbursed?**	**YES** ☒	**NO** ☐
	If yes, please detail why it is necessary.	Reimbursement is necessary to facilitate recruitment and allow the researcher to reach a group of the population that has not accessed services. Reimbursement will also serve as a token of appreciation for research participants and the time they offer to take part in the study, particularly as participants will be people who self-identify as being on a low income.	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	£10 Amazon vouchers	
3.11	**Data analysis:**	Study 1: Logistic regression will be performed to assess the impact of socio-economic group on referral and treatment rates. Study 2: Interview data will be analysed with the use of reflexive Thematic Analysis to identify patterns across participants. The researcher aims to remain data-	

		driven and will adopt an inductive approach, allowing data to determine themes. The researcher will, however, attempt to develop latent themes, to explore societal narratives shaping participants' experiences.

Section 4 – Confidentiality, Security and Data Retention			
It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations. If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.			
4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.	Study 1: Data on IAPT has already been anonymised for the purpose of being publicly available. Study 2: data will not be anonymised at source.	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	Participants will be pseudonymised; a key linking pseudonyms to participant initials will be created and kept separately to the rest of the data collected or created for the study; identifying information will be removed from transcriptions, recordings of interviews will be deleted once transcription is completed; the thesis and any subsequent publications will only include group-level demographic characteristics and anonymised extracts from the interviews;	

		identifying information such as participants' contact details and the pseudonymisation log will be deleted once the study is completed.
4.3	**How will you ensure participant details will be kept confidential?**	All data collected or created for this study will be saved onto UEL storage OneDrive, which benefits from multi-factor authentication.
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	. All data collected or created for this study will be saved onto UEL storage OneDrive, which benefits from multi-factor authentication; only the researcher has access to this. Anonymised transcriptions, group-level demographic information, the excel spreadsheets used for the quantitative part of the study and SPSS outputs produced as part of data analysis will also be saved in an encrypted folder, in a password protected laptop only the researcher has access to and shared with the DoS via the UEL One Drive. The thesis and any subsequent publications will only include anonymised extracts of interviews and group-level demographic information.
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	The researcher will have access to all data collected or produced as part of this study, for the duration of the study. The DoS will have access to interview transcriptions, anonymised group-level demographic data, the excel spreadsheets used for the quantitative part of the study and SPSS outputs produced as part of data analysis. Access to this data will be extended to the examiners upon request.
4.6	**Which data are of long-term value and will be retained?**	Consent forms, the pseudonymisation log and all personal information will be deleted following thesis completion and examination. Audio files

	(e.g., anonymised interview transcripts, anonymised databases)	will be deleted immediately after transcription. Transcriptions and anonymised demographic characteristics will be retained by the DoS for a period of up to three years for dissemination purposes. The spreadsheets used for the quantitative part of the study, as well as the SPSS outputs following data analysis will also be retained by the DoS. No data will be deposited on the UEL depository, except for the thesis itself.	
4.7	**What is the long-term retention plan for this data?**	The DoS will retain anonymised group-level demographic characteristics, interview transcriptions, the SPSS outputs and excel spreadsheets for a period of 3 years.	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	The interview process may be triggering for people who share difficult experiences. Furthermore, participants will be people who have not been able to access mental health services and may continue to experience distress or difficulties across different domains (eg. housing, health). Participants will be informed in advance about the purpose and the content of the interview, as part of discussing the participant information sheet and obtaining consent for the study. Participants will also be informed that they can skip questions they do not feel comfortable answering. At the same time, interview questions will be designed to minimise the risk of upsetting participants; service user feedback has been sought as part of devising the interview guide. Information on further support available and relevant contact details, including crisis information, will be included in the participant debrief sheet.	
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	Potential risk associated with conducting interviews in community settings. I will only use public spaces; I will visit the site earlier to	

		familiarise myself with safety protocols (eg. fire exit); I will sign in at the reception of the community centre and let them know what time we are expected to return the room; I will share the location and time of the interview with a trusted person, who will be able to contact the community centre or escalate (police) if they do not hear back from me.		
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	In public spaces like community centres local to the participant, if they prefer this over attending the UEL campus.		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be	**YES** ☐		

	completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on ‘sign in’ and then ‘register here’ using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). ▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the	

	inexperience of the students and the time constraints they have to complete their degree.

Section 6 – Disclosure and Barring Service (DBS) Clearance			
6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☐	**NO** ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☒	**NO** ☐

6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☒	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	001702984828	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions			
7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☒	**NO** ☐
	If yes, please provide their details.	National Service User Network; The Patients Association; Healthwatch	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting	**YES** ☒	

	data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.	

Section 8 – Declarations		
8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	Zaneta Eleni Melissourgaki
8.3	**Student's number:**	U2075216
8.4	**Date:**	19/07/2022

Supervisor's declaration of support is given upon their electronic submission of the application

Student checklist for appendices – ***for student use only***

Documents attached to ethics application	**YES**	**N/A**
Study advertisement	☒	☐
Participant Information Sheet (PIS)	☒	☐
Consent Form	☒	☐
Participant Debrief Sheet	☒	☐
Risk Assessment Form	☒	☐
Country-Specific Risk Assessment Form	☐	☒
Permission(s) from an external organisation(s)	☒	☐
Pre-existing questionnaires that will be administered	☐	☒
Researcher developed questionnaires/questions that will be administered	☐	☒
Pre-existing tests that will be administered	☐	☒
Researcher developed tests that will be administered	☐	☒
Interview guide for qualitative studies	☒	☐
Any other visual material(s) that will be administered	☒	☐
All suggested text in RED has been removed from the appendices	☒	☐
All guidance boxes have been removed from the appendices	☒	☐

Appendix A: Participant Information Sheet (PIS) template

Guidance: Below is a suggested template for your Participant Information Sheet (PIS). The material in RED should be completed by you and tailored to the specifics of your study.

Ensure the language used is jargon-free and appropriate for your sample. You may need to adapt the wording to ensure that it is suitable for your participants (e.g., children) but the suggested headings should be covered in some form in the final version.

There is a checklist at the end of the template to ensure that you have included all the necessary information.

DO NOT LEAVE ANY RED TEXT IN THE FINAL VERSION OF YOUR PIS

Version: 1

Date: 19/07/2022

Understanding barriers and facilitators to accessing IAPT for people on low incomes: a mixed methods study.

Contact person: Zeny Melissourgaki

E-mail: u2075216@uel.ac.uk

Thank you for considering taking part in this research study!

I am a Trainee Clinical Psychologist at the University of East London (UEL) and I am carrying out this study as part of my Doctorate in Clinical Psychology.

This document offers additional information on the study, why it is important and what it involves, to help you decide whether to take part. Please read it carefully. You are welcome to discuss this information with other people, friends and family. If you have questions or for further information, please do not hesitate to contact me.

➢ What is this study about and why is it important?

Research suggests that people on low incomes are more likely to experience mental health difficulties and that these tend to be more severe or last longer. Research has also shown that people on low incomes may be more likely to need mental health support but often cannot access it. Researchers call this the treatment access gap.

One of the services where this access gap has been identified is Improving Access to Psychological Therapies (IAPT). This is the main service providing mental health support in primary care in the UK and it was set up to make therapy available to more people. The evidence indicates that low-income communities are under-represented in IAPT, which would reflect inequalities in access to mental health care.

It is important to ensure that everyone who needs support for their mental health can access it. To remove the barriers people face when they seek support, we first need to understand what these are. This study aims to hear from people who have experienced economic adversity and mental health difficulties but were not able to access IAPT for support. By listening to those directly affected, the study aims to better understand their experiences and what got in the way of them accessing help, as well as to contribute to current efforts to make services more accessible.

- **What does taking part involve?**

If you decide to participate, you will be invited to one research interview of about an hour. This will be with me as the researcher and we can meet in a confidential space (eg. community centre) in your local area or at the UEL campus. Alternatively, , we can have a video call over Microsoft Teams or speak on the phone. Interviews will be recorded on a digital recorder. I will ask you some questions about your experience of seeking support for your mental health, the difficulties you faced in trying to access IAPT and your ideas about what would have been helpful for you and how services can become more accessible. You will not be asked to disclose personal details and you can skip questions that you do not feel comfortable answering. To thank you for your time, you will receive a £10 Amazon voucher.

- **What happens to what I say?**

Interviews will be held in a private space, with one participant at a time. Interviews will be recorded on a digital recorder to be transcribed. This is so that I can look for common themes across participants as part of data analysis. Any identifiable information will be altered in the transcripts to protect your identity. For example, if your name is mentioned during the interview, I will change it in the transcription. Every recording will be deleted once transcribed. I will be the only one with access to your personal details and I will store all information collected or produced as part of this study securely on OneDrive, a cloud service provided by UEL that benefits from multi-factor authentication.

I will have access to this information while working on this project. My research supervisor at UEL will have access to the transcripts, but not the recordings or personal information. The examiners who will assess this study may request access to the transcripts to assess the quality of my work. If I need to share information with them, this will be pseudonymised and it will be shared via secure channels like UEL e-mail or One Drive. I will delete all the information I hold related to this study once it has been examined. My thesis supervisor will keep the transcripts and group-level demographic information for three years, to be used for disseminating the results of this study, following which all data will be deleted.

The final research will include brief quotes from interviews and demographic information on participants as a group. The study will be written up as a thesis, which will be uploaded on UEL's online repository and available to the public. I also intend to share the findings will other professionals, for example by submitting an article to academic journals or presenting to people who work in mental health care. In all material produced, your identity will be protected with the use of a pseudonym and it will not be possible to identify you personally. You can also ask to receive a summary of the research findings once the study has been completed.

Please note that if I am concerned about your safety or the safety of someone else following the interview, I might need to share information with others to ensure yours and other people's safety. I will make every effort to discuss this fully with you first, however I am legally required to act on this information even without your consent.

For the purposes of data protection, UEL is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the

GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection.

- **Who has reviewed this research?**

This study has been approved by the School of Psychology Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society. If you have any concerns about how this study is conducted, please contact my research supervisor, Dr. Lorna Farquharson. You will find her details below.

- **Do I have to take part? What if I change my mind later?**

It is completely up to you to decide whether you would like to take part in this study. Your decision to not take part will not disadvantage you in any way.

If you decide to participate, you can choose not to answer a question if you do not want to. You can also choose to stop the interview while it is taking place, at which point the recording will be deleted. You do not have to explain your reasons for not answering a question or for asking for the interview to stop.

If you change your mind about participating after the interview has taken place, please contact me within three weeks. You can withdraw without explanation or consequence. Your interview data will be destroyed and will not be used for the study. Three weeks after your interview, the data will be moved to data analysis, after which it will not be possible to remove your data. Please see the section above (What happens to what I say?) for information on how your identity will be protected.

- **What are the advantages and the risks of taking part?**

If you decide to take part in this study, you will help us better understand why low-income communities are under-represented in services, what barriers people face when they try to access support for their mental health and what services can do to be more accessible. Improving existing services will make it possible for more people to get the support they need for the mental health difficulties they experience.

Sometimes people find it distressing to talk about their experiences of seeking help. While care has been taken to minimise this risk and if you find any of the topics difficult, please remember that you can ask for the interview to pause or stop. After the interview, you will also be given some information on services that can offer support with mental health and other problems, in case this is helpful to you.

- **What are the next steps?**

If you decide that you would like to participate in this study, an interview will be arranged at a time convenient to you. You will be given a consent form to sign before the interview takes place. There will be time for questions or concerns before and after the interview. Please retain this information sheet for your reference.

If you are unsure about taking part, you are more than welcome to contact me and discuss this further. If you have decided that you would not like to participate, please feel free to discard this information sheet.

- **Who can I contact if I have any questions or concerns?**

If you would like further information about this study or have any questions or concerns, please do not hesitate to contact me: Zeny Melissourgaki, Trainee Clinical Psychologist

E-mail: u2075216@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor: Dr Lorna Farquharson. School of Psychology, University of East London, Water Lane, London E15 4LZ,

(Email: l.farquharson@uel.ac.uk)

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet!

Appendix B: Consent Form template

Guidance: Below is a suggested template for your Consent Form. The material in RED should be completed by you and tailored to the specifics of your study.

Ensure the language used is jargon-free and appropriate for your sample. You may need to adapt the wording to ensure that it is suitable for your participants (e.g., children).

DO NOT LEAVE ANY RED TEXT IN THE FINAL VERSION OF YOUR CONSENT FORM

Version: 1

Date: 19/07/2022

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Understanding barriers and facilitators to accessing IAPT for people on low incomes; a mixed methods study.

Contact person: Zeny Melissourgaki

E-mail: u2075216@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 19/07/2022 (version 1) and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw without explanation or disadvantage.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using a digital recorder.	

