Ensuring your trial is designed for all who could benefit

Trial teams need to do everything possible to make their trial relevant to the people to whom the results are intended to apply (often patients) and those expected to apply them (often healthcare professionals). The four questions below are intended to prompt trial teams to think about who should be involved as participants, and how to facilitate their involvement as much as possible. These questions should be considered by trial teams in partnership with patient and public partners, including individuals from, or representing, groups identified in Question 1. Note that:

* *‘Intervention*’ means the treatment, initiative or service being evaluated.
* ‘*Comparator*’ means the what the intervention is being compared to.
* ‘*Effective*’ means the intervention provides important benefits for people with the disease or condition that is the focus of the trial.

We recommend that trial teams use the worksheets to help them think through their answers to the four key questions.

**1.** Who should my trial results apply to?

Which groups in the community could benefit from the intervention if it was found effective, or benefit from not having it if it was found ineffective and/or harmful?

**2.** Are the groups identified in Question 1 likely to respond to the treatment in different ways?

How might the disease or cultural factors mean that some groups in the community respond to, or engage with, the treatment(s) being tested in different ways?

**3.** Will my trial intervention and/or comparator make it harder for any of the groups identified in Question 1 to engage with the intervention and/or comparator?

How might the intervention and/or comparator, including how they are provided, make it harder for some groups in the community to take part in the trial?

**4.** Will the way I have planned and designed my trial make it harder for any of the groups identified in Question 1 to consider taking part?

How might elements of trial design, such as eligibility criteria or the recruitment and consent process, make it harder for some groups in the community to take part?

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| **1. Who should my trial results apply to?** |
| **The key document used regarding the trial was the** [**final report**](https://www.journalslibrary.nihr.ac.uk/hta/hta25700#/abstract) **and the** [**registration document**](https://www.isrctn.com/ISRCTN47998710)**. Given the above, the information in the worksheets may not be a proper reflection of the trial because we did not have access to all the trial materials. The information is therefore intended to be illustrative, not definitive.**  The study was run in the UK and aimed to test whether or not social recovery therapy provided as an adjunct to enhanced standard care over 9 months is superior to enhanced standard care alone. Enhanced standard care aimed to provide an optimal combination of existing evidence-based interventions. Young people with social disability and non-psychotic severe and complex mental health problems are an important group. Without intervention, their social problems can persist and have large economic and personal costs. Thus, more effective evidence-based interventions are needed. Social recovery therapy is an individual therapy incorporating cognitive–behavioural techniques to increase structured activity as guided by the participant’s goals. The trial is funded by the National Institute for Health and Care Research (NIHR) (UK), meaning the findings are intended to be of immediate clinical relevance. Participants were aged 16–25 years with persistent social disability, defined as < 30 hours per week of structured activity with social impairment for at least 6 months. Additionally, participants had severe and complex mental health problems, defined as at-risk mental states for psychosis or non-psychotic severe and complex mental health problems indicated by a Global Assessment of Functioning score ≤ 50 persisting for ≥ 6 months.  [2014 UK data](https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-common-mental-disorders/latest) measuring the percentage of people aged 16 or older who experience a common mental disorder (generalised anxiety disorder; mild, moderate and severe depression; phobias; obsessive compulsive disorder; panic disorder), by ethnicity was 17.9% Asian people, 22.5% Black people, 19.5% Mixed people, 17.3% White British and 14.4% White other. The data does not show large variety between ethnicities, but it only shows data for common mental disorders together and not depression on its own. [The same survey data](https://webarchive.nationalarchives.gov.uk/ukgwa/20180328140249/http:/digital.nhs.uk/catalogue/PUB21748) also found that overall, around one in six adults (17 per cent) surveyed in England met the criteria for a common mental disorder in 2014. Black adults have the lowest mental health treatment rate of any ethnic group, at 6% (compared to 13% in the White British group).  In the UK, the estimated [prevalence of psychotic disorders is 0.7%](https://www.nice.org.uk/guidance/cg155/resources/psychosis-and-schizophrenia-in-children-and-young-people-final-scope2) across all ages. [African Caribbean groups](https://pubmed.ncbi.nlm.nih.gov/15902407/) have particularly high rates of psychotic disorders when compared to the white population of the UK. [In the past year in the UK, the percentage of people who were positively screened for a psychotic disorder were](https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-a-psychotic-disorder/latest): Asian – 0.9%, Black – 1.4%, Mixed/Other – 0.0%, White – 0.5%. There were dramatic differences between sexes, for example 3.2% of black men receiving a positive diagnosis, compared with 0.3% of white men. Asian men were the next most likely to receive a positive diagnosis at 1.3%. On average, across all ethnicities, men are more likely to be positively screened for a psychotic disorder than women.  The above proportions should be considered when establishing participation of different ethnicities in the trial. The proportion of minority ethnic individuals, predominantly black groups, need to represent the higher percentage of individuals in society being diagnosed with a psychotic illness. However, the study only differentiated participants by ethnicity as either “White” or “Non-white” with White participants making up 91% of participants, respectively Non-white participants – only 9%.  The results should be applicable to everyone, but there could be large differences between ethnic groups in how social recovery therapy is perceived and how it needs to be organised for it to be effective. |

