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# Group intervention for sexual minority adults with common mental health problems: preliminary evaluation

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## Abstract

**Background:** Stigma against lesbian, gay, bisexual or queer (LGBQ) people may increase their risk of mental illness and reduce their access to and/or benefit from evidence-based psychological treatments. Little is known about the feasibility, acceptability and effectiveness of adapted psychological interventions for sexual minority individuals in the UK.

**Aims:** To describe and evaluate a novel LGBQ Wellbeing group therapy for sexual minority adults experiencing common mental health problems, provided in a UK Improving Access to Psychological Therapies (IAPT) service.

**Method:** An eight-session LGBQ Wellbeing group intervention was developed drawing on CBT and LGBQ affirmative principles. We compare the socio-demographic and clinical characteristics of patients who completed and dropped out of the groups, and explore changes in self-reported symptoms of depression, anxiety and functional impairment.

**Results:** Over eight courses provided, 78 service-users attended at least one session, of whom 78.2% completed the intervention (drop-out rate 21.8%). Older participants were more likely to drop out. There was a lower proportion of female and bisexual or ethnic/racial minority individuals than would be expected. There were significant reductions in severity of depression, anxiety and functional impairment following the group, and more than half of those who completed the intervention needed no further treatment.

**Conclusions:** There was preliminary evidence of the feasibility of, and potential clinical benefit in, a group therapy intervention for sexual minority adults experiencing common mental health problems. Future research should investigate access and outcomes for participants with additional social disadvantage, e.g. those who are female, older, bisexual or ethnic/racial minority.

**Keywords:** cognitive behaviour therapy; group therapy; outcome; sexual minorities; sexual orientation

## Introduction

Sexual minority individuals, including those who identify as lesbian, gay, bisexual and/or queer (LGBQ), have a significantly increased risk of developing common mental health problems, such as depression and anxiety disorders, as well as deliberate self-harm and suicide attempts compared with heterosexual people (King *et al.*, 2008; Plöderl and Tremblay, 2015; Semlyen *et al.*, 2016). There is evidence that bisexual individuals experience greater risk of mental health difficulties than heterosexual, gay or lesbian populations, with the effects of biphobia and 'double

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discrimination' within heterosexual and queer communities likely to play a role (Welzer-Lang, 2008). Even in the most liberal of communities, LGBTQ people still experience significant societal oppression, discrimination and stigmatisation throughout their life course. A national survey of LGBTQ and transgender individuals commissioned by the UK government indicates that respondents were less satisfied with life compared with the general population and just under half reported feeling comfortable being LGBTQ in the UK (Government Equalities Office, 2018). Hate crimes directed at LGBTQ people are commonplace in the UK and there is evidence that these crimes are increasing (Chao-Fong, 2021).

It has been proposed that chronic exposure to stigmatising and discriminatory social environments give rise to unique stressors and stress processes that, over time, contribute to excess rates of mental health problems amongst LGBTQ communities (Hatzenbuehler, 2009; Meyer, 2003). Minority stress theory (Meyer, 2003) proposes that the impact of these unique social stressors on mental health operates at various levels: (1) a structural level (including: governmental policies, e.g. absence of pro-LGBTQ political initiatives; systemic discrimination under the law such as absence of same-sex marriage and/or same-sex parenting laws, and of hate crime laws) (e.g. Ogolsky *et al.*, 2019); (2) an interpersonal level (e.g. familial rejection, bullying, daily microaggressions) (Balsam *et al.*, 2005); and (3) an intrapersonal level (e.g. internalisation of negative sociocultural messages and representations of LGBTQ identities). Sexual minority stressors can be distal (e.g. experiences of victimisation, harassment or discrimination) and proximal (e.g. concealing one's sexual orientation, hypervigilance, internalised stigma). There is growing evidence that minority stress is an important framework for understanding the increased risk of health inequalities seen in LGBTQ people (e.g. Pitman *et al.*, 2021).

When sexual minority individuals do seek help for mental health difficulties, they can face barriers to accessing appropriate care and can perceive the care that they receive as inadequate (Elliott *et al.*, 2015). This may extend to their experiences of accessing help from Improving Access to Psychological Therapies (IAPT) services in England. IAPT services were initially set up in 2008 to increase access to evidence-based psychological interventions for adults experiencing common mental health problems, primarily mood and anxiety disorders. Foy *et al.* (2019) surveyed LGBTQ service-users who had sought help from IAPT services and found that they experienced a range of potential barriers to accessing and benefiting from talking therapy, including reluctance to disclose one's sexuality due to perceived stigma from professionals, as well as absent, insensitive or mismatched discussion of sexuality in treatment, and a general lack of understanding and awareness of LGBTQ identities and minority stressors among clinicians.