I understand that my personal information and data, including recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview and group level data may be used in material such as conference presentations, reports or academic articles resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………………

Participant's Signature

……………………………………………………………………………………………

Researcher's Name (BLOCK CAPITALS)

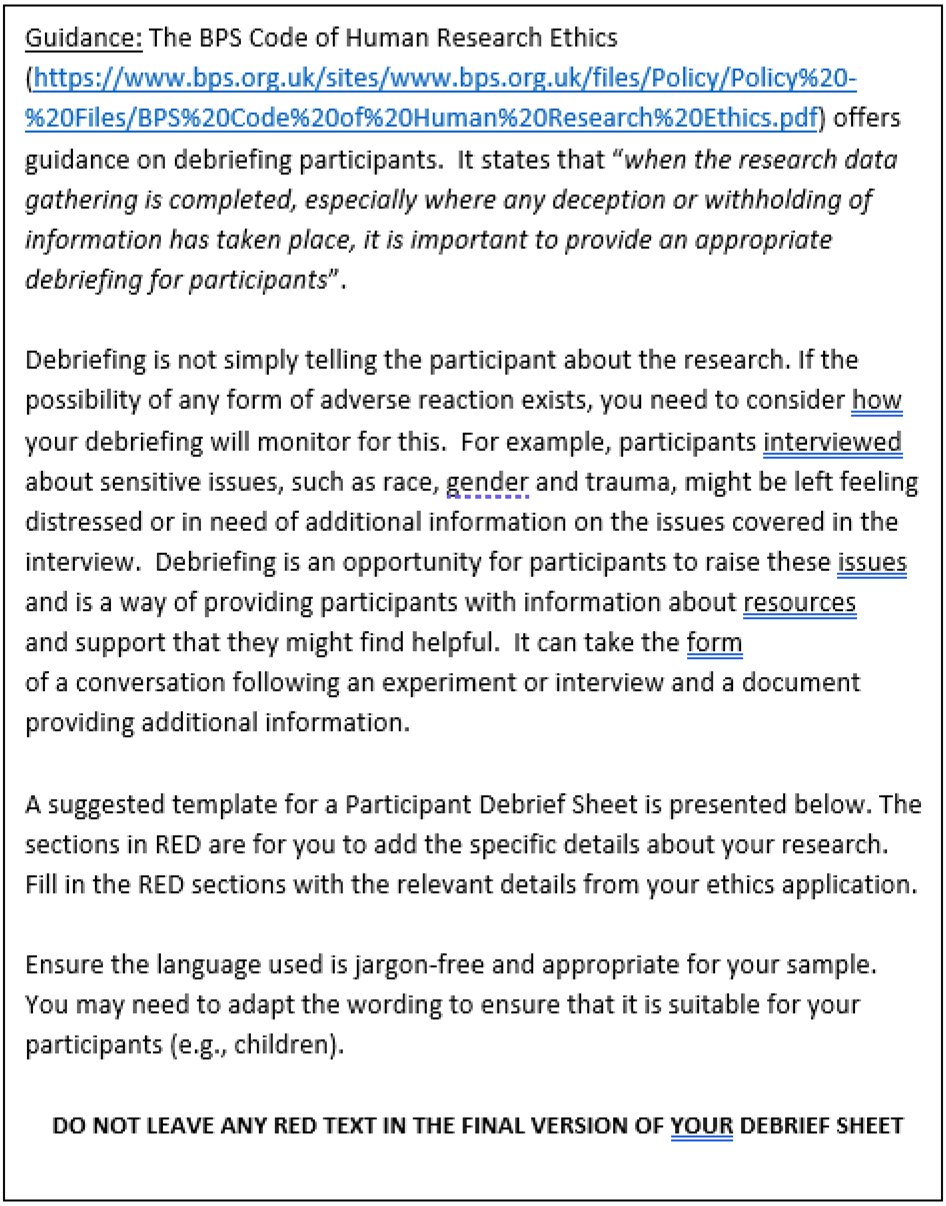
……………………………………………………………………………………………

Researcher’s Signature

……………………………………………………………………………………………

Date

Appendix C: Participant Debrief Sheet template



Guidance: The BPS Code of Human Research Ethics (https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf) offers guidance on debriefing participants. It states that "*when the research data gathering is completed, especially where any deception or withholding of information has taken place, it is important to provide an appropriate debriefing for participants*".

Debriefing is not simply telling the participant about the research. If the possibility of any form of adverse reaction exists, you need to consider how your debriefing will monitor for this. For example, participants interviewed about sensitive issues, such as race, gender and trauma, might be left feeling distressed or in need of additional information on the issues covered in the interview. Debriefing is an opportunity for participants to raise these issues and is a way of providing participants with information about resources and support that they might find helpful. It can take the form of a conversation following an experiment or interview and a document providing additional information.

A suggested template for a Participant Debrief Sheet is presented below. The sections in RED are for you to add the specific details about your research. Fill in the RED sections with the relevant details from your ethics application.

Ensure the language used is jargon-free and appropriate for your sample. You may need to adapt the wording to ensure that it is suitable for your participants (e.g., children).

DO NOT LEAVE ANY RED TEXT IN THE FINAL VERSION OF YOUR DEBRIEF SHEET

DO NOT LEAVE ANY RED TEXT IN THE FINAL VERSION OF YOUR DEBRIEF SHEET

Version: 1

Date: 19/07/2022

PARTICIPANT DEBRIEF SHEET

Understanding barriers and facilitators to accessing IAPT for people on low incomes; a mixed methods study.

Contact person: Zeny Melissourgaki

E-mail: u2075216@uel.ac.uk

Thank you for participating in this research study!

Your participation will help us better understand what barriers people on low incomes face in accessing IAPT services and how services can make this process easier, to ensure more people can get the support they need. This document offers information that may be relevant in light of you having now taken part.

➢ How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the

GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

- **What will happen to the results of the study?**

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. I also intend to share the findings will other professionals, for example by submitting an article to academic journals or presenting to people who work in mental health care. In all material produced, your identity will be protected with the use of a pseudonym and it will not be possible to identify you personally. The thesis and all subsequent publications or material produced will only include brief quotes from the interviews and demographic information on participants as a group.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

I will delete all the information I hold related to this study once it has been examined. My thesis supervisor will keep the transcripts and group-level demographic information for three years, to be used for disseminating the results of this study, following which all data will be deleted.

- **What if I have been adversely affected by taking part?**

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- **If you are having suicidal thoughts**:
- Go to A&E or call an ambulance if you don't feel able to keep yourself safe
- Call your GP for an emergency appointment

- Contact the Samaritans for advice and support: call/text 116 123 (free of charge) or e-mail jo@samaritans.org

- **If you would like support with your mental health**:
- Mind: A mental health charity offering advice and support. To find your local service please visit: https://www.mind.org.uk/information-support/local-minds/
- Sane: A mental health charity offering information and emotional support, including peer support. Call 07984 967 708 and leave your name and contact details for a call back.
- Rethink Mental Illness: a mental health charity with a range of support networks and groups. Call 0808 801 0525 for practical help or visit https://www.rethink.org/ to find support available in your local area.

- **If you would like advice about money**:
- Citizens Advice Bureau: an independent organisation offering information and advice with legal, debt, housing and other problems. National phone line (free): 0800 144 8848. For your local branch visit https://www.citizensadvice.org.uk/.
- Turn2us: for help with benefits, debt, housing and legal issues, you can call 0808 802 200 (free). More information on https://www.turn2us.org.uk/
- StepChange: for debt advice and money guidance please visit: https://www.stepchange.org/
- PayPlan: for free debt advice and debt solutions, you can call 0800 280 2816 (free). More information: https://www.payplan.com/
- Mental Health and Money Advice: website providing free information, support and advice (sample letters and templates, financial tools and calculators) for people affected by mental health and money issues. Visit: https://www.mentalhealthandmoneyadvice.org/en/

- **If you would like support for housing problems**:
- Shelter: a charity offering housing advice. Visit https://england.shelter.org.uk/ or call 0808 800 4444 for urgent advice.
- Z2K: for support with benefits, tribunal representation, support with housing and other issues, visit https://z2k.org/get-help/

- The housing department of your local authority may also be able to help you. You can find details about your local council here: https://www.gov.uk/find-local-council

- **Further help**:
- Carers UK: if you care for a loved one and would like some support in this role call 0808 808 7777 or e-mail advice@carersuk.org.
- Family Lives: if your difficulties relate to aspects of the family life, such as child development, school or family breakdown, please call 0808 800 2222 or email askus@familylives.org.uk.
- CRUSE: a charity offering bereavement support. Call 0808 808 1677.
- If you are experiencing domestic violence and you need a refuge space, please contact the National Domestic Abuse Helpline on 0808 2000 247
- Victim support: if you have been affected by crime you can call 08 08 16 89 111 (free) or find your nearest Victim support service here: https://www.victimsupport.org.uk/help-and-support/get-help/support-near-you/

- **Who can I contact if I have any questions or concerns?**

If you would like further information about this study or have any questions or concerns, please do not hesitate to contact me:

Zeny Melissourgaki, Trainee Clinical Psychologist, E-mail: u2075216@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor:

Dr. Lorna Farquharson, School of Psychology, University of East London, Water Lane, London, E15 4LZ.Email: l.farquharson@uel.ac.uk

Or

Chair of School Ethics Committee: Dr. Trishna Patel

School of Psychology, University of East London, Water Lane, London, E15 4LZ.

Thank you for taking part in this study!

Appendix D: General Risk Assessment Form template

Guidance: A comprehensive guide to risk assessments and health and safety in general can be found in *UEL's health and safety handbook*. A comprehensive guide to risk assessment is also available on the *Health & Safety Executive's website*. An example risk assessment (for a wellbeing conference/event) is presented below, please replace text in RED with your own/study specific information. This form should consider both physical and/or psychological risks and how these can be minimised.

DO NOT LEAVE ANY RED TEXT IN THE FINAL VERSION OF YOUR RISK ASSESSMENT FORM

Ethics and Integrity Sub-Committee (EISC) Risk Assessment Form **Use this form for assessing risk related to the research activity/event and COVID-19 secure mitigating measures if the activity/event will be conducted in person.**					
Name of person completing the risk assessment:	Zaneta Eleni Melissourgaki	**Student or Staff member:**	2075216	**Date of Assessment:**	03/07/2022
				Date and time (if applicable):	
Research title:	Understanding barriers and facilitators to accessing IAPT for people on low incomes: a mixed methods study			**Location of activity:**	
Signed off by (Dean / Director of Impact and Innovation) Print Name:	Dr. Lorna Farquharson			**Electronic signature:**	[redacted]
Financial Cost to UEL (if applicable):	N/A			**UEL resources required (if applicable):**	Participant vouchers
Please describe the activity/event in as much detail as possible. Please include information about what you want to do, the resources required, and the number of participants.					

a. A time-series analysis of referral and treatment rates to IAPT.

- National data on IAPT services are publicly available and can be freely accessed. Monthly and yearly reports are published on NHS Digital.
- The analysis will compare different groups based on Index of Multiple Deprivation (IMD) scores with regards to their rates of accessing the service, number of people starting treatment and number of cases closed before treatment starts.
- The analysis will further attempt to explore changes in access and referral rates in between 2018 and 2022, to explore the potential impact of Covid-19 and the associated changes in service provision.
- Data will be analysed with the use of Excel and IBM SPSS Statistics 26, both of which are available for UEL students. No further resources will be required.

b. Interviews with people on low incomes who have not been able to access primary mental healthcare. Participants will be people who self-identify as being on a low income, have been referred or invited to self-refer to Improving Access to Psychological Therapies (IAPT) services and have subsequently not accessed the service.

- Interviews will be conducted in person, in a community centre in the area local to the participant. Community centres often offer rooms for hire at affordable prices. Online interviews over MST Teams will be offered as an alternative for those who do not wish to meet in person.
- Participants will be reimbursed for their time with a voucher.
- Interviews will be audio-recorded for transcription using a recording device.
- For the purposes of this study, a sample of about 12 participants is required.

Guide to risk ratings:

A) Likelihood of Risk	**B) Hazard Severity**	**C) Risk Rating (Likelihood x Severity)**
1 = Low (Unlikely)	1 = Slight (Minor/less impacted for less than 3 days)	1-2 = Minor (No further action required0
2: Moderate (Quite likely)	2 = Serious (impacted for more than 3 days)	3-5 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (impact for more than 7 days, specified injury or death)	6-9 = High (Further control measures essential)

Risks attached to activity

When considering hazards please ensure that you read up to date UK government guidance on COVID-19 and adhere to the restrictions currently in force under the Coronavirus Act 2020: https://www.gov.uk/coronavirus

What is the risk?	Who is at risk?	Likelihood of risk	Severity of risk	Risk Score: (Likelihood x Severity)	Actions to mitigate the risk	Likelihood after mitigation	Severity after mitigation	Final risk rating after mitigation (Likelihood x Severity)
The interview process may be triggering for people who share difficult experiences. Furthermore, participants will be people who have not been able to access mental	Interviewees	**2**	**2**	**4**	Provide information on further support available and relevant contact details after the interview, including crisis information.	**2**	**1**	**2**

health services and may continue to experience distress or difficulties across different domains (eg. housing, health).								
Risk from Covid-19	Interviewees, researcher	**1**	**2**	**2**	Adhere to governmental guidelines and monitor changes in guidance. Self-test on the day of the	**1**	**1**	**1**

					interview, before meeting the interviewee. I also continue to have twice weekly lateral flow testing in accordance with local NHS Trust policy.			
Potential risks and hazards associated with the community settings where interviews will	Interviewees, researcher	**1**	**2**	**2**	Visit the site earlier to familiarise myself with safety protocols (eg. fire exit)	**1**	**1**	**1**

be taking place.								
Potential risks and hazards associated with being alone with a person with limited prior contact.	Researcher	**1**	**3**	**3**	Interviews to only take place in public spaces (community centres) and not individuals' homes. Implement buddy system, ie share location and time of the interview with trusted individual; for them to	**1**	**1**	**1**

					contact community centre or escalate (police) if they do not hear back from me at the expected time. Sign in at reception of community centre and let them know how long the room booking is for.			
Online data collection (in	Interviewees	1	2	2	Used trusted software,	1	1	1

case participants decline in person interview)					such as Microsoft Teams			

Appendix E: Recruitment Poster

Barriers and facilitators to accessing psychological services for people on low incomes

University of East London

Are you experiencing:

- **Challenges like unemployment, low pay, and poor housing?**

and

- **Mental health problems, like anxiety or low mood?**

If your GP has suggested Improving Access to Psychological Therapies (IAPT) but you have **not accessed** the service, we want to hear about your experience.