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| **2. Are the groups identified in Question 1 likely to respond to the treatment in different ways?** [**( VIEW WORKSHEET )**](#WorksheetONE) |
| Mental health stigma is widespread, irrespective of ethnicity and has been described as a significant public health concern. It is estimated to be more severe for racial-ethnic minority groups in society, with higher risk of prejudice and discrimination being experienced because of belonging to two stigmatised groups – minority and mentally ill. There is evidence that mental illness is more highly stigmatised in some ethnic minority groups. In Indian and South Asian households, mental illness may be seen as a ‘taboo’ subject and results in some people feeling the need to hide their illness to uphold their social status or reputation. Black African communities are more likely to manage adversities on their own and more inclined to rely on spirituality, as opposed to seeking medical attention. There is also a higher risk of ‘self-stigma’ in these minority groups, in turn directly affecting the likelihood of seeking help and support.  [Members of some ethnic minority](https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/making-a-difference-ethnic-inequality-and-severe-mental-illness/03FFD6DA621D528D5741897CD0D977AA) groups experience an increased risk of a first diagnosis of severe mental illnesses, especially psychoses.  There is no information on whether social recovery therapy response could differ depending on ethnic group. |

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| **3. Will my trial intervention and/or comparator make it harder for any of the groups identified in Question 1 to engage with the intervention and/or comparator?** [**( VIEW WORKSHEET )**](#WorksheetTWO) | |
| This was a pragmatic, multicentre, single-blind, superiority RCT with ascertainment of the clinical effectiveness and cost-effectiveness of SRT delivered over a 9-month period plus ESC compared with ESC alone in young people (aged 16–25 years) with non-psychotic severe and complex mental health problems and showing early signs of persistent social disability. Primary and secondary outcomes were evaluated at 15 months post randomisation (i.e. 6 months after the end of intervention or control) and limited assessment of longer-term outcomes was evaluated at 24 months post randomisation.  The intervention was SRT plus ESC delivered by trial therapists who were clinical psychologists or qualified CBT therapists trained in the intervention. SRT was delivered individually in face-to-face sessions, with interim telephone, text and e-mail contact. Sessions were delivered over 9 months. Sessions took place in participants’ homes, NHS premises, community and public locations. All sessions, except where conducted in public locations, were audio-recorded with participant consent.  The option to have the sessions at homes, NHS premises, community and public locations could make the treatment more accessible and acceptable to people of different ethnicities, removing the usual barriers of feeling uncomfortable in clinical settings and/or not being able to travel for socioeconomic reasons.  The identity of the clinicians leading a trial could limit participation if social identities are not shared, as this can lead to distrust and unease. There was limited information available about the ethnicities of who was responsible for leading the intervention/comparator sessions, and if opinions of different ethnic groups were considered when designing this trial. However as mentioned, a lack of shared social or ethnic identity between clinician and patient could limit participation of certain ethnic groups. It has been shown that black patients may be more wary of white doctors than black doctors, and white doctors may feel less comfortable treating ethnic minority patients compared with white patients. Improvements in participation could be seen by increasing the presence of minority clinicians in the wider care team, which may support more trust building between care team and patient. Economic and social disadvantage can also amplify identity differences. Several studies have shown that ethnic minority populations are less likely to start, continue or finish mental health treatments. Shared decision making is also important to increase participation, as this can either encourage or discourage collaborative engagement between patient and clinician.  Some ethnic groups may prefer a clinician of the same gender, as this can result in someone feeling more at ease ‘opening up’ or expressing themselves. Where possible using the patient’s first language can support problem solving and aid the clinician to understand the problem through the patient’s eyes. This trial requested participants to be fluent in English to take part. Although the reasons for this may be justified, this may limit participation of ethnic minority groups most affected by psychosis. For example, migrant groups, who are also at high risk of developing psychotic disorders, tend to rely on people who share their language and cultural practices. | |
| 1. **Will the way I have planned and designed my trial make it harder for any of the groups identified in Question 1 to consider taking part?** [**( VIEW WORKSHEET )**](#WorksheetTHREEA) |
| Participants were recruited from child, adolescent and adult primary and secondary care mental health services (including youth mental health, early detection and early intervention services), and from youth, social, education and third-sector (i.e. voluntary, charitable and community) services. There is a risk that this could affect recruitment, based on bias and cultural awareness of the staff involved. As previously discussed, black groups may be more wary of white clinicians and would potentially be more trusting if a black clinician approached them to participate.  The intervention was SRT plus ESC delivered by trial therapists who were clinical psychologists or qualified CBT therapists trained in the intervention. SRT was delivered individually in face-to-face sessions, with interim telephone, text and e-mail contact. Sessions were delivered over 9 months. Sessions took place in participants’ homes, NHS premises, community and public locations. All sessions, except where conducted in public locations, were audio-recorded with participant consent.  The option to have the sessions at homes, NHS premises, community and public locations could make the treatment more accessible and acceptable to people of different ethnicities, removing the usual barriers of feeling uncomfortable in clinical settings and/or not being able to travel for socioeconomic reasons.  Individualistic and collective perspectives can influence how likely someone is to rely on their wider social circles for support. British white groups who have never immigrated to another country are likely to not have a great sense of ethnic identity, when compared with ethnic groups who live in a foreign country. This has been shown to affect their idea of receiving care and they may be more likely to have an individualistic perspective. Asian ethnic groups are more likely to rely on their wider family when making healthcare decisions and Black African communities may be more likely to rely on religious leaders for support and guidance. Depending on the participant, the trial team may decide to speak with their family as this could ensure that the participant fully understands what the trial entails. This may be most beneficial for people who have low literacy levels or have not read the trial information in their native language, or those who rely heavily on their family to make healthcare decisions, e.g., Asian groups. No information was available regarding how understanding was confirmed for this trial. |