There is also objective evidence of disparities in treatment outcomes for some sexual minority adults in IAPT services. Rimes and colleagues (Rimes *et al.*, 2018; Rimes *et al.*, 2019) have found that final treatment session scores on self-report measures of depression, anxiety and functional impairment were worse in lesbian and bisexual women compared with heterosexual women accessing treatment in IAPT services, after adjusting for baseline scores and sociodemographic and treatment characteristics. Lesbian and bisexual women were also less likely to 'reliably recover' than heterosexual women. A similar finding was also reported for bisexual men in comparison with heterosexual and gay men (Rimes *et al.*, 2019).

Minority stressors therefore may affect sexual minority individuals' risk of experiencing mental health problems, but also their access to and ability to benefit from evidence-based treatments. Increasing the availability of services specific to sexual minority populations has been noted as an intervention to address these inequalities (Ash, 2013; Foy *et al.*, 2019; Rimes *et al.*, 2019). A growing body of evidence from the USA has demonstrated that cognitive behavioural therapy (CBT) interventions adapted specifically to meet the needs of sexual minority populations drawing on minority stress theory are both acceptable and effective (Pachankis *et al.*, 2015; Pachankis *et al.*, 2020; Ross *et al.*, 2007). These interventions have adopted an

explicitly LGBQ affirmative stance and in some cases also sought to address the minority stress processes (e.g. internalised stigma) thought to increase risk of mental health difficulties amongst this group. A narrative review of the literature in this area has identified key factors thought to improve therapy outcomes for sexual minority service-users, including overt therapist affirmation, normalisation and acceptance of clients' sexual minority identity and skills for navigating challenging life events, such as coming out (O'Shaughnessy and Speir, 2018).

The purpose of the current study was to describe and evaluate a novel, culturally adapted, group CBT intervention designed specifically for sexual minority adults accessing an IAPT service in South London, UK. The aims of the study were to: (1) describe and compare the socio-demographic and clinical characteristics of patients attending and dropping-out of the LGBQ Wellbeing Group, and (2) explore changes in clinical outcome measures following the LGBQ Wellbeing Group. Acceptability and feasibility were assessed through whether sufficient numbers were recruited and retained in the group. We also conducted preliminary analyses to investigate any gender differences in outcomes.

## Method

### Service setting

The LGBQ Wellbeing Group was developed and provided in Talking Therapies Southwark (TTS), an IAPT service in South London. TTS is commissioned and funded by NHS South East London Clinical Commissioning Group (CCG) and operated by the South London & Maudsley NHS Foundation Trust. TTS offers evidence-based psychological interventions for people aged 16 years and over experiencing mild to moderately severe common mental health problems, primarily mood and anxiety disorders. Like other IAPT services and in line with clinical guidance from the National Institute for Health and Care Excellence (NICE), TTS operates a 'stepped care' model; a system of delivering and monitoring treatments, so that after assessment (step 1) the most effective yet least resource-intensive treatments (e.g. group therapies, guided self-help) are provided first (step 2), and service-users are only 'stepped up' to more intensive individual face-to-face therapies (step 3) as clinically required. Research suggests that Southwark is the local authority area with the second highest sexual minority population in the UK, at around 5% of the local population (Office for National Statistics, 2017).

### The intervention

The LGBQ Wellbeing Group was initially designed for service-users who identified as lesbian, gay, bisexual, queer, or other sexual-minority orientation, and who were experiencing symptoms of depression, anxiety, and/or stress. It has subsequently been extended to include gender minority individuals too (e.g. those who identify as transgender or gender non-binary), but the current evaluation focuses on the iterations of the group when it was open to sexual minority patients only. The LGBQ Wellbeing Group was developed by two clinical psychologists (D.H. and K.R.), who hold full accreditation with the British Association of Behavioural and Cognitive Psychotherapies (BABCP). They have undertaken research in the mental health of sexual minority populations and they drew on existing theory and research findings in this area when developing the group. The group was designed as a step 2 'low-intensity' IAPT intervention and aimed to teach patients CBT skills and tools for managing low mood, anxiety and stress, whilst also addressing some of the additional 'minority stress' variables that have been identified by research as impacting the mental wellbeing of sexual minority populations (e.g. internalised stigma, discrimination, loneliness, identity concealment, rejection sensitivity, etc.). The intervention had an explicitly LGBQ affirmative stance (O'Shaughnessy and Speir, 2018) and consisted of eight weekly 90-minute sessions. Each week

focused on a specific topic/theme: (1) Introduction to CBT and the group; Mental health of sexual minority people; (2) Tackling avoidance; (3) Tackling negative and unhelpful thinking; (4) Tackling self-criticism and unhelpful ways of managing difficult emotions (being more self-compassionate); (5) Tackling over-thinking and worry; (6) Negative beliefs about the self (low self-esteem); (7) Loneliness and making connections; and (8) Developing LGBTQ confidence, resilience and pride; Relapse prevention. Each 90-minute session includes an introduction, recap on last session and homework review, presentation of the session's theme and mixture of psychoeducation, experiential exercises, group/pair discussions, and skills practice followed by summary and homework setting. Discussion of CBT methods (e.g. tackling unhelpful thinking) uses both general and LGBTQ+ specific examples. Homework tasks were set each session to consolidate learning and encourage application of skills to patients' daily lives, and these were reviewed in the following session. The intervention was a closed group, i.e. an individual begins the intervention at the start of a new course with no new attendees joining mid-course. However, if an attendee missed the first session they were permitted to join at session 2. One of the authors (D.H.) co-facilitated every course, with K.R. and other staff co-facilitating the groups over time. The data presented here relate to the first eight cycles of the LGBTQ Wellbeing Group, which took place between May 2017 and December 2019.