Research Study

What: one 1:1 interview, up to an hour
Where: a local community centre, the UEL Startford campus or remotely
When: a date and time that work for you

To thank you for your time, participants will receive a 🎁 **£10 Amazon voucher.**

Please contact me, Zeny Melissourgaki:

✉ u2075216@uel.ac.uk

☎ 07XXXXX

This study aims to examine inequalities in access to IAPT services.

Your participation can help us understand what barriers people on low incomes face and how to address these.

Appendix F: Interview Guide

Demographic Characteristics

Age ____

Gender:

- Male
- Female
- Non-binary
- Other, please specify: _______________

Ethnicity:

- White British
- White Other: ______________
- Black British
- Black Other: ______________
- Asian British
- Asian Other: ______________
- Other, please specify: _______________
- Mixed, please specify: _______________

Employment status:

- Employed
- Unemployed and seeking work
- Long-term sick or disabled, or in receipt of benefit payments
- Unpaid voluntary work
- Retired

- Student

I have experienced mental health problems related to:

- Anxiety and stress-related difficulties
- Depression and mood-related difficulties
- Other, please specify: _______________

I have experienced challenges related to living on a low income:

- Financial problems
- Job insecurity/Unemployment
- Poor housing
- Limited access to services and resources
- Social isolation
- Other, please specify: __________________

4. Introduction

Thank participant for coming

Setting the scene, explaining the process and what will be involved

Acknowledge it might be difficult to talk about personal experiences, invite to only share what they feel comfortable with, remind they can ask for break / to stop

Ask participant how they feel about the interview and if there is anything I can do to make them feel more comfortable

Complete demographics

5. Main Part

History of mental health difficulties and seeking help

- When did you first see your GP for support for your mental health? What kind of difficulties were you having at the time?
- To what extent do you think the mental health difficulties you have experienced are related to living on a low income?
- What were you hoping or expecting when you sought help for your mental health?
- How was it for you when IAPT was suggested as a possibility? (What information did your GP share with you about IAPT? Did they offer to put in a referral or did they invite you to self-refer?)

Barriers and facilitators

- What was helpful about the conversation you had around IAPT and what would you like to have been different?
- What stopped you from accessing IAPT? (What do you think got in the way for you? What are some of the barriers you think people face when it comes to getting support from IAPT?)
- What would have made accessing the service easier for you?

Service provision

- What advice would you offer to mental health professionals who want to make sure their services are accessible to people on low incomes? (What do you think services can do improve in terms of their accessibility?)

- Is there anything else you would like to add about this conversation?

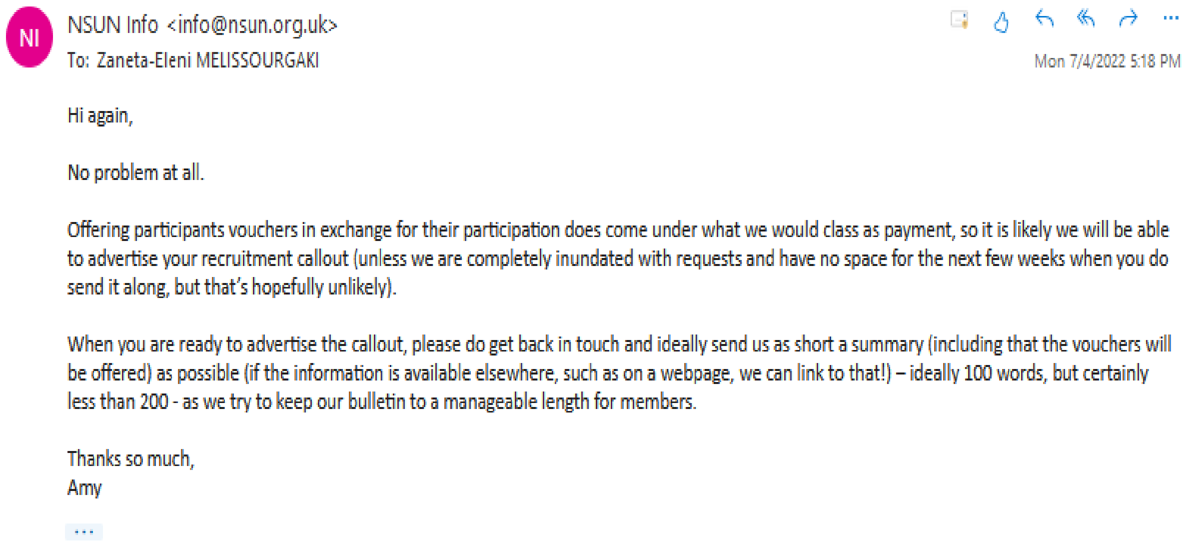
6. Debrief

Invite questions, reflections, any concerns

Thank participant for their participation, explain next steps

Offer participant debrief sheet and voucher

Appendix G: Written permission from partner organisations



NSUN Info <info@nsun.org.uk>
To: Zaneta-Eleni MELISSOURGAKI
Mon 7/4/2022 5:18 PM

Hi again,

No problem at all.

Offering participants vouchers in exchange for their participation does come under what we would class as payment, so it is likely we will be able to advertise your recruitment callout (unless we are completely inundated with requests and have no space for the next few weeks when you do send it along, but that's hopefully unlikely).

When you are ready to advertise the callout, please do get back in touch and ideally send us as short a summary (including that the vouchers will be offered) as possible (if the information is available elsewhere, such as on a webpage, we can link to that!) – ideally 100 words, but certainly less than 200 - as we try to keep our bulletin to a manageable length for members.

Thanks so much,
Amy

noreply@salesforce.com on behalf of Sarah Tilsed <sarah.tilsed@patients-association.org.uk>
To: Zaneta-Eleni MELISSOURGAKI
Fri 6/24/2022 11:27 AM

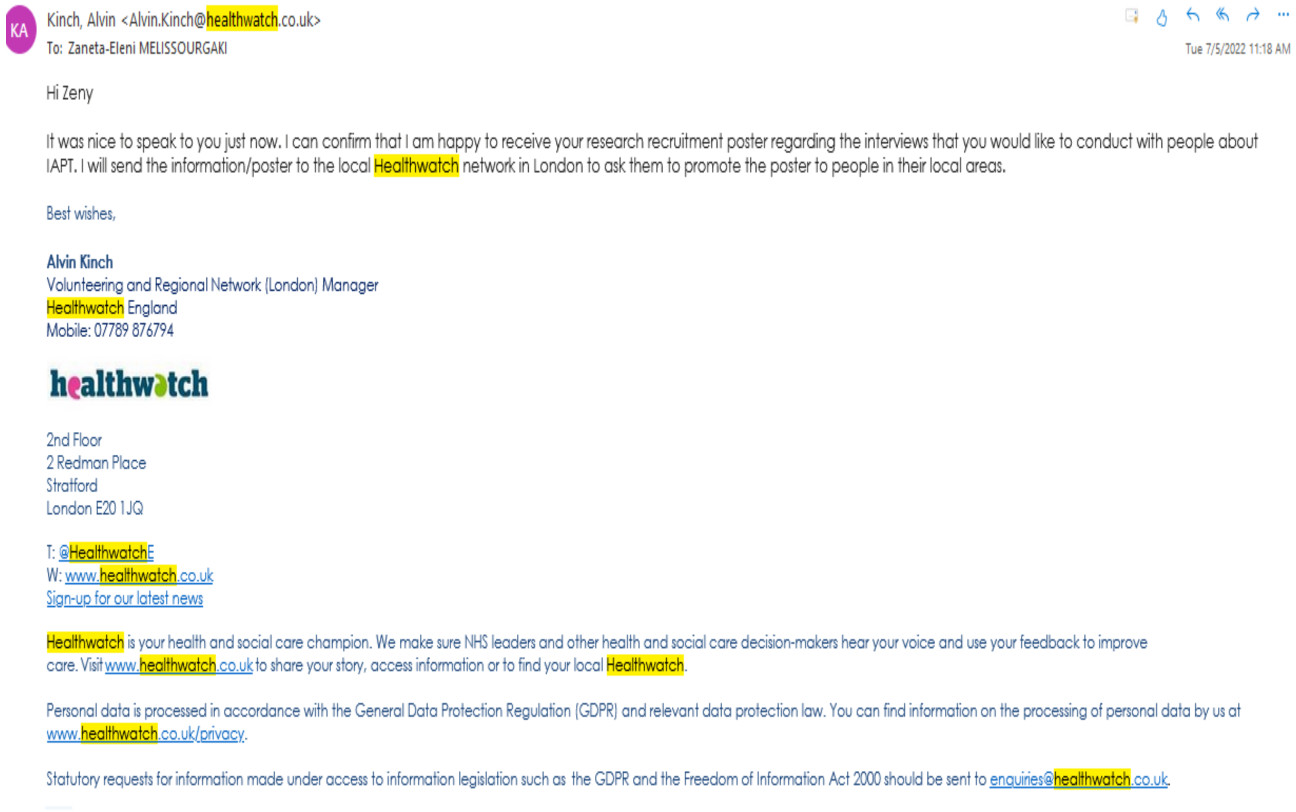
Dear Zeny,

If you send me a link to your social media posts we can reshare.

Best wishes,

Sarah Tilsed
Head of Patient Partnership

Email: sarah.tilsed@patients-association.org.uk
General enquiries: 020 8423 9111 **Helpline:** 0800 345 7115
Website: www.patients-association.org.uk **Twitter:** @PatientsAssoc **Facebook:** Patients Association
Out now, *Shared decision making from the perspective of clinicians and healthcare professionals*, our latest report. Read the findings and our recommendations.



Kinch, Alvin <Alvin.Kinch@healthwatch.co.uk>
To: Zaneta-Eleni MELISSOURGAKI
Tue 7/5/2022 11:18 AM

Hi Zeny

It was nice to speak to you just now. I can confirm that I am happy to receive your research recruitment poster regarding the interviews that you would like to conduct with people about IAPT. I will send the information/poster to the local Healthwatch network in London to ask them to promote the poster to people in their local areas.

Best wishes,

Alvin Kinch
Volunteering and Regional Network (London) Manager
Healthwatch England
Mobile: 07789 876794

healthwatch

2nd Floor
2 Redman Place
Stratford
London E20 1JQ

T: @HealthwatchE
W: www.healthwatch.co.uk
Sign-up for our latest news

Healthwatch is your health and social care champion. We make sure NHS leaders and other health and social care decision-makers hear your voice and use your feedback to improve care. Visit www.healthwatch.co.uk to share your story, access information or to find your local Healthwatch.

Personal data is processed in accordance with the General Data Protection Regulation (GDPR) and relevant data protection law. You can find information on the processing of personal data by us at www.healthwatch.co.uk/privacy.

Statutory requests for information made under access to information legislation such as the GDPR and the Freedom of Information Act 2000 should be sent to enquiries@healthwatch.co.uk.

APPENDIX H: Ethics Review Decision Letter

University of
East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in **blue** | **Student:** Please complete/read sections in orange

Details	
Reviewer:	**Matthew Boardman**
Supervisor:	**Lorna Farquharson**
Student:	**Zaneta-Eleni Melissourgaki**
Course:	**Prof Doc Clinical Psychology**
Title of proposed study:	Understanding barriers and facilitators to accessing IAPT for people on low incomes: a mixed methods study.

Checklist (Optional)			
	YES	**NO**	**N/A**
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐

Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED <u>BEFORE</u> THE	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **<u>before</u>** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all

RESEARCH COMMENCES	amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study	
Please indicate the decision:	**APPROVED**

Minor amendments
Please clearly detail the amendments the student is required to make

Major amendments
Please clearly detail the amendments the student is required to make

Assessment of risk to researcher		
Has an adequate risk assessment been offered in the application form?	**YES** ☒	**NO** ☐
	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐

MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature	
Reviewer: (Typed name to act as signature)	**Matthew Boardman**
Date:	**09/08/2022**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	Please type your full name
Student number:	Please type your student number
Date:	Click or tap to enter a date
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

APPENDIX I: Consent Form

Version: 1

Date: 19/07/2022

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Understanding barriers and facilitators to accessing IAPT for people on low incomes: a mixed methods study.

Contact person: Zeny Melissourgaki

E-mail: u2075216@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 19/07/2022 (version 1) and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw without explanation or disadvantage.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using a digital recorder.	
I understand that my personal information and data, including recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	

It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview and group level data may be used in material such as conference presentations, reports or academic articles resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Participant's Name (BLOCK CAPITALS)

……………………………………………………………………………………………

Participant's Signature

……………………………………………………………………………………………

Researcher's Name (BLOCK CAPITALS)

……………………………………………………………………………………………

Researcher's Signature

……………………………………………………………………………………………

Date

……

APPENDIX J: Debrief Sheet

Version: 1

Date: 19/07/2022

PARTICIPANT DEBRIEF SHEET

Understanding barriers and facilitators to accessing IAPT for people on low incomes: a mixed methods study.