Worksheets for thinking through factors that might affect ethnic group involvement in a trial

These worksheets are intended to be used by trial teams in partnership with patient and public partners to ensure that ethnic group involvement is considered at the trial design stage.Before completing the worksheets, the trial team **should have answered Question 1** **of the INCLUDE Key Questions with regard to ethnic group involvement**.

The worksheet may cover issues that some trial teams already think about. The intention is that the worksheet will help to highlight issues consistently across trials for all trial teams, as well as raising some questions that may not be routinely considered at present.

Finally, while the worksheet asks trial teams to think about possible differences between ethnic groups, it is important to remember that there are also differences *within* ethnic groups, especially between generations and between men and women. No ethnic group is homogenous. See [Appendix 1](https://www.trialforge.org/trial-forge-centre/include/) for more on our definition of ethnicity.

**Worksheet 1**

This worksheet provides some questions **to guide your thinking about ethnic group involvement when answering Question 2** of the INCLUDE Key Questions.

**Disease and cultural factors that might influence the effect of treatment for some ethnic groups**

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| **Disease** | How might the prevalence of the disease vary between each ethnic group in the target population? | Response:  [2014 UK data](https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-common-mental-disorders/latest) measuring the percentage of people aged 16 or older who experience a common mental disorder (generalised anxiety disorder; mild, moderate and severe depression; phobias; obsessive compulsive disorder; panic disorder), by ethnicity was 17.9% Asian people, 22.5% Black people, 19.5% Mixed people, 17.3% White British and 14.4% White other. The data does not show large variety between ethnicities, but it only shows data for common mental disorders together and not depression on its own. [The same survey data](https://webarchive.nationalarchives.gov.uk/ukgwa/20180328140249/http:/digital.nhs.uk/catalogue/PUB21748) also found that overall, around one in six adults (17 per cent) surveyed in England met the criteria for a common mental disorder in 2014. Black adults have the lowest mental health treatment rate of any ethnic group, at 6% (compared to 13% in the White British group). |
| How might the severity of the disease vary between each ethnic group? | Response:  [Members of some ethnic minority](https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/making-a-difference-ethnic-inequality-and-severe-mental-illness/03FFD6DA621D528D5741897CD0D977AA) groups experience an increased risk of a first diagnosis of severe mental illnesses, especially psychoses. People in all ethnic minority groups – but most notably Black Caribbean, Black African and Black British people – with a diagnosis of severe mental illness experience higher rates of contact with the police and criminal justice system, more admission to psychiatric hospitals, less voluntary in-patient care and less primary care intervention. |
| How might the disease present in people from each ethnic group (this may include symptoms, type or pattern or rate of disease progression)? | Response:  [A review of USA data](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6390869/) showed that while minority populations are less likely to suffer from acute episodes of MDD than Caucasians, they are more likely to suffer from prolonged, chronic, and severely debilitating depression with heavy consequences on their level of daily functioning. Studies have also shown differences in presenting symptoms between African Americans and non-Hispanic Caucasians, with one study highlighting the presence of the symptom of negative affect and interpersonal problems domains as a harbinger of depressive disorder in African Americans.  [Another review](https://www.liebertpub.com/doi/abs/10.1089/jwh.2019.7975) looked at depression symptoms in women of different ethnicities. A pattern emerged with African American and Hispanic/Latina women with depression or depressive symptoms more likely to report somatic symptoms compared with White women. However, it is not clear whether differences were a function of culturally acceptable presentation of symptoms or if the stress of being depressed increased somatization in minority women. | |
| How close is the match between each ethnic group living with the disease and the ethnic groups living in the areas where the trial is to be run? | Response:  [2014 UK data](https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-common-mental-disorders/latest) measuring the percentage of people aged 16 or older who experience a common mental disorder (generalised anxiety disorder; mild, moderate and severe depression; phobias; obsessive compulsive disorder; panic disorder), by ethnicity was 17.9% Asian people, 22.5% Black people, 19.5% Mixed people, 17.3% White British and 14.4% White other. The data does not show large variety between ethnicities, but it only shows data for common mental disorders together and not depression on its own.  However, the study only recorded ethnicity as either White or Ethnic minority (due to low numbers in the Ethnic minority group) with 91% of the people participating being White and thus only 9% being from an Ethnic minority group. | |