### **Participants**

Data from 78 service-users were analysed, all of whom attended at least one session of the LGBTQ Wellbeing Group. These individuals were initially referred to the service via self-referral or by a health professional. Following referral there was an initial telephone triage assessment completed by a clinician within the service to establish the nature of the presenting problems and to determine their suitability for the service. Where the individual met the inclusion criteria of the LGBTQ Wellbeing Group, referral to this group was offered. Inclusion criteria for the intervention were met if the service-user identified as a sexual minority (lesbian, gay, bisexual, 'queer', or other term to indicate a minority sexual orientation) and their main presenting problems were symptoms of depression, anxiety, and/or stress. Service-users who expressed an interest in the group then attended a further brief telephone assessment with one of the group's lead facilitators (D.H.), during which they were provided with further information about the intervention. Service-users who were considered suitable by the facilitator and who still wished to attend the group were booked into the next course available.

### **Measures**

Patients completed the IAPT minimum data set of self-report outcome measures at each group session they attended. This includes the following:

#### *Patient Health Questionnaire-9 (PHQ-9)*

The PHQ-9 (Kroenke *et al.*, 2001) is a self-report tool widely used in IAPT services that intends to measure severity of low mood across the past 2 weeks. It consists of nine items rated on a 4-point Likert scale (scored 0, 1, 2 or 3) as to how often in the last 2 weeks the individual has been bothered by each item. Higher scores represent greater severity of symptomatology. The PHQ-9 is responsive to treatment and has good test-retest reliability (Löwe *et al.*, 2004), with high specificity and sensitivity (Kroenke *et al.*, 2010).

#### *Generalised Anxiety Disorder-7 (GAD-7)*

The GAD-7 (Spitzer *et al.*, 2006) is also a brief self-report measure of generalised anxiety symptom severity used in IAPT settings. Like the PHQ-9 it measures symptom frequency within the

preceding 2 weeks. The GAD-7 is composed of seven items rated on a 4-point Likert scale (scored 0, 1, 2 or 3), and total scores range between 0 and 21. Higher scores indicate greater symptom severity. The GAD-7 is a valid and reliable measure of anxiety symptom severity and shows good sensitivity to change (Swinson, 2006).

#### *Work and Social Adjustment Scale (WSAS)*

The WSAS (Mundt *et al.*, 2002) measures the impact of the individual's mental health problems on their day-to-day functioning. It consists of five items assessing domains of impairment in work, home management, social leisure activities, private leisure activities, and family and relationships. These are rated on a 9-point Likert scale (scored from 0 to 8) from 'not at all' to 'very severely' impaired. Total scores range between 0 and 40, with a total score of  $\geq 10$  indicating significant overall functional impairment. The WSAS possesses high internal reliability, and sensitivity comparable to the PHQ-9 and GAD-7 (Zahra *et al.*, 2014).

#### *Sociodemographic and clinical characteristics*

Sociodemographic and clinical descriptor data were captured for the following variables from standard fields in IAPTus, the patient electronic record system: gender (male, female, not known or not specified as classified in the IAPTus system), age, sexual orientation, employment, primary problem descriptor and race/ethnicity. (Gender identity is not recorded on IAPTus and as we have broadened the group to include gender minority individuals, we now collect this information separately.) For the purposes of classification, 'employment' included any part- or full-time work, including higher education or training. Primary problem descriptor is a provisional label that service-users are assigned following their initial assessment and is equivalent to an ICD-10 (World Health Organization, 1993) diagnostic code that best matches their main presenting problem at time of assessment. For the purposes of this analysis, service-users with a primary problem descriptor of obsessive-compulsive disorder (OCD) or post-traumatic stress disorder (PTSD) were included under the 'anxiety disorders' subgroup.

#### *Referral outcomes following the group*

Next-step treatment outcomes after patients completed the group were recorded, indicating whether service-users were stepped across to another step 2 low-intensity intervention, stepped up to a step 3 high-intensity intervention, or discharged.