Contact person: Zeny Melissourgaki

E-mail: u2075216@uel.ac.uk

Thank you for participating in this research study!

Your participation will help us better understand what barriers people on low incomes face in accessing IAPT services and how services can make this process easier, to ensure more people can get the support they need. This document offers information that may be relevant in light of you having now taken part.

➢ How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the

GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

- **What will happen to the results of the study?**

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. I also intend to share the findings will other professionals, for example by submitting an article to academic journals or presenting to people who work in mental health care. In all material produced, your identity will be protected with the use of a pseudonym and it will not be possible to identify you personally. The thesis and all subsequent publications or material produced will only include brief quotes from the interviews and demographic information on participants as a group.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

I will delete all the information I hold related to this study once it has been examined. My thesis supervisor will keep the transcripts and group-level demographic information for three years, to be used for disseminating the results of this study, following which all data will be deleted.

- **What if I have been adversely affected by taking part?**

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- **If you are having suicidal thoughts**:
  - Go to A&E or call an ambulance if you don't feel able to keep yourself safe
  - Call your GP for an emergency appointment

  - Contact the Samaritans for advice and support: call/text 116 123 (free of charge) or e-mail jo@samaritans.org

- **If you would like support with your mental health**:
  - Mind: A mental health charity offering advice and support. To find your local service please visit: https://www.mind.org.uk/information-support/local-minds/
  - Sane: A mental health charity offering information and emotional support, including peer support. Call 07984 967 708 and leave your name and contact details for a call back.
  - Rethink Mental Illness: a mental health charity with a range of support networks and groups. Call 0808 801 0525 for practical help or visit https://www.rethink.org/ to find support available in your local area.

- **If you would like advice about money**:
  - Citizens Advice Bureau: an independent organisation offering information and advice with legal, debt, housing and other problems. National phone line (free): 0800 144 8848. For your local branch visit https://www.citizensadvice.org.uk/.
  - Turn2us: for help with benefits, debt, housing and legal issues, you can call 0808 802 200 (free). More information on https://www.turn2us.org.uk/
  - StepChange: for debt advice and money guidance please visit: https://www.stepchange.org/
  - PayPlan: for free debt advice and debt solutions, you can call 0800 280 2816 (free). More information: https://www.payplan.com/
  - Mental Health and Money Advice: website providing free information, support and advice (sample letters and templates, financial tools and calculators) for people affected by mental health and money issues. Visit: https://www.mentalhealthandmoneyadvice.org/en/

- **If you would like support for housing problems**:
  - Shelter: a charity offering housing advice. Visit https://england.shelter.org.uk/ or call 0808 800 4444 for urgent advice.

  - Z2K: for support with benefits, tribunal representation, support with housing and other issues, visit https://z2k.org/get-help/
  - The housing department of your local authority may also be able to help you. You can find details about your local council here: https://www.gov.uk/find-local-council

- **Further help**:
  - Carers UK: if you care for a loved one and would like some support in this role call 0808 808 7777 or e-mail advice@carersuk.org.
  - Family Lives: if your difficulties relate to aspects of the family life, such as child development, school or family breakdown, please call 0808 800 2222 or email askus@familylives.org.uk.
  - CRUSE: a charity offering bereavement support. Call 0808 808 1677.
  - If you are experiencing domestic violence and you need a refuge space, please contact the National Domestic Abuse Helpline on 0808 2000 247
  - Victim support: if you have been affected by crime you can call 08 08 16 89 111 (free) or find your nearest Victim support service here: https://www.victimsupport.org.uk/help-and-support/get-help/support-near-you/

➢ Who can I contact if I have any questions or concerns?

If you would like further information about this study or have any questions or concerns, please do not hesitate to contact me:

Zeny Melissourgaki, Trainee Clinical Psychologist, E-mail: u2075216@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor:

Dr. Lorna Farquharson, School of Psychology, University of East London, Water Lane, London, E15 4LZ.Email: l.farquharson@uel.ac.uk

Or

Chair of School Ethics Committee: Dr. Trishna Patel

School of Psychology, University of East London, Water Lane, London, E15 4LZ.

Thank you for taking part in this study!

APPENDIX K: Extract from Reflective Diary

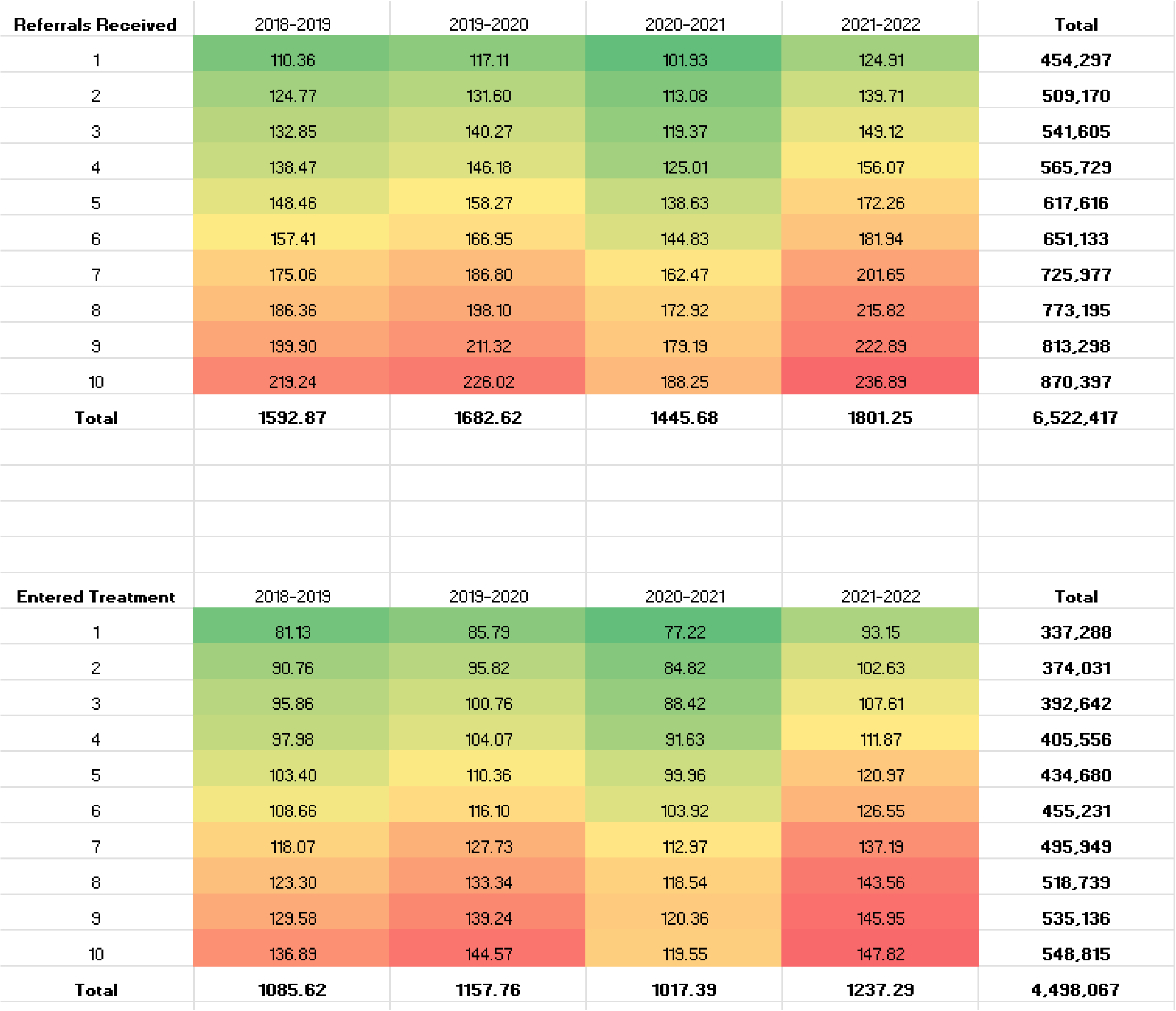
Today the government published its new mini budget and growth plan. I took some time to go through the proposed measures, and felt very concerned about the potential implications on those already struggling financially. Wondered about how some of the people who have taken part in the study might be feeling, and how they might be affected.

It was alarming to notice some of the usual discourses around poverty re-emerge and profoundly shape policy. The mini budget includes a plan to increase working hours – isn't this the myth that work is the road out of poverty, the assumption that those in poverty don't work long or hard enough? The mini budget also warns about restrictions to benefits, once again perpetuating the narrative that those receiving them are somehow undeserving. I came across older examples in the thesis write-up, yet they could just as well be replaced by these announcements, the message is the same. It feels really important to include a section on narratives surrounding poverty in the thesis.

None of this is really new, however it feels more frustrating than before. Reflected on whether this has to do with my increased awareness or my involvement with this study. Doing this study has indeed made me more aware of how pervasive certain narratives are and of how many people live in poverty in the UK. There is always an element of surprise with this; Greece was deemed one of Europe's PIGS, we look up to countries like the UK. Maybe things look better on the outside.

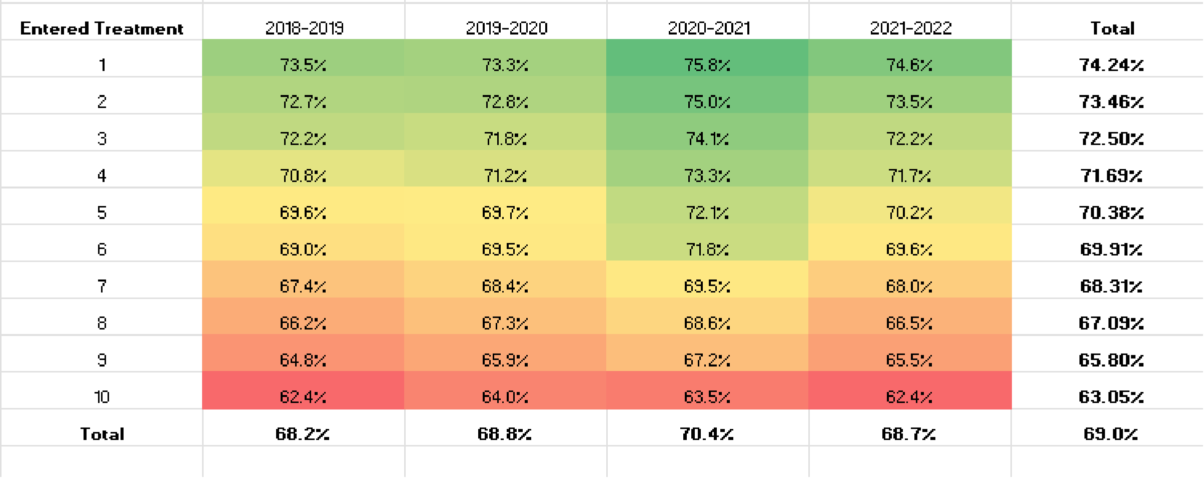
Reflecting on the mini budget in relation to this study brings a new sense of responsibility. I am reminded of how important this area of research is, and I feel the pressure to deliver, to honour the voice of those who have shared their experiences with me and to add to a body of research that hopes for something different. Need to be mindful of managing this pressure – review the timeline and plan for next steps in supervision.

APPENDIX L: Data Output

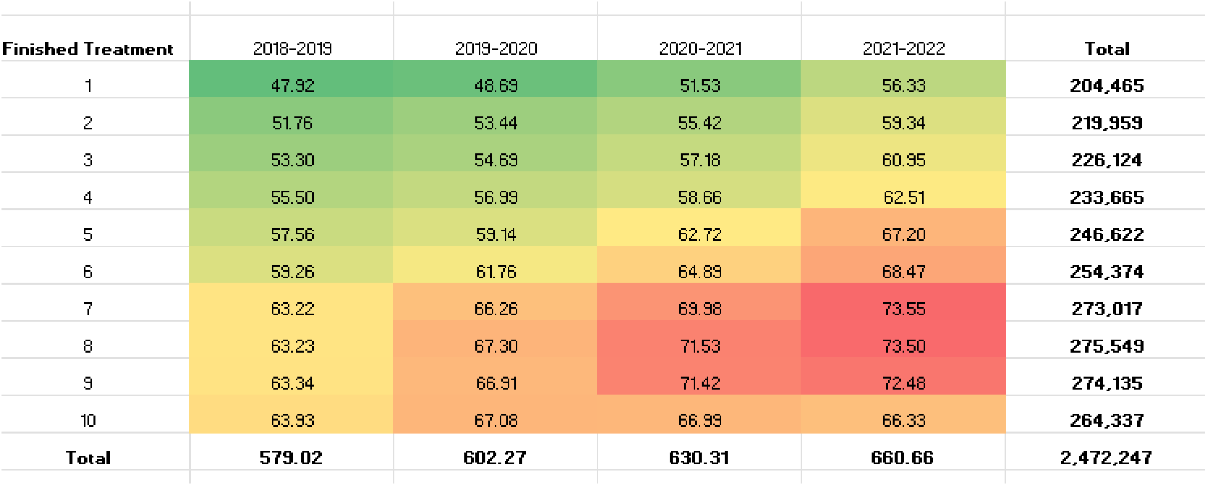


Referrals Received	2018-2019	2019-2020	2020-2021	2021-2022	Total
1	110.36	117.11	101.93	124.91	**454,297**
2	124.77	131.60	113.08	139.71	**509,170**
3	132.85	140.27	119.37	149.12	**541,605**
4	138.47	146.18	125.01	156.07	**565,729**
5	148.46	158.27	138.63	172.26	**617,616**
6	157.41	166.95	144.83	181.94	**651,133**
7	175.06	186.80	162.47	201.65	**725,977**
8	186.36	198.10	172.92	215.82	**773,195**
9	199.90	211.32	179.19	222.89	**813,298**
10	219.24	226.02	188.25	236.89	**870,397**
Total	**1592.87**	**1682.62**	**1445.68**	**1801.25**	**6,522,417**