| Other factors to consider: | | |
| **Cultural** | How might perceptions of the disease and social stigma around it be different for each ethnic group in the target population? | Response:  Mental health stigma is widespread, irrespective of ethnicity and has been described as a significant public health concern. It is estimated to be more severe for racial-ethnic minority groups in society, with higher risk of prejudice and discrimination being experienced because of belonging to two stigmatised groups – minority and mentally ill.  In some ethnic communities, mental illness is more highly stigmatised than others. It is a multidimensional issue, that not only can determine negative public opinion, but it can also contribute to self-stigma and the chances of someone seeking treatment/support for their mental health condition. [Research has shown that non-white groups perceive mental illness](https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-08964-3) to be more dangerous and express more need to segregate from those who have mental illness. There is also further difference in perception of danger with mental illness between minority groups. There is also intersectionality between experiences of stigma, with structural and interpersonal discrimination and low socioeconomic status also affecting level of stigma perceived and experienced. | |
| How might ways of describing the disease be different for each ethnic group? | Response:  It is possible that clinician’s lack of awareness or bias of certain cultural issues, or inability to speak the patient’s first language can affect the diagnosis of the patient. It can also mean that some ethnic groups do not feel able to appropriately describe their symptoms in a second tongue.  It is a taboo subject in some Indian and South Asian households to have a mental health diagnosis, and this can cause some people from this community to hide it – in attempt to uphold their reputation or social status. In turn, this negatively impacts their ability to access mental health services.  [There is also research to suggest](https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/Black-African-American) that black ethnic groups may consider mental illness to equate being considered as “crazy” in their social circles. Black people may also be more like to use physical descriptions when attempting to describe their mental health, such as describing bodily aches when talking about depression. If a clinician is not culturally aware, they may not be competent to adequately recognise such symptoms. This has also been found to be a similar issue with Asian groups. | |
| How might cultural practices, beliefs and traditions influence the acceptability of, and adherence to, the treatment(s) for each ethnic group? | Response:  [African communities](https://journals.sagepub.com/doi/abs/10.1177/2156759X0801100302) are more likely to manage adversities on their own and more inclined to rely on spirituality, as opposed to seeking medical attention. Africans may rely more on religious ministers than psychiatrists and psychologists.  [Asian Americans](https://pubmed.ncbi.nlm.nih.gov/18229996/) have been shown to show more stigma to mental health than the white American population. There is much variation within an ethnic group too, for example Chinese Americans are less likely to use mental health services due to the perceived shame that is associated with a diagnosis. Whereas [Filipino Americans](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7578164/) are less like to seek support due to mistrust of systems. Filipino Americans are more likely to seek help from friends and family, as opposed to mental health services, affected in part by immigration status, health insurance and issues with language. | |
| How or when might people in each ethnic group access healthcare for this disease differently? | Response:  [In the US, data suggests](https://pubmed.ncbi.nlm.nih.gov/8864145/) that minority groups are less likely or fail to seek help for their mental health illness when compared with the white population. In the UK, black and ethnic minority groups are more likely to be diagnosed with a psychotic disorder and are more likely to seek help in A&E or when they are in a crisis. This could suggest that psychoses is more severe in black and ethnic minority groups for the reason that they are less likely to seek help or support earlier on in their illness, when less severe.  [UK survey data](https://webarchive.nationalarchives.gov.uk/ukgwa/20180328140249/http:/digital.nhs.uk/catalogue/PUB21748) also found that Black adults have the lowest mental health treatment rate of any ethnic group, at 6% (compared to 13% in the White British group). | |
| Other factors to consider: | | |