#### **Data analysis**

All statistical analysis was completed using IBM SPSS Statistics v26 (IBM Corporation, 2019). Socio-demographic and first and final session clinical characteristics are reported for the whole sample, and baseline characteristics compared between the 'dropped-out' and 'attended' subsamples. 'Dropped-out' was defined as attending at least one but less than four sessions of the intervention (with 'attended' therefore defined as attending four or more sessions), with the drop-out rate being used as a metric for feasibility of the group. 'Attended' and 'dropped-out' subgroup comparisons were made for socio-demographic characteristics and first session PHQ9, GAD7 and WSAS scores. Independent-samples *t*-tests were used for normally distributed data, and Mann-Whitney *U*-tests used for non-normal distributions. For categorical data, either chi-square or Fisher's exact tests were used depending on whether data met the assumptions for chi-square tests. For gender, employment and sexual orientation, a 2×2 contingency table was used (for the latter, comparing lesbian/gay and bisexual patients). A 2×2 contingency table was also used for race/ethnicity due to small sample sizes in some

cells (in one case, 0), therefore comparing patients of colour with white patients. Patients with other/undisclosed ethnicities were not included in this analysis as it could not be determined which category would best fit them. For problem descriptor, a 2×3 contingency table was used, comparing patients with problem descriptors of depression, anxiety, and ‘other’. The comparisons between attendees/drop-outs were not subject to adjustment for multiple comparisons to reduce the risk of type II errors.

Changes in depression, anxiety and functional impairment between first and final session attended were examined for those service-users who had attended four or more sessions. Wilcoxon signed rank tests and paired-samples *t*-tests were used depending on whether the data were normally distributed. A total of three statistical tests were undertaken to explore primary outcomes, with a Bonferroni correction applied in determining the statistical significance in these tests ( $\alpha=0.05/3=0.017$ ). Effect sizes were calculated using either the formula  $r=Z/\sqrt{N}$  (Rosenthal *et al.*, 1994) or Cohen’s *d* (Cohen, 1988). Effect sizes were classified according to Cohen’s recommendations (Cohen, 1988), defining  $d=0.2$  as a ‘small effect’,  $d=0.5$  as a ‘medium effect’, and  $d=0.8$  as a ‘large effect’. Group-level change in caseness was also examined using a McNemar test to compare first session–last session change in caseness.

Preliminary analyses were conducted comparing treatment outcomes for male and female patients. First/last session changes in scores in PHQ-9, GAD-7 and WSAS were compared using independent *t*-tests (all normally distributed). Reliable improvement and deterioration data were compared using a chi-square test with a 2×3 contingency table (for reliable improvement, reliable deterioration, and neither being met). These supplementary analyses were not subject to adjustment for multiple comparisons to reduce the risk of type II errors.

#### *IAPT recovery metrics*

Individual-level changes were examined using IAPT recovery metrics – recovery, reliable improvement, reliable recovery, and reliable deterioration – with caseness determined at first and last sessions attended. In an IAPT context, ‘caseness’ describes a situation in which an individual is considered to be a clinical case when reporting symptoms of anxiety and/or depression at or above a certain threshold of severity (National Collaborating Centre for Mental Health, 2018). A service-user is considered to be a *case* if their scores on either the PHQ-9, GAD-7, or both, meet the clinical cut-off; this is a score of  $\geq 10$  for the PHQ-9 and  $\geq 8$  for the GAD-7. In this evaluation, caseness was determined at initial assessment, as well as the first and final sessions attended.

Further outcomes include *recovery*, *reliable improvement/deterioration* and *reliable recovery*. Moving to *recovery* occurs when a service-user moves from caseness to non-caseness by the end of treatment; that is, if they met the clinical cut-off on *either* the PHQ-9 or GAD-7 prior to treatment and are below the clinical cut-off on *both* measures at the end of treatment (National Collaborating Centre for Mental Health, 2018). Individuals who began treatment below caseness and remain so at the end of treatment are not considered recovered. Nationally, IAPT services are expected to achieve ‘recovery’ for at least 50% of all patients who complete treatment and this is a key performance indicator for such services.

*Reliable improvement* examines the amount of change observed. It is determined by a reduction in either the PHQ-9 or GAD-7 of an amount greater than the measurement error of that scale, also known as the reliable change index, which in this case is  $\geq 6$  for the PHQ-9 and  $\geq 4$  for the GAD-7 (National Collaborating Centre for Mental Health, 2018). In addition, as well as a reduction of at least this amount in either measure, neither measure must have shown an increase in score beyond the measurement error. *Reliable deterioration* refers to an increase in at least one scale beyond the measurement error by the end of treatment, with no decrease in the other scale beyond the measurement error (National Collaborating Centre for Mental Health, 2018). Lastly, *reliable*