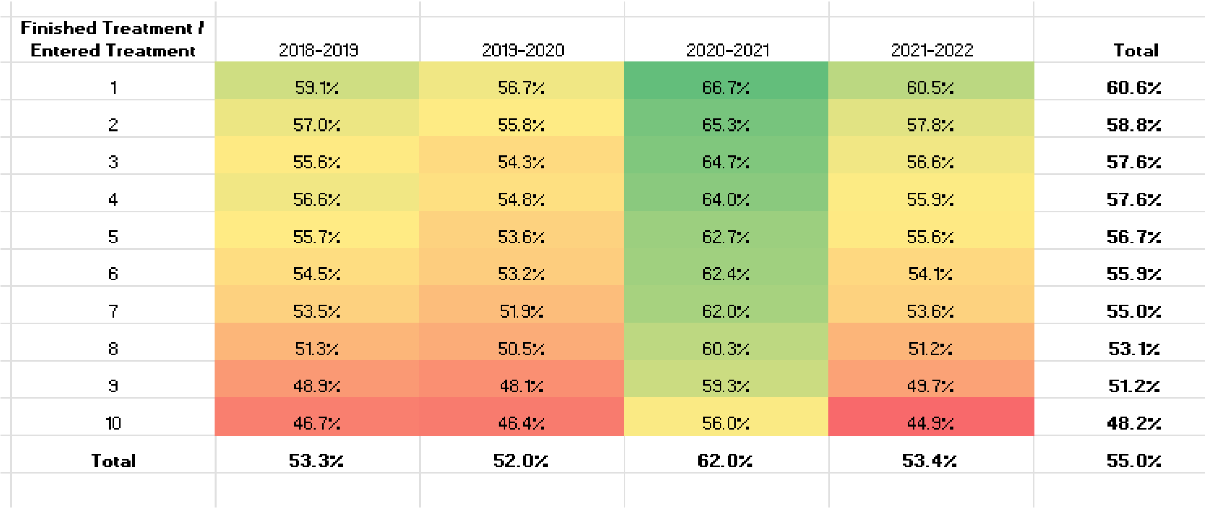
Entered Treatment	2018-2019	2019-2020	2020-2021	2021-2022	Total
1	81.13	85.79	77.22	93.15	**337,288**
2	90.76	95.82	84.82	102.63	**374,031**
3	95.86	100.76	88.42	107.61	**392,642**
4	97.98	104.07	91.63	111.87	**405,556**
5	103.40	110.36	99.96	120.97	**434,680**
6	108.66	116.10	103.92	126.55	**455,231**
7	118.07	127.73	112.97	137.19	**495,949**
8	123.30	133.34	118.54	143.56	**518,739**
9	129.58	139.24	120.36	145.95	**535,136**
10	136.89	144.57	119.55	147.82	**548,815**
Total	**1085.62**	**1157.76**	**1017.39**	**1237.29**	**4,498,067**



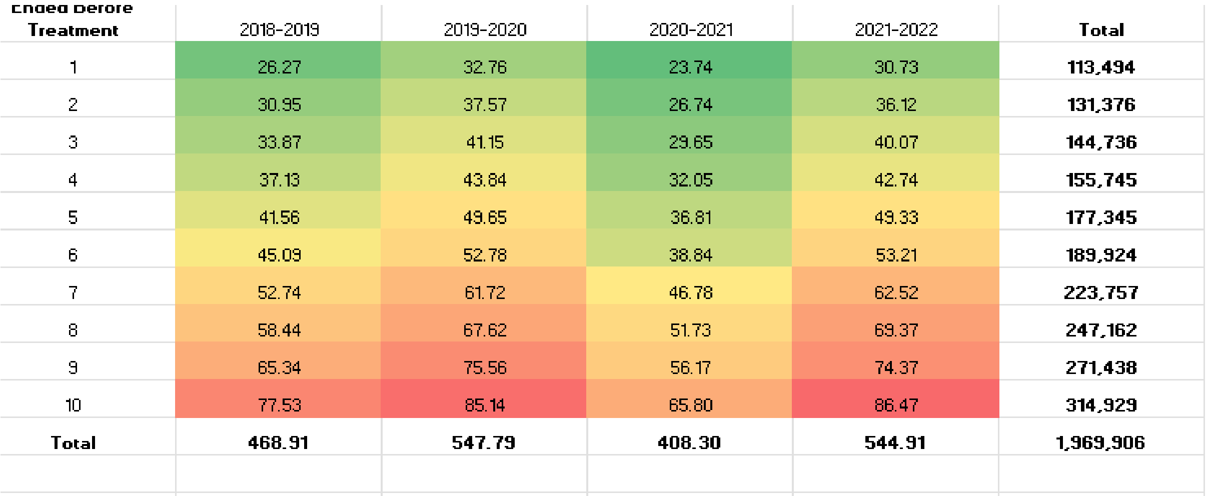
Entered Treatment	2018-2019	2019-2020	2020-2021	2021-2022	Total
1	73.5%	73.3%	75.8%	74.6%	**74.24%**
2	72.7%	72.8%	75.0%	73.5%	**73.46%**
3	72.2%	71.8%	74.1%	72.2%	**72.50%**
4	70.8%	71.2%	73.3%	71.7%	**71.69%**
5	69.6%	69.7%	72.1%	70.2%	**70.38%**
6	69.0%	69.5%	71.8%	69.6%	**69.91%**
7	67.4%	68.4%	69.5%	68.0%	**68.31%**
8	66.2%	67.3%	68.6%	66.5%	**67.09%**
9	64.8%	65.9%	67.2%	65.5%	**65.80%**
10	62.4%	64.0%	63.5%	62.4%	**63.05%**
Total	**68.2%**	**68.8%**	**70.4%**	**68.7%**	**69.0%**



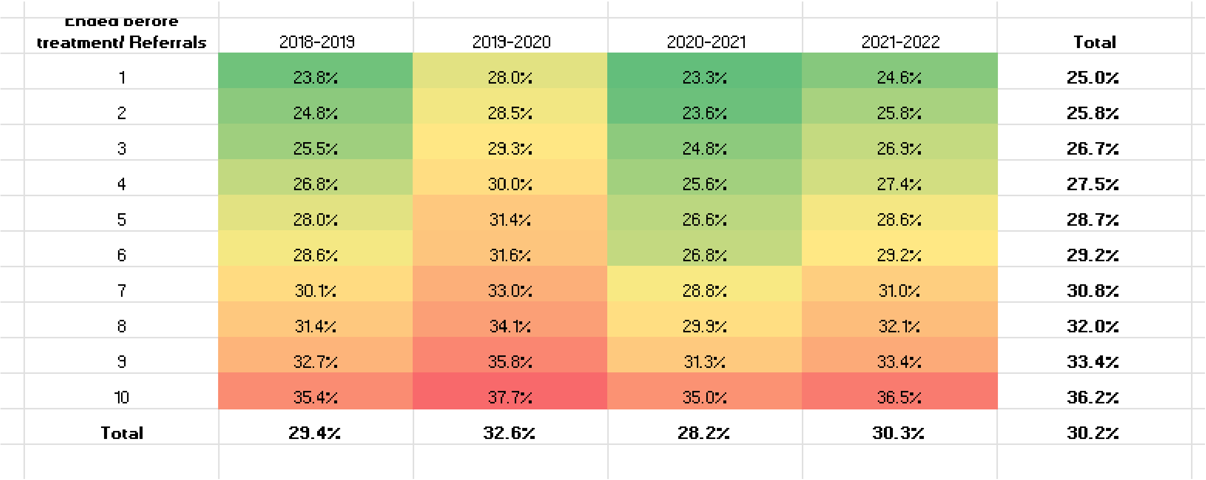
Finished Treatment	2018-2019	2019-2020	2020-2021	2021-2022	Total
1	47.92	48.69	51.53	56.33	204,465
2	51.76	53.44	55.42	59.34	219,959
3	53.30	54.69	57.18	60.95	226,124
4	55.50	56.99	58.66	62.51	233,665
5	57.56	59.14	62.72	67.20	246,622
6	59.26	61.76	64.89	68.47	254,374
7	63.22	66.26	69.98	73.55	273,017
8	63.23	67.30	71.53	73.50	275,549
9	63.34	66.91	71.42	72.48	274,135
10	63.93	67.08	66.99	66.33	264,337
Total	**579.02**	**602.27**	**630.31**	**660.66**	**2,472,247**



Finished Treatment / Entered Treatment	2018-2019	2019-2020	2020-2021	2021-2022	Total
1	59.1%	56.7%	66.7%	60.5%	60.6%
2	57.0%	55.8%	65.3%	57.8%	58.8%
3	55.6%	54.3%	64.7%	56.6%	57.6%
4	56.6%	54.8%	64.0%	55.9%	57.6%
5	55.7%	53.6%	62.7%	55.6%	56.7%
6	54.5%	53.2%	62.4%	54.1%	55.9%
7	53.5%	51.9%	62.0%	53.6%	55.0%
8	51.3%	50.5%	60.3%	51.2%	53.1%
9	48.9%	48.1%	59.3%	49.7%	51.2%
10	46.7%	46.4%	56.0%	44.9%	48.2%
Total	**53.3%**	**52.0%**	**62.0%**	**53.4%**	**55.0%**



Ended before Treatment	2018-2019	2019-2020	2020-2021	2021-2022	Total
1	26.27	32.76	23.74	30.73	113,494
2	30.95	37.57	26.74	36.12	131,376
3	33.87	41.15	29.65	40.07	144,736
4	37.13	43.84	32.05	42.74	155,745
5	41.56	49.65	36.81	49.33	177,345
6	45.09	52.78	38.84	53.21	189,924
7	52.74	61.72	46.78	62.52	223,757
8	58.44	67.62	51.73	69.37	247,162
9	65.34	75.56	56.17	74.37	271,438
10	77.53	85.14	65.80	86.47	314,929
Total	**468.91**	**547.79**	**408.30**	**544.91**	**1,969,906**



Ended before treatment/ Referrals	2018-2019	2019-2020	2020-2021	2021-2022	Total
1	23.8%	28.0%	23.3%	24.6%	**25.0%**
2	24.8%	28.5%	23.6%	25.8%	**25.8%**
3	25.5%	29.3%	24.8%	26.9%	**26.7%**
4	26.8%	30.0%	25.6%	27.4%	**27.5%**
5	28.0%	31.4%	26.6%	28.6%	**28.7%**
6	28.6%	31.6%	26.8%	29.2%	**29.2%**
7	30.1%	33.0%	28.8%	31.0%	**30.8%**
8	31.4%	34.1%	29.9%	32.1%	**32.0%**
9	32.7%	35.8%	31.3%	33.4%	**33.4%**
10	35.4%	37.7%	35.0%	36.5%	**36.2%**
Total	**29.4%**	**32.6%**	**28.2%**	**30.3%**	**30.2%**

```
NEW FILE.
DATASET NAME DataSet1 WINDOW=FRONT.
WEIGHT BY Frequency.
CROSSTABS
  /TABLES=IMD BY Access_Rate
  /FORMAT=AVALUE TABLES
  /STATISTICS=CHISQ PHI
  /CELLS=COUNT EXPECTED ROW COLUMN TOTAL
  /COUNT ROUND CELL.
```

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
IMD * Access_Rate	1324694	100.0%	0	0.0%	1324694	100.0%

IMD * Access_Rate Crosstabulation

			Access_Rate		
			No treatment	Entered Treatment	Total
IMD	Low	Count	117009	337288	454297
		Expected Count	150412.5	303884.5	454297.0
		% within IMD	25.8%	74.2%	100.0%
		% within Access_Rate	26.7%	38.1%	34.3%
		% of Total	8.8%	25.5%	34.3%
	High	Count	321582	548815	870397
		Expected Count	288178.5	582218.5	870397.0
		% within IMD	36.9%	63.1%	100.0%
		% within Access_Rate	73.3%	61.9%	65.7%
		% of Total	24.3%	41.4%	65.7%
Total		Count	438591	886103	1324694
		Expected Count	438591.0	886103.0	1324694.0
		% within IMD	33.1%	66.9%	100.0%
		% within Access_Rate	100.0%	100.0%	100.0%
		% of Total	33.1%	66.9%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	16878.360[a]	1	.000		
Continuity Correction[b]	16877.855	1	.000		
Likelihood Ratio	17266.694	1	.000		
Fisher's Exact Test				.000	.000

Linear-by-Linear Association	16878.347	1	.000		
N of Valid Cases	1324694				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 150412.5.

b. Computed only for a 2x2 table

Symmetric Measures

		Value	Approximate Significance
Nominal by Nominal	Phi	-.113	.000
	Cramer's V	.113	.000
N of Valid Cases		1324694	

```
NEW FILE.
DATASET NAME DataSet2 WINDOW=FRONT.
WEIGHT BY Frequency.
CROSSTABS
  /TABLES=IMD BY Access_Gap
  /FORMAT=AVALUE TABLES
  /STATISTICS=CHISQ PHI
  /CELLS=COUNT EXPECTED ROW COLUMN TOTAL
  /COUNT ROUND CELL.
```