**Worksheet 2**

This this worksheet provides some questions **to guide your thinking about ethnic group involvement when answering Question 3** of the INCLUDE Key Questions.

**Intervention and comparator factors that might affect how some groups engage with the intervention and/or comparator\***

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| **What** | How might the intervention(s) and comparator limit participation of people from each ethnic group in the target population? | Response:  Black and ethnic minority groups in the UK are more likely to disengage from mental health services and experience a poor outcome from treatment.  [There could be limited participation if social identities are not shared](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6953572/) between clinicians and patients, as this can lead to distrust and unease. Economic and social disadvantage can also amplify these identity differences. Several studies have shown that ethnic minority populations are less likely to start, continue or finish mental health treatments. [Shared decision making](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3580315/) is also important to increase participation, as this can either encourage or discourage collaborative engagement between patient and clinician.  As discussed in previous sections, where possible using the patient’s first language can support problem solving and aid the clinician understand the problem through the patient’s eyes. This trial requested participants to be fluent in English to take part. Although the reasons for this may be justified (e.g. lack of money to hire translators), this may limit participation of participants from more ethnic minority groups most affected by psychosis. |
| How, and in what way, were people from each ethnic group involved in selecting or designing the trial intervention/comparator? | Response:  There is no information about the ethnic groups of the people involved in selecting or designing the trial intervention/comparator. |
| Other factors to consider: | |
| **Who** | How might the person delivering the intervention/comparator limit participation of people from each ethnic group in the target population? | Response:  As mentioned above, a lack of shared social or ethnic identity between clinician and patient could limit participation of certain ethnic groups. [Trust in the doctor-patient relationship is a core element of successful treatment.](https://labblog.uofmhealth.org/rounds/minority-patients-benefit-from-having-minority-doctors-but-thats-a-hard-match-to-make-0) Black patients may be more wary of white doctors than black doctors, and white doctors may feel less comfortable treating ethnic minority patients compared with white patients. A study found that black doctors were more likely to write detailed notes for their black patients. Due to many reasons, the diversity of the physician workforce is unlikely to mirror the population any time soon, therefore it is important to find appropriate solutions in the meantime. Even just increasing the presence of minority clinicians in the wider care team may make a difference.  [In the UK, 77.9% of NHS staff are white and 22.1% are from all other ethnic groups.](https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest) Asian, Chinese, and mixed ethnic groups make up a larger percentage. There are more non-medical staff in the NHS who belong to black groups. This could directly impact the experience of black people taking part in this trial – the ethnicity most at risk of being diagnosed with psychosis.  Same gender preference of clinician with the patient may also have an effect on participation. Certain ethnic groups may feel more at ease ‘opening up’ or expressing themselves with a clinician of the same gender, e.g., south Asian women. |
| Other factors to consider: | |
| **How** | How might the mode of delivery (e.g. telephone, video-call, face-to-face, in groups) limit participation of people from each of the ethnic groups in the target population? | Response:  SRT was delivered individually in face-to-face sessions, with interim telephone, text and e-mail contact. Sessions were delivered over 9 months. Sessions took place in participants’ homes, NHS premises, community and public locations  Face-to-face 1:1 sessions could be a barrier for people who would struggle to pay for travel to and from the clinic – participants were recompensed for time but there was no further financial incentive. Sometimes even reimbursing travel comes with challenges as this does not help those who do not have the finances to begin with. In London, poverty rates are highest for Bangladeshi and Pakistani households and lowest for white households. The timing of appointments can also cause challenges for those who work and have families to support. Unless there is flexibility with appointment times, some people will be unable to attend, no matter the mode of delivery.  On the topic of poverty and socioeconomic status, this can directly impact a person’s ability to use technology in the home, thus meaning video calls etc could be more of a challenge. Age can also impact someone’s ability to use and understand how to use technology in the home.  Language and literacy can also directly impact all modes of delivery. A self-report questionnaire was used in this study, where literacy levels will affect ability to complete |
| Other factors to consider: | |
| **Where** | How might where the intervention/comparator is delivered (e.g. hospital, general practice, local library) limit the participation of people from each ethnic group in the target population? | Response:  SRT was delivered individually in face-to-face sessions, with interim telephone, text and e-mail contact. Sessions were delivered over 9 months. Sessions took place in participants’ homes, NHS premises, community and public locations.  In the UK, it has been shown that groups other than white groups, [report inferior NHS experiences](https://bmjopen.bmj.com/content/12/3/e053827). This potentially explains their lower reported trust in the government and healthcare professionals. Lower trust in institutions could affect where some groups feel most comfortable – they may feel more at ease in their local library than hospital for example. |
| Other factors to consider: | |
| **When & Intensity** | How might when the intervention/comparator is delivered (e.g. during working hours) or the intensity (e.g. number of times it is delivered, over what period, time commitment for each session and overall) limit participation of people from each ethnic group in the target population? | Response:  The level of family commitment that someone has can affect their ability to attend more lengthy and intense sessions. [In 2011,](https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/families-and-households/latest) 47% of Asian households were made up of married couples, the highest percentage of all ethnic groups. This could imply that this group may have more support to care for dependents (however it does get a little more complicated with the relationship between men and women, with women tending to hold more responsibility). 18.9% of black households were single parent households, the highest of all other ethnic groups for this category. With black ethnic groups being more at risk of being diagnosed with psychosis, this could affect their ability to participate in sessions that require more time away from home. |
| Other factors to consider: | |