**Table 1.** Characteristics of total sample, attendees and patients who dropped out

	Total (n=78)	Attended (n=61)	Dropped out (n=17)	Attendee/drop-out comparison Statistical test, test statistic (p-value)
<b>Gender</b>				
Male	61 (78.2%)	45 (73.8%)	16 (94.1%)	Fisher's exact test p=0.100
Female	17 (21.8%)	16 (26.2%)	1 (5.9%)	
<b>Sexual orientation</b>				
Gay	53 (67.9%)	38 (62.3%)	15 (88.2%)	Fisher's exact test p=1.0
Lesbian	13 (16.7%)	12 (19.7%)	1 (5.9%)	
Bisexual men	4 (5.1%)	3 (4.9%)	1 (5.9%)	
Bisexual women	2 (2.6%)	2 (3.3%)	0 (0.0%)	
Uncertain/undisclosed	6 (7.7%)	6 (9.8%)	0 (0.0%)	
<b>Age (years)</b>				
Mean (SD)	35.4 (10.8)	34.0 (10.4)	40.5 (11.3)	Independent t-test t=-2.232, p=0.03
Range	21-59	21-59	21-58	
<b>Employment</b>				
Employed	55 (70.5%)	43 (70.5%)	12 (70.6%)	Chi-square test $\chi^2=0.0001$ , p=0.994
Unemployed	23 (29.5%)	18 (29.5%)	5 (29.4%)	
<b>Problem descriptor</b>				
Depressive disorders	46 (59.0%)	35 (57.4%)	11 (64.7%)	Fisher's exact test p=0.798
Anxiety disorders (inc. OCD and PTSD)	16 (20.5%)	12 (19.7%)	4 (23.5%)	
Other	14 (17.9%)	12 (19.7%)	2 (11.8%)	
Missing	2 (2.6%)	2 (3.3%)	0 (0.0%)	
<b>Race/ethnicity</b>				
White	54 (69.2%)	39 (63.9%)	15 (88.2%)	Fisher's exact test p=0.131
Black/Black British	6 (10.3%)	5 (8.2%)	1 (5.9%)	
Asian/Asian British	8 (7.7%)	8 (13.1%)	0 (0.0%)	
Mixed ethnicity	6 (7.7%)	5 (8.2%)	1 (5.9%)	
Other/undisclosed	4 (5.1%)	4 (6.6%)	0 (0.0%)	
<b>Sessions attended</b>				
Mean (SD)	5.6 (2.3)	6.7 (1.2)	1.8 (1.0)	n/a

\*For the dropped out subsample, n=8 for final session data as there were nine individuals for whom first and last session data were the same (they only attended one session).

recovery is determined by a service-user showing both recovery and reliable improvement – this indicates a substantial reduction of symptoms to a level considered insufficiently severe to be considered a clinical case (National Collaborating Centre for Mental Health, 2018).

## Results

### *Characteristics and drop-out/completion rates of patients accessing the LGBQ Wellbeing Group*

A total of 78 service-users attended at least one session, with 61 attending four or more sessions (therefore being included in the 'attended' subsample). The remaining 17 (21.8%) service-users formed the 'dropped-out' subsample. Clinical characteristics of both attended and dropped out subsamples can be found in Tables 1 and 2 below. Group attenders were mainly male, gay, white and had a depressive disorder. Those who dropped out were significantly older than those who did not.

As can be seen in Table 2, no significant differences were found between attendees and drop-outs in depression, anxiety or functional impairment scores at first session attended, or in the number of patients demonstrating caseness. Comparisons were not made between subsamples for final session scores due to only eight drop-outs having attended more than one session, but are presented here for reference.

**Table 2.** Depression, anxiety and functional impairment at first and final session for ‘attended’ and ‘dropped-out’ subsamples

	Attendees ( <i>n</i> =61) Mean ( <i>SD</i> )	Drop-outs ( <i>n</i> =17 for session 1, <i>n</i> =8 for final session) Mean ( <i>SD</i> )	Test statistic ( <i>p</i> -value)
<b>Depression<sup>1</sup></b>			
First session	11.5 (6.1)	13.5 (6.1)	-1.191 ( <i>p</i> =0.238)
Final session	8.2 (5.5)	11.1 (5.5)	<i>n/a</i>
<b>Anxiety<sup>2</sup></b>			
First session	9.7 (5.3)	11.9 (5.2)	-1.529 ( <i>p</i> =0.130)
Final session	7.5 (5.7)	11.9 (5.4)	<i>n/a</i>
<b>Functional impairment<sup>3</sup></b>			
First session	18.0 (7.3)	21.2 (9.7)	-1.519 ( <i>p</i> =0.133)
Final session	15.0 (8.4)	20.6 (7.1)	<i>n/a</i>
<b>Caseness</b>			
First session	43 (70.5%)	13 (76.5%)	Fisher’s exact test*
Final session	34 (55.7%)	6 (75%)	<i>p</i> =0.7656

<sup>1</sup>PHQ-9; <sup>2</sup>GAD-7; <sup>3</sup>WSAS. For the dropped out sub-sample, *n*=8 for final session data as there were nine individuals for whom first and last session data were the same (they only attended one session). \*Fisher’s exact test was used to compare proportion of patients showing caseness between subgroups.