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent

IMD * Access_Gap	1740794	100.0%	0	0.0%	1740794	100.0%

IMD * Access_Gap Crosstabulation

			Access_Gap		
			Ended	Accepted	Total
IMD	Low	Count	113494	756903	870397
		Expected Count	214211.5	656185.5	870397.0
		% within IMD	13.0%	87.0%	100.0%
		% within Access_Gap	26.5%	57.7%	50.0%
		% of Total	6.5%	43.5%	50.0%
	High	Count	314929	555468	870397
		Expected Count	214211.5	656185.5	870397.0
		% within IMD	36.2%	63.8%	100.0%
		% within Access_Gap	73.5%	42.3%	50.0%
		% of Total	18.1%	31.9%	50.0%
Total		Count	428423	1312371	1740794
		Expected Count	428423.0	1312371.0	1740794.0
		% within IMD	24.6%	75.4%	100.0%
		% within Access_Gap	100.0%	100.0%	100.0%
		% of Total	24.6%	75.4%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	125628.404[a]	1	.000		

Continuity Correction[b]	125627.157	1	.000		
Likelihood Ratio	129591.564	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	125628.332	1	.000		
N of Valid Cases	1740794				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 214211.5.

b. Computed only for a 2x2 table

Symmetric Measures

		Value	Approximate Significance
Nominal by Nominal	Phi	-.269	.000
	Cramer's V	.269	.000
N of Valid Cases		1740794	

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
IMD * Access_Gap	343129	100.0%	0	0.0%	343129	100.0%

IMD * Access_Gap Crosstabulation

			Access_Gap		
			Ended	Accepted	Total
IMD	Low	Count	32764	84342	117106

		% within IMD	28.0%	72.0%	100.0%
		% within Access_Gap	27.8%	37.4%	34.1%
		% of Total	9.5%	24.6%	34.1%
	High	Count	85139	140884	226023
		% within IMD	37.7%	62.3%	100.0%
		% within Access_Gap	72.2%	62.6%	65.9%
		% of Total	24.8%	41.1%	65.9%
Total		Count	117903	225226	343129
		% within IMD	34.4%	65.6%	100.0%
		% within Access_Gap	100.0%	100.0%	100.0%
		% of Total	34.4%	65.6%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3211.538[a]	1	.000		
Continuity Correction[b]	3211.108	1	.000		
Likelihood Ratio	3268.503	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	3211.528	1	.000		
N of Valid Cases	343129				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 40238.94.

b. Computed only for a 2x2 table

Symmetric Measures

		Value	Approximate Significance
Nominal by Nominal	Phi	-.097	.000
	Cramer's V	.097	.000
N of Valid Cases		343129	

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent

IMD * Access_Gap	290181	100.0%	0	0.0%	290181	100.0%

IMD * Access_Gap Crosstabulation

			Access_Gap		Total
			Ended	Accepted	
IMD	Low	Count	23738	78190	101928
		% within IMD	23.3%	76.7%	100.0%
		% within Access_Gap	26.5%	39.0%	35.1%
		% of Total	8.2%	26.9%	35.1%
	High	Count	65796	122457	188253
		% within IMD	35.0%	65.0%	100.0%
		% within Access_Gap	73.5%	61.0%	64.9%
		% of Total	22.7%	42.2%	64.9%
Total		Count	89534	200647	290181
		% within IMD	30.9%	69.1%	100.0%
		% within Access_Gap	100.0%	100.0%	100.0%
		% of Total	30.9%	69.1%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	4215.204[a]	1	.000		
Continuity Correction[b]	4214.657	1	.000		
Likelihood Ratio	4329.624	1	.000		
Fisher's Exact Test				.000	.000

Linear-by-Linear Association	4215.189	1	.000		
N of Valid Cases	290181				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 31449.41.

b. Computed only for a 2x2 table

Symmetric Measures

		Value	Approximate Significance
Nominal by Nominal	Phi	-.121	.000
	Cramer's V	.121	.000
N of Valid Cases		290181	

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
IMD * Treatment_Completion	886103	100.0%	0	0.0%	886103	100.0%

IMD * Treatment_Completion Crosstabulation

			Treatment_Completion		Total
			Disengaged	Completed Treatment	
IMD	Low	Count	132823	204465	337288
		% within IMD	39.4%	60.6%	100.0%

		% within Treatment_Completion	31.8%	43.6%	38.1%
	High	Count	284478	264337	548815
		% within IMD	51.8%	48.2%	100.0%
		% within Treatment_Completion	68.2%	56.4%	61.9%
Total		Count	417301	468802	886103
		% within IMD	47.1%	52.9%	100.0%
		% within Treatment_Completion	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	13007.007[a]	1	.000		
Continuity Correction[b]	13006.507	1	.000		
Likelihood Ratio	13078.088	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	13006.993	1	.000		
N of Valid Cases	886103				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 158842.3.

b. Computed only for a 2x2 table

Symmetric Measures

		Value	Approximate Significance
Nominal by Nominal	Phi	-.121	.000
	Cramer's V	.121	.000

N of Valid Cases	886103	

Hierarchical Loglinear Analysis

Data Information

		N
Cases	Valid	8
	Out of Range[a]	0
	Missing	0
	Weighted Valid	1324694
Categories	Time_of_measurement	2
	IMD_Group	2
	Outcome_AccessRate	2

a. Cases rejected because of out of range factor values.

Design 1

Convergence Information

Generating Class	Time_of_measurement*IMD_Group*Outcome_AccessRate
Number of Iterations	1
Max. Difference between Observed and Fitted Marginals	.000
Convergence Criterion	281.453

Cell Counts and Residuals

Time_of_measurement	IMD_Group	Outcome_AccessRate	Observed		Expected		Residuals	Std. Residuals
			Count[a]	%	Count	%		
Pre	Least Deprived	No_treatment	60544.500	4.6%	60544.500	4.6%	.000	.000
		Entered_treatment	166918.500	12.6%	166918.500	12.6%	.000	.000
	Most Deprived	No_treatment	163806.500	12.4%	163806.500	12.4%	.000	.000
		Entered_treatment	281453.500	21.2%	281453.500	21.2%	.000	.000
Post	Least Deprived	No_treatment	56465.500	4.3%	56465.500	4.3%	.000	.000
		Entered_treatment	170370.500	12.9%	170370.500	12.9%	.000	.000
	Most Deprived	No_treatment	157776.500	11.9%	157776.500	11.9%	.000	.000
		Entered_treatment	267362.500	20.2%	267362.500	20.2%	.000	.000

a. For saturated models, .500 has been added to all observed cells.

Goodness-of-Fit Tests

	Chi-Square	df	Sig.
Likelihood Ratio	.000	0	.
Pearson	.000	0	.

K-Way and Higher-Order Effects

	K	df	Likelihood Ratio	Pearson

			Chi-Square	Sig.	Chi-Square	Sig.	Number of Iterations
K-way and Higher Order Effects[a]	1	7	305054.597	.000	282713.174	.000	0
	2	4	17594.177	.000	17218.350	.000	2
	3	1	164.596	.000	164.577	.000	3
K-way Effects[b]	1	3	287460.420	.000	265494.823	.000	0
	2	3	17429.581	.000	17053.774	.000	0
	3	1	164.596	.000	164.577	.000	0

a. Tests that k-way and higher order effects are zero.

b. Tests that k-way effects are zero.

Partial Associations

Effect	df	Partial Chi-Square	Sig.	Number of Iterations
Time_of_measurement*IMD_Group	1	127.104	.000	2
Time_of_measurement*Outcome_AccessRate	1	21.821	.000	2
IMD_Group*Outcome_AccessRate	1	17252.732	.000	2
Time_of_measurement	1	324.979	.000	2
IMD_Group	1	132940.168	.000	2
Outcome_AccessRate	1	154195.273	.000	2

Parameter Estimates

Effect	Parameter	Estimate	Std. Error	Z	Sig.	95% Confidence Interval

						Lower Bound	Upper Bound
Time_of_measurement*IMD_Group*Outcome_AccessRate	1	.013	.001	12.828	.000	.011	.015
Time_of_measurement*IMD_Group	1	-.005	.001	-4.880	.000	-.007	-.003
Time_of_measurement*Outcome_AccessRate	1	.010	.001	9.412	.000	.008	.012
IMD_Group*Outcome_AccessRate	1	-.131	.001	-129.391	.000	-.133	-.129
Time_of_measurement	1	.017	.001	17.028	.000	.015	.019
IMD_Group	1	-.374	.001	-369.270	.000	-.376	-.373
Outcome_AccessRate	1	-.398	.001	-392.841	.000	-.400	-.396

Backward Elimination Statistics

Step Summary

Step[a]			Effects	Chi-Square[c]	df	Sig.	Number of Iterations
0	Generating Class[b]		Time_of_measurement*IMD_Group*Outcome_AccessRate	.000	0	.	
	Deleted Effect	1	Time_of_measurement*IMD_Group*Outcome_AccessRate	164.596	1	.000	3
1	Generating Class[b]		Time_of_measurement*IMD_Group*Outcome_AccessRate	.000	0	.	

a. At each step, the effect with the largest significance level for the Likelihood Ratio Change is deleted, provided the significance level is larger than .050.

b. Statistics are displayed for the best model at each step after step 0.

c. For 'Deleted Effect', this is the change in the Chi-Square after the effect is deleted from the model.

Convergence Information[a]

Generating Class	Time_of_measurement*IMD_Group*Outcome_AccessRate
Number of Iterations	0
Max. Difference between Observed and Fitted Marginals	.000
Convergence Criterion	281.453

a. Statistics for the final model after Backward Elimination.

Cell Counts and Residuals

Time_of_measurement	IMD_Group	Outcome_AccessRate	Observed		Expected		Residuals	Std. Residuals
			Count	%	Count	%		

Pre	Least Deprived	No_treatment	60544.000	4.6%	60544.000	4.6%	.000	.000
		Entered_treatment	166918.000	12.6%	166918.000	12.6%	.000	.000
	Most Deprived	No_treatment	163806.000	12.4%	163806.000	12.4%	.000	.000
		Entered_treatment	281453.000	21.2%	281453.000	21.2%	.000	.000
Post	Least Deprived	No_treatment	56465.000	4.3%	56465.000	4.3%	.000	.000
		Entered_treatment	170370.000	12.9%	170370.000	12.9%	.000	.000
	Most Deprived	No_treatment	157776.000	11.9%	157776.000	11.9%	.000	.000
		Entered_treatment	267362.000	20.2%	267362.000	20.2%	.000	.000

Goodness-of-Fit Tests

	Chi-Square	df	Sig.
Likelihood Ratio	.000	0	.
Pearson	.000	0	.

```
WEIGHT BY Frequency.
CROSSTABS
  /TABLES=IMD_Group BY Outcome_AccessRate BY Time_of_measurement
  /FORMAT=AVALUE TABLES
  /CELLS=COUNT EXPECTED ROW COLUMN TOTAL
  /COUNT ROUND CELL.
```

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
IMD_Group * Outcome_AccessRate * Time_of_measurement	1324694	100.0%	0	0.0%	1324694	100.0%

IMD_Group * Outcome_AccessRate * Time_of_measurement Crosstabulation

				Outcome_AccessRate		
Time_of_measurement				No_treatment	Entered_treatment	Total
Pre	IMD_Group	Least Deprived	Count	60544	166918	227462
			Expected Count	75857.7	151604.3	227462.0
			% within IMD_Group	26.6%	73.4%	100.0%
			% within Outcome_AccessRate	27.0%	37.2%	33.8%
			% of Total	9.0%	24.8%	33.8%
		Most Deprived	Count	163806	281453	445259
			Expected Count	148492.3	296766.7	445259.0
			% within IMD_Group	36.8%	63.2%	100.0%

			% within Outcome_Access Rate	73.0%	62.8%	66.2%
			% of Total	24.3%	41.8%	66.2%
	Total		Count	224350	448371	672721
			Expected Count	224350.0	448371.0	672721.0
			% within IMD_Group	33.3%	66.7%	100.0%
			% within Outcome_Access Rate	100.0%	100.0%	100.0%
			% of Total	33.3%	66.7%	100.0%
Post	IMD_Group	Least Deprived	Count	56465	170370	226835
			Expected Count	74538.9	152296.1	226835.0
			% within IMD_Group	24.9%	75.1%	100.0%
			% within Outcome_Access Rate	26.4%	38.9%	34.8%
			% of Total	8.7%	26.1%	34.8%
		Most Deprived	Count	157776	267362	425138
			Expected Count	139702.1	285435.9	425138.0
			% within IMD_Group	37.1%	62.9%	100.0%
			% within Outcome_Access Rate	73.6%	61.1%	65.2%
			% of Total	24.2%	41.0%	65.2%
	Total		Count	214241	437732	651973