\*These factors are taken from TIDieR ([http://www.equator-network.org/reporting-guidelines/tidier/](about:blank)).

**Worksheet 3a**

This worksheet provides some questions **to guide your thinking about ethnic group involvement when answering Question 4** of the INCLUDE Key Questions.

**Trial eligibility and participation factors that might affect how some groups engage with the trial**

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| **Eligibility** | How might eligibility criteria exclude members of each ethnic group in the target population for reasons other than their clinical eligibility for the trial (e.g. availability of medical history, must speak English, location, gender, age, discussing pregnancy, internet/mobile telephone access)? | Response:  Most of the eligibility criteria were purely clinical except for the need to speak English fluently enough to provide consent and participate in the research (involving talk therapy). |
| Other factors to consider: | |
| **Opportunity to participate** | How might the way(s) (and by whom) potential participants are made aware of the trial (e.g. posters in clinic, written letter from a doctor, asked by a nurse) limit the participation of each ethnic group in the target population? | Response:  Participants were recruited from child, adolescent and adult primary and secondary care mental health services (including youth mental health, early detection and early intervention services), and from youth, social, education and third-sector (i.e. voluntary, charitable and community) services. Limited trial information is available on who was responsible for first approaching patients and who took them through the screening procedure. There is a risk that this could affect recruitment, based on bias and cultural awareness of the staff involved.  As previously discussed, black groups may be more wary of white clinicians and potentially be more trusting if a black clinician approached them to participate.  Posters in clinics may be suitable for groups that are likely to utilise mental health services, e.g., White groups, however, they would not be suitable for those who tend to first receive treatment through A&E or in crisis e.g., black groups. Limited information is available regarding how different ethnic groups were made aware of the study. |
| How might the information that tells potential participants about the trial (e.g. participant information leaflet) limit the participation of each ethnic group? | Response:  The participant information sheets tend to be a lengthy document that requires a good level of English to fully understand and be informed of the trial procedures. This trial did not provide the option for a translator. This is most likely to affect the participation of some Asian groups, who do not speak English as their first language.  A higher percentage of Asian ethnic groups in the UK do not speak English as their first language, when compared with black ethnic groups. The highest group that do not speak English as their first language in the UK are non-British white groups, [with only 36% of them speaking English as their main language.](https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/english-language-skills/latest#by-ethnicity)  It is unclear whether people were given the option to read the information sheet in their first language, an option that may not only increase recruitment but also support participants from all groups fully inform themselves of the trial – possibly leading to higher engagement rates. It is also unclear whether the information sheet was written with input from people from different ethnicities.  The information sheets for this trial were not available. The images and content of the information can influence participation of different groups. For example, if pictures/images of people were included, they should be as representative as possible of the different ethnic groups. |
| How might cultural practices, beliefs and traditions change the way each ethnic group perceives the information they are given? | Response:  British white groups who have never immigrated to another country are likely to not have a great sense of ethnic identity, when compared with ethnic groups who live in a foreign country. This has been shown to affect their idea of receiving care [from an individualistic point of view, to a collective.](https://pubmed.ncbi.nlm.nih.gov/22869345/) Ethnic minority groups in the UK are more likely to have a collective point of view and lean on their social circles for support and care, as opposed to institutions. |
| Other factors to consider: | |