**Table 3.** Changes in depression, anxiety and functional impairment following LGBQ Wellbeing Group

	First session Mean ( <i>SD</i> )	Final session Mean ( <i>SD</i> )	Test statistic ( <i>p</i> -value)	Effect size
<b>Depression<sup>1</sup> (<i>n</i>=61)</b>	11.5 (6.1)	8.2 (5.5)	<i>z</i> =-4.217 ( <i>p</i> <0.0005)	<i>r</i> =0.54
<b>Anxiety<sup>2</sup> (<i>n</i>=61)</b>	9.7 (5.3)	7.5 (5.7)	<i>z</i> =-3.114 ( <i>p</i> =0.002)	<i>r</i> =0.40
<b>Functional impairment<sup>3</sup> (<i>n</i>=59)</b>	18.0 (7.3)	15.0 (8.4)	<i>t</i> =3.325 ( <i>p</i> =0.002)	<i>d</i> =0.43

<sup>1</sup>PHQ-9; <sup>2</sup>GAD-7; <sup>3</sup>WSAS.

**Table 4.** IAPT recovery metrics (attended subsample only)

<b>All attendees (<i>n</i>=61)</b>	First session/last session data	
	%	( <i>N</i> /total eligible)
Reliable improvement	46	(28/61)
Reliable deterioration	13	(8/61)
<b>For those meeting caseness at session 1 (<i>n</i>=43)</b>		
Moved to recovery	33	(14/43)
Reliable recovery	30	(13/43)

**Changes in clinical outcome measures following the LGBQ Wellbeing Group**

There were significant reductions in depressive symptoms, anxiety symptoms and functional impairment, with a medium effect size for depression and small effect size for anxiety and impairment; see Table 3.

Summary statistics of IAPT recovery metrics can be found in Table 4. Almost half of those who attended achieved reliable improvement by the end of the group, while 13% showed a reliable deterioration. Of the 43 service-users who met caseness criteria at the first session, one-third moved to recovery and almost one-third achieved reliable recovery. The number of service-users meeting caseness changed from 43 to 34 by the final session, with a McNemar test finding this change in caseness to be non-significant (*n*=61, *p*>0.05). Five service-users who did not meet caseness at first session did meet caseness by the last session.



**Table 5.** Changes in depression, anxiety and functional impairment in male and female patients

	Men Mean (SD)	Women Mean (SD)	First/last session change comparison Test statistic ( <i>p</i> -value)
<b>Depression<sup>1</sup></b>			
First session	11.8 (6.2)	10.6 (6.0)	<i>t</i> =0.205 ( <i>p</i> =0.838)
Last session	8.4 (6.0)	7.6 (4.0)	
<b>Anxiety<sup>2</sup></b>			
First session	9.8 (5.2)	9.6 (5.5)	<i>t</i> =0.064 ( <i>p</i> =0.949)
Last session	7.6 (6.1)	7.4 (4.6)	
<b>Functional impairment<sup>3</sup></b>			
First session	18.8 (6.8)	15.8 (8.3)	<i>t</i> =0.739 ( <i>p</i> =0.463)
Last session	15.5 (8.5)	13.8 (8.1)	
<b>Caseness</b>			
First session	32 (71.1%)	11 (68.8%)	
Last session	25 (55.6%)	9 (56.3%)	

<sup>1</sup>PHQ-9; <sup>2</sup>GAD-7; <sup>3</sup>WSAS.

### Referral outcomes following the group

Of the 61 patients who completed the intervention, 32 were discharged following the intervention (52.5%), 21 were 'stepped up' for more intensive step 3 interventions (34.4%), and eight were 'stepped across' to another step 2 low-intensity intervention (13.1%).

### Gender differences in treatment outcomes

Treatment outcomes for 16 female and 45 male attenders are shown in Table 5. There were no significant differences in pre–post changes for depression, anxiety or functional impairment. For the men, 23 (51%) showed reliable improvement, six (13%) showed reliable deterioration and 16 (36%) showed neither. Of the women, five (31%) showed reliable improvement, two (13%) showed reliable deterioration and nine (56%) showed neither. A chi-square test comparing these outcomes showed no significant difference ( $\chi^2=2.25$ ,  $p=0.324$ ). Recovery rates were not compared as there were only 11 female patients who met caseness criteria at pre-treatment.

## Discussion

To our knowledge, Talking Therapies Southwark was the first IAPT service in England to have developed and offered an LGBQ-specific intervention, based on evidence-based CBT principles. Since its initial cycle in 2017, the group has been expanded to include trans and non-binary service-users, but this paper reports outcomes for the initial groups that were for sexual minority patients only. The characteristics of attendees and drop-outs as well as changes in clinical outcome indices are discussed below.

### Demographic composition of the group

A key finding regarding participant characteristics was the predominance of males (78%) in those who attended at least one session. Previous research in IAPT services in the same NHS Trust found that 4.1% of patients were sexual minority women (1.7% lesbian, 2.1% bisexual) and 6.7% were sexual minority men (6.0% gay, 0.7% bisexual) (Rimes *et al.*, 2018). A national IAPT study also found higher proportions of sexual minority men relative to sexual minority women accessing services, although lower proportions of sexual minority patients overall (1.5% lesbian, 1.2% bisexual women, 3.7% gay men, 0.8% bisexual men) (Rimes *et al.*, 2019). This is consistent with Office for National Statistics data indicating that higher proportions of sexual minority individuals live in the South London boroughs covered by our NHS Trust

compared with national rates (Office for National Statistics, 2017). Therefore, a greater number of male attendees to this group would be expected but not to such an extent as occurs.