			Expected Count	214241.0	437732.0	651973.0
			% within IMD_Group	32.9%	67.1%	100.0%
			% within Outcome_Access Rate	100.0%	100.0%	100.0%
			% of Total	32.9%	67.1%	100.0%
Total	IMD_Group	Least Deprived	Count	117009	337288	454297
			Expected Count	150412.5	303884.5	454297.0
			% within IMD_Group	25.8%	74.2%	100.0%
			% within Outcome_Access Rate	26.7%	38.1%	34.3%
			% of Total	8.8%	25.5%	34.3%
		Most Deprived	Count	321582	548815	870397
			Expected Count	288178.5	582218.5	870397.0
			% within IMD_Group	36.9%	63.1%	100.0%
			% within Outcome_Access Rate	73.3%	61.9%	65.7%
			% of Total	24.3%	41.4%	65.7%
	Total		Count	438591	886103	1324694
			Expected Count	438591.0	886103.0	1324694.0
			% within IMD_Group	33.1%	66.9%	100.0%

	% within Outcome_Access Rate	100.0%	100.0%	100.0%
	% of Total	33.1%	66.9%	100.0%

```
SORT CASES  BY Time_of_measurement.
SPLIT FILE SEPARATE BY Time_of_measurement.
CROSSTABS
  /TABLES=IMD_Group BY Outcome_AccessRate
  /FORMAT=AVALUE TABLES
  /STATISTICS=CHISQ PHI
  /CELLS=COUNT EXPECTED ROW COLUMN TOTAL ASRESID
  /COUNT ROUND CELL
  /BARCHART.
```

Time_of_measurement = Pre

Case Processing Summary[a]

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
IMD_Group * Outcome_AccessRate	672721	100.0%	0	0.0%	672721	100.0%

a. Time_of_measurement = Pre

IMD_Group * Outcome_AccessRate Crosstabulation[a]

			Outcome_AccessRate		
			No_treatment	Entered_treatment	Total
IMD_Group	Least Deprived	Count	60544	166918	227462
		Expected Count	75857.7	151604.3	227462.0
		% within IMD_Group	26.6%	73.4%	100.0%
		% within Outcome_AccessRate	27.0%	37.2%	33.8%
		% of Total	9.0%	24.8%	33.8%
		Adjusted Residual	-83.7	83.7	
	Most Deprived	Count	163806	281453	445259
		Expected Count	148492.3	296766.7	445259.0
		% within IMD_Group	36.8%	63.2%	100.0%
		% within Outcome_AccessRate	73.0%	62.8%	66.2%
		% of Total	24.3%	41.8%	66.2%
		Adjusted Residual	83.7	-83.7	
Total		Count	224350	448371	672721
		Expected Count	224350.0	448371.0	672721.0
		% within IMD_Group	33.3%	66.7%	100.0%
		% within Outcome_AccessRate	100.0%	100.0%	100.0%

% of Total	33.3%	66.7%	100.0%

a. Time_of_measurement = Pre

Chi-Square Tests[a]

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7007.817[b]	1	.000		
Continuity Correction[c]	7007.360	1	.000		
Likelihood Ratio	7152.487	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	7007.807	1	.000		
N of Valid Cases	672721				

a. Time_of_measurement = Pre

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 75857.75.

c. Computed only for a 2x2 table

Symmetric Measures[a]

		Value	Approximate Significance
Nominal by Nominal	Phi	-.102	.000
	Cramer's V	.102	.000
N of Valid Cases		672721	

a. Time_of_measurement = Pre

Time_of_measurement = Post

Case Processing Summary[a]

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
IMD_Group * Outcome_AccessRate	651973	100.0%	0	0.0%	651973	100.0%

a. Time_of_measurement = Post

IMD_Group * Outcome_AccessRate Crosstabulation[a]

			Outcome_AccessRate		
			No_treatment	Entered_treatment	Total
IMD_Group	Least Deprived	Count	56465	170370	226835
		Expected Count	74538.9	152296.1	226835.0
		% within IMD_Group	24.9%	75.1%	100.0%
		% within Outcome_AccessRate	26.4%	38.9%	34.8%
		% of Total	8.7%	26.1%	34.8%
		Adjusted Residual	-100.1	100.1	
	Most Deprived	Count	157776	267362	425138
		Expected Count	139702.1	285435.9	425138.0
		% within IMD_Group	37.1%	62.9%	100.0%

	% within Outcome_AccessRate	73.6%	61.1%	65.2%
	% of Total	24.2%	41.0%	65.2%
	Adjusted Residual	100.1	-100.1	
Total	Count	214241	437732	651973
	Expected Count	214241.0	437732.0	651973.0
	% within IMD_Group	32.9%	67.1%	100.0%
	% within Outcome_AccessRate	100.0%	100.0%	100.0%
	% of Total	32.9%	67.1%	100.0%

a. Time_of_measurement = Post

Chi-Square Tests[a]

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	10010.188[b]	1	.000		
Continuity Correction[c]	10009.634	1	.000		
Likelihood Ratio	10264.841	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	10010.172	1	.000		
N of Valid Cases	651973				

a. Time_of_measurement = Post

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 74538.91.

c. Computed only for a 2x2 table

Symmetric Measures[a]

		Value	Approximate Significance
Nominal by Nominal	Phi	-.124	.000
	Cramer's V	.124	.000
N of Valid Cases		651973	

a. Time_of_measurement = Post

Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
IMD_Group * Outcome_Treatment * Time_of_measurement	886103	100.0%	0	0.0%	886103	100.0%

IMD_Group * Outcome_Treatment * Time_of_measurement Crosstabulation

		Outcome_Treatment		
Time_of_measurement		Disengaged	Completed	Total
Pre	Count	70312	96606	166918

	IMD_Group	Least Deprived	Expected Count	82179.3	84738.7	166918.0
			% within IMD_Group	42.1%	57.9%	100.0%
			% within Outcome_Treatment	31.9%	42.4%	37.2%
			% of Total	15.7%	21.5%	37.2%
		Most Deprived	Count	150436	131017	281453
			Expected Count	138568.7	142884.3	281453.0
			% within IMD_Group	53.4%	46.6%	100.0%
			% within Outcome_Treatment	68.1%	57.6%	62.8%
			% of Total	33.6%	29.2%	62.8%
	Total		Count	220748	227623	448371
			Expected Count	220748.0	227623.0	448371.0
			% within IMD_Group	49.2%	50.8%	100.0%
			% within Outcome_Treatment	100.0%	100.0%	100.0%
			% of Total	49.2%	50.8%	100.0%
Post	IMD_Group	Least Deprived	Count	62511	107859	170370
			Expected Count	76500.5	93869.5	170370.0
			% within IMD_Group	36.7%	63.3%	100.0%

			% within Outcome_Treatment	31.8%	44.7%	38.9%
			% of Total	14.3%	24.6%	38.9%
		Most Deprived	Count	134042	133320	267362
			Expected Count	120052.5	147309.5	267362.0
			% within IMD_Group	50.1%	49.9%	100.0%
			% within Outcome_Treatment	68.2%	55.3%	61.1%
			% of Total	30.6%	30.5%	61.1%
	Total		Count	196553	241179	437732
			Expected Count	196553.0	241179.0	437732.0
			% within IMD_Group	44.9%	55.1%	100.0%
			% within Outcome_Treatment	100.0%	100.0%	100.0%
			% of Total	44.9%	55.1%	100.0%
Total	IMD_Group	Least Deprived	Count	132823	204465	337288
			Expected Count	158842.3	178445.7	337288.0
			% within IMD_Group	39.4%	60.6%	100.0%
			% within Outcome_Treatment	31.8%	43.6%	38.1%
			% of Total	15.0%	23.1%	38.1%
			Count	284478	264337	548815

	Most Deprived	Expected Count	258458.7	290356.3	548815.0
		% within IMD_Group	51.8%	48.2%	100.0%
		% within Outcome_Treatment	68.2%	56.4%	61.9%
		% of Total	32.1%	29.8%	61.9%
	Total	Count	417301	468802	886103
		Expected Count	417301.0	468802.0	886103.0
		% within IMD_Group	47.1%	52.9%	100.0%
		% within Outcome_Treatment	100.0%	100.0%	100.0%
		% of Total	47.1%	52.9%	100.0%

```
HILOGLINEAR Time_of_measurement(0 1) IMD_Group(0 1) Outcome_Treatment(0
1)
  /METHOD=BACKWARD
  /CRITERIA MAXSTEPS(10) P(.05) ITERATION(20) DELTA(.5)
  /PRINT=FREQ RESID ASSOCIATION ESTIM
  /DESIGN.
```

Hierarchical Loglinear Analysis

Data Information

		N
Cases	Valid	8
	Out of Range[a]	0
	Missing	0
	Weighted Valid	886103
Categories	Time_of_measurement	2
	IMD_Group	2
	Outcome_Treatment	2

a. Cases rejected because of out of range factor values.

Design 1

Convergence Information

Generating Class	Time_of_measurement*IMD_Group*Outcome_Treatment
Number of Iterations	1
Max. Difference between Observed and Fitted Marginals	.000
Convergence Criterion	150.436

Cell Counts and Residuals

Observed	Expected		

Time_of_measurement	IMD_Group	Outcome_Treatment	Count[a]	%	Count	%	Residuals	Std. Residuals
Pre	Least Deprived	Disengaged	70312.500	7.9%	70312.500	7.9%	.000	.000
		Completed	96606.500	10.9%	96606.500	10.9%	.000	.000
	Most Deprived	Disengaged	150436.500	17.0%	150436.500	17.0%	.000	.000
		Completed	131017.500	14.8%	131017.500	14.8%	.000	.000
Post	Least Deprived	Disengaged	62511.500	7.1%	62511.500	7.1%	.000	.000
		Completed	107859.500	12.2%	107859.500	12.2%	.000	.000
	Most Deprived	Disengaged	134042.500	15.1%	134042.500	15.1%	.000	.000
		Completed	133320.500	15.0%	133320.500	15.0%	.000	.000

a. For saturated models, .500 has been added to all observed cells.

Goodness-of-Fit Tests

	Chi-Square	df	Sig.
Likelihood Ratio	.000	0	.
Pearson	.000	0	.

K-Way and Higher-Order Effects

	K	df	Likelihood Ratio	Pearson

			Chi-Square	Sig.	Chi-Square	Sig.	Number of Iterations
K-way and Higher Order Effects[a]	1	7	69102.217	.000	65078.613	.000	0
	2	4	14993.767	.000	15057.823	.000	2
	3	1	114.090	.000	114.065	.000	3
K-way Effects[b]	1	3	54108.450	.000	50020.791	.000	0
	2	3	14879.677	.000	14943.757	.000	0
	3	1	114.090	.000	114.065	.000	0

a. Tests that k-way and higher order effects are zero.

b. Tests that k-way effects are zero.

Partial Associations

Effect	df	Partial Chi-Square	Sig.	Number of Iterations
Time_of_measurement*IMD_Group	1	133.679	.000	2
Time_of_measurement*Outcome_Treatment	1	1532.168	.000	2
IMD_Group*Outcome_Treatment	1	12942.346	.000	2
Time_of_measurement	1	127.740	.000	2
IMD_Group	1	50985.744	.000	2
Outcome_Treatment	1	2994.966	.000	2

Parameter Estimates

Effect	Parameter	Estimate	Std. Error	Z	Sig.	95% Confidence Interval

						Lower Bound	Upper Bound
Time_of_measurement*IMD_Group*Outcome_Treatment	1	.012	.001	10.680	.000	.010	.014
Time_of_measurement*IMD_Group	1	-.011	.001	-10.182	.000	-.013	-.009
Time_of_measurement*Outcome_Treatment	1	.045	.001	40.548	.000	.043	.047
IMD_Group*Outcome_Treatment	1	-.126	.001	-113.213	.000	-.128	-.124
Time_of_measurement	1	.013	.001	11.849	.000	.011	.015
IMD_Group	1	-.255	.001	-229.399	.000	-.257	-.253
Outcome_Treatment	1	-.090	.001	-80.915	.000	-.092	-.088

Backward Elimination Statistics

Step Summary

Step[a]			Effects	Chi-Square[c]	df	Sig.	Number of Iterations
0	Generating Class[b]		Time_of_measurement*IMD_Group*Outcome_Treatment	.000	0	.	
	Deleted Effect	1	Time_of_measurement*IMD_Group*Outcome_Treatment	114.090	1	.000	3
1	Generating Class[b]		Time_of_measurement*IMD_Group*Outcome_Treatment	.000	0	.	

a. At each step, the effect with the largest significance level for the Likelihood Ratio Change is deleted, provided the significance level is larger than .050.

b. Statistics are displayed for the best model at each step after step 0.

c. For 'Deleted Effect', this is the change in the Chi-Square after the effect is deleted from the model.

Convergence Information[a]

Generating Class	Time_of_measurement*IMD_Group*Outcome_Treatment
Number of Iterations	0
Max. Difference between Observed and Fitted Marginals	.000
Convergence Criterion	150.436

a. Statistics for the final model after Backward Elimination.