| **Consent procedures** | How might the way consent is sought (i.e. where, by whom, written vs verbal, verbal translations/multiple languages, access to interpreters) limit the participation of each ethnic group in the target population? | Response:  As discussed, language is likely to be the main barrier preventing some ethnic groups from participating in this trial. It is unclear if information sheets were provided in different languages for people who preferred to read in their own language, but still had good spoken English.  As previously discussed, the staff member involved in obtaining consent could also influence someone’s trust in the trial. | |
| How might the way people would like to discuss participation with family before providing consent differ for each ethnic group? | Response:  As already mentioned, individualistic and collective perspectives can influence how likely someone is to rely on their wider social circles for support.  [Asian ethnic groups](https://spcare.bmj.com/content/5/Suppl_2/A65.1) are more likely to rely on their wider family when making healthcare decisions. As discussed, Black African communities are likely to rely on religious leaders for support and guidance. | |
| How might the way the research team can check how well consent information is understood differ for each ethnic group? | Response:  As already mentioned, individualistic and collective perspectives can influence how likely someone is to rely on their wider social circles for support.  [Asian ethnic groups](https://spcare.bmj.com/content/5/Suppl_2/A65.1) are more likely to rely on their wider family when making healthcare decisions. As discussed, Black African communities are likely to rely on religious leaders for support and guidance. | |
| Other factors to consider: | | |

**Worksheet 3b**

This worksheet provides some questions **to guide your thinking about ethnic group involvement when answering Question 4** of the INCLUDE Key Questions.

**Trial data collection factors that might affect how some groups engage with the trial**

|  |  |  |
| --- | --- | --- |
| **What** | How, and in what way, were people from each ethnic group in the target population involved in selecting the trial outcomes? | Response:  Depending on the individual and their relationship with their family/support network, speaking with their family could also ensure the participant fully understands the trial procedures. This may be most beneficial for people who have not read the trial information in their first language, or those who rely heavily on their family to make healthcare decisions, e.g., Asian groups.  There is no information available regarding how understanding is confirmed for this trial. |
| How might the trial outcomes themselves, or other data being collected (e.g. a patient’s background information) limit the participation of each ethnic group? | Response:  There is no information available about how trial outcomes were selected. |
| Other factors to consider: | |
| **Who** | How might the people who collect data limit the participation of each ethnic group in the target population? | Response:  It was unclear who the people were in this trial who were responsible for this, what their ethnic/cultural backgrounds were or if they were very experienced collecting this type of data from a variety of different ethnic groups. |
| Other factors to consider: | |
| **How** | How might data collection methods limit the participation of each ethnic group in the target population? | Response:  For this trial the outcomes collected were time and mood symptoms. The only limiting factor could be the unwillingness to participate in the treatment (talk and activity therapy) or not being completely honest with the clinicians. |
| Other factors to consider: | |
| **Where** | How might where data are collected limit the participation of each ethnic group in the target population? | Response:  There is no information available on where the data was collected. Face-to-face 1:1 sessions could be a barrier for people who would struggle to pay for travel to and from the clinic – participants were recompensed for time but there was no further financial incentive. Sometimes even reimbursing travel comes with challenges as this does not help those who do not have the finances to begin with. In London, poverty rates are highest for Bangladeshi and Pakistani households and lowest for white households. The timing of appointments can also cause challenges for those who work and have families to support. |
| Other factors to consider: | |

**Worksheet 3c**

This worksheet provides some questions **to guide your thinking about ethnic group involvement when answering Question 4** of the INCLUDE Key Questions.