It is possible that female sexual minority individuals were less likely to be offered the group by clinicians conducting their initial triage assessments. Female patients may also be less likely to choose the group when offered. It is possible that some female service-users may fear the group would be male-dominated or otherwise privilege a masculine perspective. Misogyny within the LGBTQ community, particularly from gay men, is a known problem (Hale and Ojeda, 2018). Although the group was co-facilitated by both a male and female therapist where possible, sometimes it was led by two male therapists and the contact person is male. We are currently investigating reasons for the gender difference in group uptake through a qualitative survey.

A lower-than-expected proportion of bisexual service-users was also observed in the groups (about 10:1), in relation to both the IAPT figures above and the ratio of gay and lesbian to bisexual individuals in the UK is roughly 2:1 (Office for National Statistics, 2020). Fewer bisexual individuals are accessing the service overall, but they may also be more reluctant to report their bisexual identity to assessors, or they may be less likely to either have this group offered to them or attend the group when offered, especially if they are currently in an opposite-sex relationship. Reluctance to disclose their bisexuality or take up the group when offered may be due to previous negative experiences and fears of biphobia and discrimination both from clinicians and other sexual minority groups (Welzer-Lang, 2008). Reasons for the low proportion of bisexual attendees requires further investigation.

National data indicates that in 2019–2020, 38.3% of patients beginning IAPT treatment had depression as the primary problem descriptor compared with 42.3% with anxiety and stress-related disorders (NHS Digital, 2020). This pattern is similar when looking at the Southwark CCG dataset, for both 2019–2020 and 2017–2018 when the intervention began (NHS Digital, 2018; NHS Digital, 2020). In contrast, 59.0% of service-users starting our group had depression as a primary problem descriptor compared with 11.5% with anxiety. One possible reason for this may be that of the low-intensity step 2 treatments available, individuals with anxiety as a primary problem are less likely to choose a group treatment (e.g. in the context of social anxiety a group therapy is unlikely to be chosen by a service-user). Individuals with a specific anxiety problem (e.g. panic disorder) may also consider the general focus of this CBT group to be less appropriate.

Comparing our group's ethnic/racial composition with local population estimates (Southwark Joint Strategic Needs Assessment, 2018), the proportion of racial/ethnic minority patients were lower than expected. Around 25% of the population of Southwark are Black/Black British (compared with 10.3% of service-users in our group) and 11% of the local population are Asian/Asian British (compared with 7.7% of service-users completing the group). A smaller proportion of racial/ethnic minority people in the UK report a minority sexual orientation compared with White British people (Office for National Statistics, 2019). However, this cannot fully account for the discrepancy. It is possible that this group of patients are less likely to be offered the group than White service-users, or that they are equally likely to be offered the group but more likely to turn it down, e.g. because they believe it will not meet their needs or the expectation that they will experience racism within the group. However, another internal audit previously identified that ethnic/racial minority patients who also report a sexual minority identity may be attending the whole service at lower-than-expected rates. Sexual and racial/ethnic minority identities intersect with each other to confer a multiplied risk of experiencing oppression, stigma and prejudice. It is possible that ethnic/racial minority patients who also identify as LGBTQ may be less likely to attend our service and if they do, they may be less likely to disclose their sexual orientation for various reasons (e.g. previous prejudice/discrimination in health services). If their minority sexual orientation is not known, this means that they will not be offered the group. It is important that the

relative lack of racial/ethnic minority patients in our group is investigated further, and increased efforts are made to make the group more accessible for them.

### **Attendance and drop-out**

The intervention was feasible and acceptable in the sense that we were able to recruit and retain a sufficient number of attendees. However, 21.8% of those who started the group attended fewer than four sessions. This is comparable to findings from a meta-analysis of CBT clinical trials which found that the average drop-out rate for group CBT was 24.6% (Fernandez *et al.*, 2015). While there are no data available specific to drop-out rates for sexual minority individuals in low-intensity IAPT treatments, national IAPT data indicate that across low and high intensity treatments combined, 50.1% of sexual minority patients finished their course of treatment – an effective drop-out rate of 49.9% (NHS Digital, 2020). Even using the strictest measure of completing treatment (attending the final session of the group) gives our LGBQ Wellbeing Group a drop-out rate of 39.7%, substantially lower than the average found in the national data. One possible factor contributing to the relatively low drop-out rate observed in our group is the LGBQ affirmative social support that the group can provide. Minority stress theory (Meyer, 2003) posits that group solidarity and cohesiveness amongst sexual minority individuals can promote coping with, and ameliorate the deleterious effects of, minority stress. Indeed, our previous qualitative analysis of feedback from patients who attended our group supports this idea, in that group members reported finding it both normalising and validating to hear other LGBQ people sharing similar experiences and to have a unique and safe space to talk openly about the impact of minority stress on their lives (Lloyd *et al.*, 2021).