Cell Counts and Residuals

	Observed	Expected		

Time_of_measurement	IMD_Group	Outcome_Treatment	Count	%	Count	%	Residuals	Std. Residuals
Pre	Least Deprived	Disengaged	70312.000	7.9%	70312.000	7.9%	.000	.000
		Completed	96606.000	10.9%	96606.000	10.9%	.000	.000
	Most Deprived	Disengaged	150436.000	17.0%	150436.000	17.0%	.000	.000
		Completed	131017.000	14.8%	131017.000	14.8%	.000	.000
Post	Least Deprived	Disengaged	62511.000	7.1%	62511.000	7.1%	.000	.000
		Completed	107859.000	12.2%	107859.000	12.2%	.000	.000
	Most Deprived	Disengaged	134042.000	15.1%	134042.000	15.1%	.000	.000
		Completed	133320.000	15.0%	133320.000	15.0%	.000	.000

Goodness-of-Fit Tests

	Chi-Square	df	Sig.
Likelihood Ratio	.000	0	.
Pearson	.000	0	.

```
SORT CASES  BY Time_of_measurement.
SPLIT FILE SEPARATE BY Time_of_measurement.
CROSSTABS
  /TABLES=IMD_Group BY Outcome_Treatment BY Time_of_measurement
  /FORMAT=AVALUE TABLES
```

```
  /STATISTICS=CHISQ PHI
  /CELLS=COUNT EXPECTED ROW COLUMN TOTAL ASRESID
  /COUNT ROUND CELL
  /BARCHART.
```

```
CROSSTABS
  /TABLES=IMD_Group BY Outcome_Treatment
  /FORMAT=AVALUE TABLES
  /STATISTICS=CHISQ PHI
  /CELLS=COUNT EXPECTED ROW COLUMN TOTAL ASRESID
  /COUNT ROUND CELL
  /BARCHART.
```

Time_of_measurement = Pre

Case Processing Summary[a]

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
IMD_Group * Outcome_Treatment	448371	100.0%	0	0.0%	448371	100.0%

a. Time_of_measurement = Pre

IMD_Group * Outcome_Treatment Crosstabulation[a]

			Outcome_Treatment		
			Disengaged	Completed	Total
IMD_Group	Least Deprived	Count	70312	96606	166918
		Expected Count	82179.3	84738.7	166918.0
		% within IMD_Group	42.1%	57.9%	100.0%
		% within Outcome_Treatment	31.9%	42.4%	37.2%
		% of Total	15.7%	21.5%	37.2%
		Adjusted Residual	-73.3	73.3	
	Most Deprived	Count	150436	131017	281453
		Expected Count	138568.7	142884.3	281453.0
		% within IMD_Group	53.4%	46.6%	100.0%
		% within Outcome_Treatment	68.1%	57.6%	62.8%
		% of Total	33.6%	29.2%	62.8%
		Adjusted Residual	73.3	-73.3	
Total		Count	220748	227623	448371
		Expected Count	220748.0	227623.0	448371.0
		% within IMD_Group	49.2%	50.8%	100.0%
		% within Outcome_Treatment	100.0%	100.0%	100.0%
		% of Total	49.2%	50.8%	100.0%

a. Time_of_measurement = Pre

Chi-Square Tests[a]

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	5377.673[b]	1	.000		

Continuity Correction[c]	5377.220	1	.000		
Likelihood Ratio	5394.772	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	5377.661	1	.000		
N of Valid Cases	448371				

a. Time_of_measurement = Pre

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 82179.30.

c. Computed only for a 2x2 table

Symmetric Measures[a]

		Value	Approximate Significance
Nominal by Nominal	Phi	-.110	.000
	Cramer's V	.110	.000
N of Valid Cases		448371	

a. Time_of_measurement = Pre

Time_of_measurement = Post

Case Processing Summary[a]

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
IMD_Group * Outcome_Treatment	437732	100.0%	0	0.0%	437732	100.0%

a. Time_of_measurement = Post

IMD_Group * Outcome_Treatment Crosstabulation[a]

			Outcome_Treatment		
			Disengaged	Completed	Total
IMD_Group	Least Deprived	Count	62511	107859	170370
		Expected Count	76500.5	93869.5	170370.0
		% within IMD_Group	36.7%	63.3%	100.0%
		% within Outcome_Treatment	31.8%	44.7%	38.9%
		% of Total	14.3%	24.6%	38.9%
		Adjusted Residual	-87.2	87.2	
	Most Deprived	Count	134042	133320	267362
		Expected Count	120052.5	147309.5	267362.0
		% within IMD_Group	50.1%	49.9%	100.0%
		% within Outcome_Treatment	68.2%	55.3%	61.1%
		% of Total	30.6%	30.5%	61.1%
		Adjusted Residual	87.2	-87.2	
Total		Count	196553	241179	437732
		Expected Count	196553.0	241179.0	437732.0
		% within IMD_Group	44.9%	55.1%	100.0%
		% within Outcome_Treatment	100.0%	100.0%	100.0%
		% of Total	44.9%	55.1%	100.0%

a. Time_of_measurement = Post

Chi-Square Tests[a]

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	7601.859[b]	1	.000		
Continuity Correction[c]	7601.316	1	.000		
Likelihood Ratio	7661.664	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	7601.842	1	.000		
N of Valid Cases	437732				

a. Time_of_measurement = Post

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 76500.54.

c. Computed only for a 2x2 table

Symmetric Measures[a]

		Value	Approximate Significance
Nominal by Nominal	Phi	-.132	.000
	Cramer's V	.132	.000
N of Valid Cases		437732	

a. Time_of_measurement = Post

APPENDIX M: Thematic Analysis

Coding Extract

Transcript Extract	Initial Codes
Researcher: Thinking about that conversation um… around IAPT … what was helpful about that and what would you like to have been different? Participant: Um … [pauses] I don’t know. Well, maybe that … I think more of a serious … seriousness from my GP in terms of her … in her sort of attitude and her … um… sort of compassion towards what I was going through … I feel that at the time it wasn’t taken as seriously when I first mentioned things about my mental health so … you know, I think for me it was more about like … taking things into consideration and really … being a bit more proactive around accessing therapy … um… and looking into different ways of … how I could be helped. R: Mmmm… so you … it sounds like what you are saying is that you feel like um your concerns weren’t … um … taken into account as seriously as you had hoped … um … P: Yeah R: And what would it … um … if they were … if your concerns were treated with the seriousness that you expected, what would that look like? I think you	*Not being taken seriously by the GP // Disappointed* *GP was not compassionate // Seeking a connection* *Not being taken seriously by the GP // The GP didn’t care?* *Wanting the GP to be more proactive around treatment options // GP as mediator* *Help can look different ways* *Be helped – receiving care*

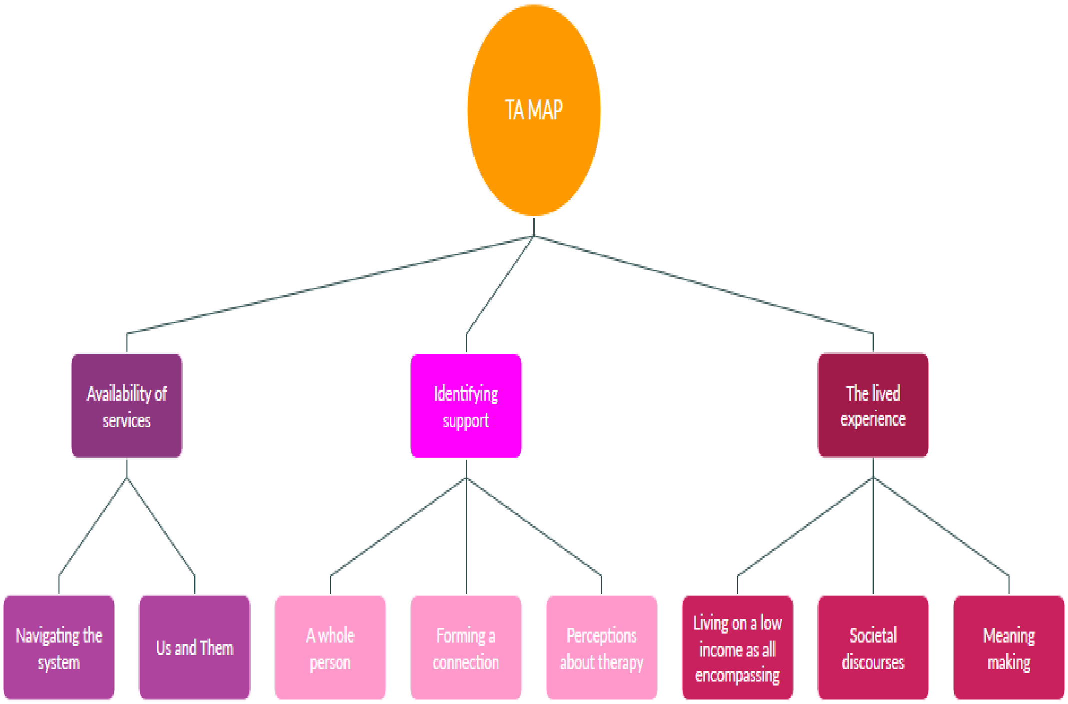
mentioned the word proactive as well and I was curious around that word.	
P: Um…	*Feeling like the GP did not listen*
R: And what you meant.	*Wanting the GP to be more actively attentive*
P: I just think … probably just feeling like I am being more listened to and like … in an active way and more of a … [sighs] more of just a serious concern in terms of the language that was used and … I feel you can generally sense when someone is a bit more … um … a bit more serious about your mental health or medical health … um … just from their, you know, body language and their tone of voice.	*Not being taken seriously by the GP* *Attention is conveyed through non-verbal language* *Mental health difficulties being downplayed*
R: Mmmm [encouraging]	
P: Um, so I think that … you know, that can play a big part.	*Being listened to is important*
R: You mentioned something about the language that was used … what did you mean by that?	*Seeking a connection*
P: Um … More sort of like … language that was quite passive I guess. So like … language that was kind of like … you know, these are options that we could do … rather than sort of options that … we should be doing now in order to … in order to help you like … in the immediate future	*GP used passive language* *GP should do more than relaying options, giving direction*
R: Mmmm [encouraging]	*GP used passive language*

P: So I guess I … it was kind of … again, the language not being as … sort of proactive perhaps [pause] R: Right, so there is something about language not being … um proactive enough, there is something about seriousness that was perhaps missing. Was there anything else that you think you would like to have been different? P: Um … [pauses] … I am not totally sure if I am honest. R: Mmmm [encouraging] P: It was quite a long time ago so it's like … R: Yeah	*GP was not proactive enough* *GP as mediator*
P: It's hard to remember [laughs] R: Mmmm, yeah, I appreciate that might be … the case. Do you remember if there was anything helpful about the conversation? Anything that you appreciated? P: Um … [pause] I guess just getting my … sort of emotions out and … yeah, getting the … getting someone to talk to in the first place about it, I think that kind of … made it a part in helping me out. R: Ok	*Sharing emotions is helpful* *Seeking a connection* *Help can be having someone to talk to* *Conversation with GP was first step in looking for support* *Mental health difficulties being downplayed*

P: It was like the first step into … sort of taking my mental health more seriously … so I think the GP appointment … at the time probably … helped … sort of spear me on or like push me forward to actually getting more support. R: Mmmm … And what kind of support did you end up getting? P: Um… so … my main support that I am kind of getting … like … and still am getting is like sort of peer support really. R: Ok P: So like peer support groups and … I've been … part of like … AA meetings and also like other peer support networks that you know … the NHS just won't … and different charities as well. R: Mhm P: So … um … you know, it is more … not really like professional advice but more just like … people that have got similar experiences and … R: Mhm P: Being able to relate to them, it kind of makes you feel like you are less alone and in turn … it kind of makes me feel … feels like my mood is sort of improved from … you know, making connections and	*GP appointment helped* *Getting support is pushing, effortful* *Getting help through peer support* *Reaching out and finding support on his own* *The NHS can't offer peer support* *The value of charities* *Peer support is different to professional advice* *Lived experience – professionals: distinct?* *Help can be being with people with similar experiences* *Relating to others is helpful* *Seeking connection*

building relationships and … with people that I feel like I can trust.	*Having mental health difficulties as an isolating experience* *Trust is important* *Mental health improves when you feel connected*

Initial thematic map



APPENDIX N: Change of Title Request Form

University of
East London

School of Psychology Ethics Committee

REQUEST FOR TITLE CHANGE TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for a proposed title change to an ethics application that has been approved by the School of Psychology

By applying for a change of title request, you confirm that in doing so, the process by which you have collected your data/conducted your research has not changed or deviated from your original ethics approval. If either of these have changed, then you are required to complete an 'Ethics Application Amendment Form'.

How to complete and submit the request

1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	Using your UEL email address, email the completed request form along with associated documents to Dr Jérémy Lemoine (School Ethics Committee Member): j.lemoine@uel.ac.uk
4	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.

Required documents

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	Zaneta Eleni Melissourgaki
Programme of study:	Prof Doc in Clinical Psychology
Title of research:	Understanding barriers and facilitators to accessing IAPT for people on low incomes: a mixed methods study.
Name of supervisor:	Dr. Lorna Farquharson

Proposed title change

Briefly outline the nature of your proposed title change in the boxes below

Old title:	Understanding barriers and facilitators to accessing IAPT for people on low incomes: a mixed methods study.
New title:	Understanding barriers and facilitators to accessing IAPT for people on low incomes.
Rationale:	All reference to mixed methods removed from the study, as per corrections requested by examiners following the viva.

Confirmation

Is your supervisor aware of your proposed change of title and in agreement with it?	**YES** ☒	**NO** ☐
Does your change of title impact the process of how you collected your data/conducted your research?	**YES** ☐	**NO** ☒

Student's signature

Student: (Typed name to act as signature)	Zaneta Eleni Melissourgaki

Date:	18/08/2023

Reviewer's decision

Title change approved:	**YES** ☒	**NO** ☐
Comments:	**The title change was suggested in the viva.**	
Reviewer: (Typed name to act as signature)	**Dr Jérémy Lemoine**	
Date:	**01/09/2023**	