**Factors that might affect the planned analysis of trial results**

|  |  |  |  |
| --- | --- | --- | --- |
| **Retention** | How might the trial data available for participants differ between each ethnic group in the target population? | Response:  See worksheet 3b. | |
| Other factors to consider: | | |
| **Benefits** | How might the benefits of the trial intervention(s) differ between each ethnic group in the target population? | Response:  Information on benefits in each ethnicity was not available | |
| Other factors to consider: | | |
| **Harms** | How might the possible harms of the trial intervention(s) differ between each ethnic group in the target population? | Response:  Information on possible harms in each ethnicity was not available. | |
| Other factors to consider: | | |
| **Subgroup analyses** | How should variation between ethnic groups in the target population be explored– should there be planned subgroup analyses? | Response:  The trial may have benefited from a pre-planned sub-group analysis looking at each of the trial outcomes by ethnic group, considering the potential differences in depression treatment response for ethnic minority, especially Black people. However, the number of ethnic minority individuals recruited in the trial was too small to make sub-group analysis possible. | |
| Other factors to consider: | | |
| **Interim analyses** | How should any interim analysis handle variation between ethnic groups in the target population? | | Response:  The interim analysis should look at any differences in each ethnic group. Over-sampling may need to be considered to account for any findings. |
| Other factors to consider: | | |
| **Stopping triggers** | How should any rules to stop the trial early on safety or benefit grounds handle variation between ethnic groups in the target population? | | Response:  Should there be any reason to stop the trial early, ethnic group variations should be considered, especially considering the potential differences between ethnicities in the response to depression treatment. |
| Other factors to consider: | | |

**Worksheet 3d**

This this worksheet provides some questions **to guide your thinking about ethnic group involvement when answering Question 4** of the INCLUDE Key Questions.

**Factors that might affect the planned reporting and dissemination of trial results**

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| --- | --- | --- |
| **What** | How, and in what way, were people from each ethnic group in the target population involved in planning the reporting and dissemination of the trial results? | Response:  There is no information available on how the planning of the reporting and dissemination of the trial results was conducted. |
| Other factors to consider: | |
| **How** | How might planned reporting and dissemination methods limit engagement with each ethnic group in the target population? | Response:  The full NIHR publication is open access, but there was limited information on how the trial results were disseminated to participants.  From the outset, it would be appropriate to consider all methods for dissemination and discuss the applicability to each ethnic group. Patient representatives as part of PPI could advise on this too. Publications would likely not be patient friendly enough even though it does include a Plain English summary. |
| Other factors to consider: | |
| **Where** | How might where trial results are planned to be reported and disseminated limit engagement of each ethnic group in the target population? | Response:  Dissemination intended for the public should always be considered, i.e., simple, lay-man language. Where possible, other languages, and literacy should be considered for each of the ethnic groups in the community and use appropriate channels too. |
| Other factors to consider: | |

Worksheet for thinking through measures to address factors that might prevent full community involvement

Use this worksheet to list key factors that might affect the involvement of some ethnic groups in the target population of your trial, along with measures to mitigate the effect of those factors and their cost. Add extra rows as needed.

Please remember that there are also differences *within* ethnic groups, especially between generations and between men and women. No ethnic group is homogenous.

|  |  |  |
| --- | --- | --- |
| **Factors that may prevent full community involvement** | **Proposed measures (several options may be needed)\*** | **Cost of measures** |
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\*See https://centreforbmehealth.org.uk/resources/toolkits/ for suggestions for how to address factors that affect community-wide involvement.

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[Centre for Black and Minority Ethnic Health](https://centreforbmehealth.org.uk/)

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[Health Research Board Trial Methodology Research](https://www.hrb-tmrn.ie/)

[Network](https://www.hrb-tmrn.ie/)

**A picture containing food, drawing

Description automatically generated**[NIHR-Medical Research Council Trial Methodology](https://www.methodologyhubs.mrc.ac.uk/about/tmrp/)

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