Analyses comparing the attended and dropped-out subsamples' composition regarding socio-demographic characteristics found only one significant difference between the groups – those who dropped out were older. It will be important to explore this finding as older LGBQ people are at even greater risk of discrimination and mental health problems (Fredriksen-Goldsen *et al.*, 2017). Further investigation is also needed with a larger sample size, including more investigation of the trend for higher pre-treatment symptoms in the patients who dropped out.

### **Clinical outcomes**

Significant reductions were observed in measures of depression, anxiety and functional impairment for patients who attended at least four sessions. National cohort data for pre-/post-treatment outcome measure scores in IAPT services combines low and high intensity treatments for the sexual minority population (Rimes *et al.*, 2019), preventing meaningful comparison with the present data. Similarly, the conflation of low and high intensity treatments in National IAPT recovery data, and their use of triage assessment data rather than first treatment session data prevents meaningful comparison. The present study used first attended group session data to calculate the IAPT recovery metrics to maximise the likelihood that change in outcome measures was associated with the intervention itself.

The deterioration rate (13%) in the present study is greater than the 5.9 and 6.8% reliable deterioration national rates reported for 'homosexual' and bisexual service-users, respectively (NHS Digital, 2020). However, direct comparison is not appropriate as the national data do not include people who deteriorated after a low-intensity intervention but who subsequently showed improvement after additional low or high intensity treatment. While 53% of participants were discharged straight after the group, over 45% remained in the service and received further treatment, as would be expected after a step 2 intervention.

Although the preliminary analyses comparing outcomes for males and female service-users did not find significant differences, further analyses are needed with a larger sample size given that

men showed almost double the reduction in functional impairment scores and 51% of males recovered following the group compared with 31% of female patients.

### **Implications**

The numbers attending and retention figures indicate that the LGBTQ Wellbeing group appears to be a feasible and acceptable treatment. This is consistent with qualitative feedback about its acceptability from those who have attended our group, which indicated that it is perceived to be an affirmative, safe and helpful space to learn about CBT (Lloyd *et al.*, 2021). There is a need to further investigate why female, bisexual and ethnic/racial minority people were less likely to attend to the group, why older patients are more likely to drop out, and whether there are gender differences in treatment outcomes for attendees. Targeted action is required to try to increase access and treatment experience for patients from these subgroups.

### **Limitations**

This was an uncontrolled service evaluation project without random allocation to a control group, and so it is not possible to conclude that the intervention caused the observed outcomes. Similarly, the lack of follow-up means the durability of potential benefits from the group are not yet known. Another limitation of this evaluation is the relatively small sample size for the subgroup comparisons, which restricts the power of statistical analyses to detect changes or differences. The generalisability of the findings to other settings is also not known. For example, there is evidence that the mental health of sexual minority individuals in London may be relatively worse compared with those who identify as heterosexual and sexual minority populations in other parts of England (Woodhead *et al.*, 2016). A further limitation relates to the way in which gender was coded. The data presented relates to the gender that is recorded on patients' electronic health records. The way in which gender, sex and gender identity are categorised and recorded on health records is a matter of ongoing debate and contention. As the group has now broadened from sexual minority individuals to include gender minority people, we now ask about participants' gender identity but there is currently no field for gender identity in the patient records.

### **Considerations for future development**

Given that older patients were more likely to drop out of the group, and that females, bisexual people, and ethnic minority patients were less likely to attend the group, we need to find ways to increase uptake and ensure retention for these subgroups of service-users. Alternatively, it may be helpful to develop, deliver and evaluate separate group interventions that cater specifically for these subgroups, although this would probably need to be provided across multiple IAPT services given the smaller numbers of suitable participants. It may also be helpful for future iterations of the group to draw on existing evidence-based psychological interventions designed to ameliorate self-stigma, e.g. in the context of HIV (e.g. Tshabalala and Visser, 2011; Yang *et al.*, 2018).

### **Conclusions**

This evaluation has demonstrated that an innovative group CBT intervention designed specifically for sexual minority service-users shows good promise, being completed by most of those who began the intervention and associated with improvements in clinical outcomes. Further work is needed to understand why some service-user groups (e.g. females, bisexuals, racial/ethnic minorities) were less likely to attend the group and whether outcomes differ between

attendees with different sociodemographic characteristics. It is important to note that while group and individual therapies aimed at helping sexual minority individuals cope with living in an unjust and discriminatory world are necessary, much further work is required to challenge the oppressive and prejudicial systemic forces that lead to minority stress. We believe that it is as important to champion policy changes, inclusive practices, and larger systemic changes towards the acceptance of sexual and gender minority people.

**Data availability statement.** The data referred to in this manuscript are not publicly available as it relates to clinical care provided in an NHS setting and is therefore highly confidential.

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